

COVID-19 AND THE ROHINGYA REFUGEES IN BANGLADESH: SOCIOECONOMIC AND HEALTH IMPACTS ON WOMEN AND ADOLESCENTS

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ABSTRACT

COVID-19 has exacerbated the existing crisis that the vulnerable refugee population faces. More than a million Rohingya refugees live in Bangladesh. COVID-19 has affected both males and females. It is critical to understand how this population group is coping during this trying period. They are constituted by 52% women and 55% adolescents. The socioeconomic and physiological repercussions of the pandemic on the Rohingya people are contextualised in this study. The socioeconomic and health impacts of COVID-19 on Rohingya women and adolescents in Bangladesh are investigated. Because of the restrictions imposed, over 63% of Rohingya adolescent females suffered from food scarcity. The vast majority of respondents (87%) stated that they had reduced their meal frequency, resulting in a protein deficiency. Since their arrival in Bangladesh, they have had limited access to medical and educational facilities. The pandemic has further exacerbated the situation. Girls are more vulnerable to sexual and gender-based abuse, early marriage, school dropout, and pregnancy. This research aims to add to existing knowledge on refugees, Rohingya, women, and adolescents.

Keywords: COVID-19, Rohingya, women and adolescents, socioeconomic impacts, health impacts, Bangladesh

INTRODUCTION

The COVID-19 pandemic has ravaged the entire world in many ways. This global crisis has been exacerbating the pre-existing systemic disparity worldwide, deepening the society's inequality and vulnerability. With its increased transmissibility, along with many countries, Bangladesh has become one of the most affected countries in the world in terms of the total case count of COVID-19 and its death rate (Islam et al. 2020). Among other disadvantaged populations, the migrant, refugees, and displaced people are one of the worst victims of the pandemic (Ullah et al. 2021; Kumar and Pinky 2020; Kumar et al. 2021). Bangladesh hosts the largest refugees (more than a million Rohingyas) in Cox's Bazar (Ullah 2016). Rohingya populations are already in dire condition, and COVID-19 has heightened their existing health risks (Ebbighausen 2020; Hoque 2020). The Rohingya are accommodated in the "mega-camp" in temporary tarpaulin and bamboo shelters made from readily available materials. The camp, which has expanded to become a city, is in the epicentre of the situation. Maintaining this camp is like managing a city but with very little money. Owing to the camps' proximity, social distancing is something entirely

unrealistic for them (Chattoraj et al. 2021). When it comes to the pandemic and any natural catastrophe, gender implications become obvious, which means that women and adolescents become the worst sufferers (Reliefweb 2020a).

The latest Rohingya refugee migration into Bangladesh drew global attention. The Rohingya refugee crisis in Bangladesh is a long-term refugee crisis with no realistic solution in sight. After arriving in Bangladesh, most Rohingyas' socioeconomic standing declined (Ullah et al. 2021) as they had to leave everything behind to save their life. The pandemic has disproportionately affected the people forcibly displaced hosted in low- and middle-income countries. Rohingyas in Bangladesh are no exception. More than a million Rohingyas are housed in two registered and 32 unregistered camps (Guglielmi et al. 2020a; Ullah and Chattoraj 2018). Of the total Rohingyas, the majority (52%) are women and girls (Reliefweb 2019).

The condition of Rohingya refugees prior to COVID-19 was no better. They were deprived of basic necessities such as food, access to school, freshwater, sanitation, and healthcare (Ullah et al. 2020; Banik et al. 2020). In the wake of the pandemic, the government-imposed lockdown has pushed them to the brink of socioeconomic collapse, as indicated by the deteriorating law and order situation in the camps (Alam et al. 2020; Barua and Karia 2020). Refugees around the world are at a higher risk of catching COVID-19 than the general population since their living conditions in camps promote the spread of this virus (Shishir 2020).

Women, particularly those of reproductive age and adolescents, face challenges as their access to sexual and reproductive healthcare is compromised due to the government's restrictions on movement. Due to a lack of pure drinking water, hygiene, and sanitation, there is also a considerable risk of developing a twin pandemic of other infectious diseases, such as diarrhoea, tuberculosis, or dengue fever with COVID-19 among refugee camp occupants (Islam et al. 2020; Tahir et al. 2021). Adolescent refugees are at a higher risk of developing psychological issues (anxiety and post-traumatic stress) because of their distinctive developmental period (Bean et al. 2007; Geltman et al. 2005) because they are more prone to internalising issues and post-traumatic symptoms than boys (Derluyn and Broekaert 2007).

Some studies were carried out in the setting of Rohingya refugees; however, no detailed structured study of the socioeconomic and health implications of COVID-19, particularly on Rohingya women and adolescents, was performed. As a result, there is a scarcity of information on

the socioeconomic and health impact of COVID-19 on Rohingya refugees, particularly women and adolescents. As a result, the purpose of this paper is to examine the socioeconomic and health impacts of COVID-19 among Rohingya women and adolescent refugees in Bangladesh. The women (15–65 years old) and adolescents (age of 10–19 years for both males and females) are the focus of this study. This study is primarily concerned with filling that void. In order to achieve this goal, this study addresses several aspects of refugees' socioeconomic and health problems, which are studied critically using literature such as recently published papers, reports, or pertinent writings gathered from various journals, books, websites, and so on. Secondary data were gathered from these sources, processed using descriptive statistics, and presented in tabular and graphical forms.

COVID-19 AND REFUGEES: SOCIOECONOMIC AND HEALTH

Socioeconomic Status (SES) has been extensively researched in relation to refugees and women. SES and human well-being are inextricably linked. This is significant in the case of the Rohingyas. The SES of a community is often determined by education, income, occupation, or a combination of these criteria (Winkleby et al. 1992). Low SES, as assessed by education, occupation, or income, has been associated with a lower level of happiness (Ullah 2007). Studies conducted on refugees in Rwanda, Lebanon, and Uganda have portrayed the deleterious effect of COVID-19 as extreme hunger, starvation, malnutrition, increased disease severity with limited healthcare facilities and increased gender-based violence (GBV) that disrupts the psychological well-being leading to stress and anxiety as well as other mental health disorders (Riley et al. 2020; Logie et al. 2021; Fouad et al. 2021; Hajjar and Abu-Sittah 2021; Manirambona et al. 2021). In line with the above, this article focuses on social impacts (GBV, child marriage, and human trafficking), economic impacts (food security, employment, and income stability) and health impacts (physical, mental, and sexual and reproductive health) on the Rohingya women and adolescent refugees in Bangladesh.

It is now more important than ever to investigate the connections between SES, COVID-19, and refugees. There have been several recent studies on this topic. For example, Dempster et al. (2020) studied the effects of COVID-19 on refugee accommodation and food facilities, livelihood, social safety nets, aid, employment, and xenophobia in eight countries.

According to Dempster et al. (2020), the loss of livelihoods and poverty among refugees has worsened as a result of this circumstance. In addition, access to aid and social safety nets has declined, while unemployment and xenophobia have increased. Bukuluki et al. (2020) investigated the pandemic's socio-cultural, economic, and psychosocial effects on Ugandan urban refugees. They observed that the lockdown had a detrimental impact on refugees' livelihoods and exacerbated income insecurity, sexual and gender-based violence (SGBV), and anxiety. Ayine et al. (2017) and UN Volunteers (2020), among others, investigated the socioeconomic impacts of refugees and discovered similar results.

In assessing health condition of a person, physical health, mental health, and sexual and reproductive health are considered (Jean and Miks 2020). The evidence derives from a range of sources, including health-related research and organisational reports that provided quantitative and qualitative details on both primary and secondary data. This study depicts that malnutrition, disease severity, chances of dual pandemics and limited healthcare facilities can reflect the physical condition while stress, anxiety, treatment incompliance, discontinuation will hamper their mental health.

RESULTS AND DISCUSSION

Socioeconomic Impacts

A number of previous epidemics have demonstrated that the most vulnerable members of society are more vulnerable to disease transmission and economic and social recovery efforts after the sickness has peaked (Guglielmi et al. 2020a). This guideline applies to the lives of persons who have been displaced, particularly refugees. The epidemic has exacerbated pre-existing vulnerabilities such as poverty, age, gender, marital status, and handicap (Lau et al. 2020).

According to the Inter-Sector Coordination Group (ISCG), gender norms and roles have remained mostly unchanged over the pandemic, with men still in control of making choices and generating money. COVID-19, which has raised social stigma and GBV in all forms, may have a negative impact on how women and girls deal with the restricted social norms that govern their lives (ISCG 2020). The ISCG also revealed that despite having COVID-19-like symptoms, 55% of Rohingya women needed permission from their husbands to purchase essential commodities such as soap and

masks, and 61% needed permission from their husbands to access critical healthcare services such as sexual, reproductive, and maternal health, including isolation and treatment centres (ISCG 2020). GBV and domestic abuse, violence against female sex workers, child marriage, human trafficking as well as polygamy have also been increased dramatically as a result of restricted access to support centres and a decrease in the presence of camp authorities (Jean and Miks 2020; ISCG 2020; Information Management and Mine Action Programs [iMMAP] 2021).

This problem has worsened during the COVID-19 pandemic because all training courses (on how to handle and limit GBV) offered by various international non-governmental organisations (INGOs) have been discontinued as a result of the subsequent lockdowns. Though the INGOs established hotline numbers to assist them, it was ineffective because the Rohingyas are not permitted to use local phone/SIM cards. Because of their financial reliance on abusive spouses, some survivors dropped their accusations. The pandemic has had a disastrous influence on refugee girls' education (Clayton 2020). Many girls have been forced to drop out of school and labour, or have been sold or married off due to lockdown (ISCG 2020; Jesuit Refugee Service [JRS] 2021; Centre of Competence on Humanitarian Negotiation [CCHN] 2020; United Nations High Commissioner for Refugees [UNHCR] 2021; Assessment Capacities Project [ACAPS] 2020; Plan International 2020). Reports of forced (often early) marriage and human trafficking are also on the rise. Parents are using negative coping techniques as an alternate choice because they are concerned about the safety and security of the girls in the camps. Adolescent girls and women are frequently sent to Malaysia for marriage by desperate and impoverished families (ACAPS 2020).

According to the Joint Multi-sector Needs Assessment of the UNHCR, just 34% of females aged 12 to 14 years old attended Temporary Learning Centres; nevertheless, attendance declined by 2%. It is found that the longer the girls are absent from school, the more vulnerable they are to SGBV, early marriage, and early pregnancy (ACAPS 2020). Unpaid childcare and domestic responsibilities consume two to 10 times as much time for women as they do for men. Cleaning, cooking, fetching water and caring for children, the elderly or ailing relatives were all unpaid care responsibilities that fell primarily on the shoulders of women and girls. Girls are more likely than boys to struggle with allocating time to home-schooling (Figure 1), resulting in girls dropping out of school (ISCG 2020; UNHCR 2021).

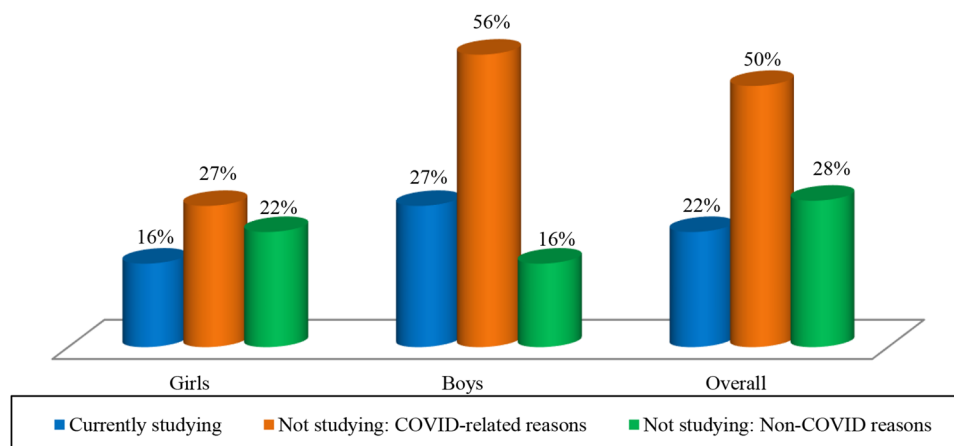


Figure 1: Education continuity and gender gaps in refugee community.
Source: ISCG (2020).

Menstrual taboo is found as one of the major social issues in the refugee camps. Because of this taboo, women and girls found it more difficult to wash and clean their menstrual garments due to material distribution delays, resulting in an increased risk of infection (ISCG 2020). Due to financial difficulties, refugees were unable to build sanitary latrines for their own families. Rather, they had to use common latrines. Almost 38% of women reported that access to latrines and bathing facilities deteriorated amid the lockdown. The privacy of women and adolescent girls has been compromised due to overcrowding in the camps. Because there is limited lighting and security at night, there is an increased risk of harassment, violence and other social problems (ISCG 2020; iMMAP 2021).

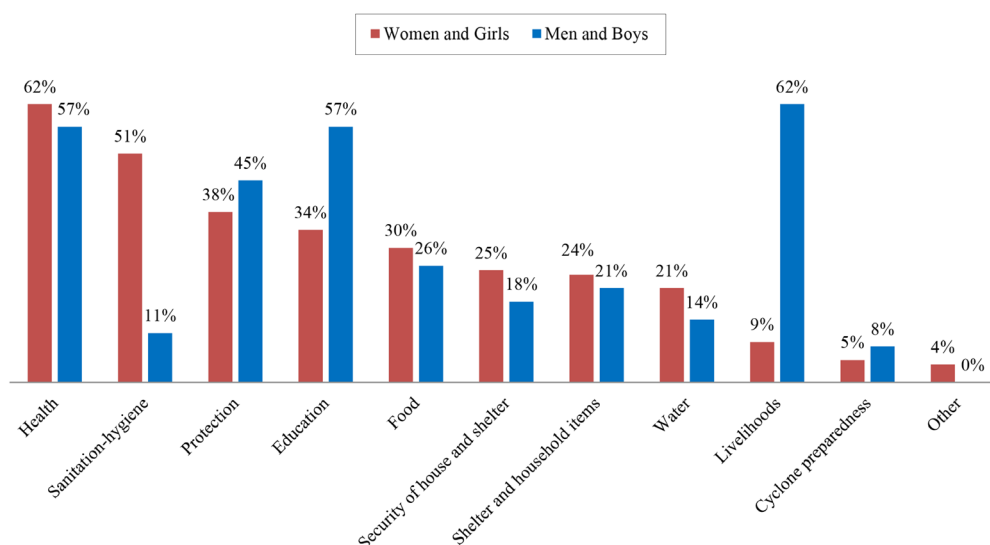


Figure 2: Priority needs or concerns for Rohingya community.
Source: ISCG (2020).

According to Sanchez (2020), 318,500 Rohingya refugees are women and girls of reproductive age who require family planning. An additional 31,200 pregnant women will seek prenatal and safe delivery services. However, these women and girls are in a vulnerable position due to financial restraints and a lack of resources (ISCG 2020; Sanchez 2020). Food insecurity is one of the most serious and unpleasant outcomes of COVID-19 on girls. According to Rahman (2020), COVID-19 restrictions caused 63% of Rohingya females to be hungry, and 87% of Rohingya teenage responders, including 92% of females, reported cutting back on protein-rich meals (Figure 2). “Because we don’t have any money, we can’t buy raw food like vegetables, seafood, or meat; thus, we are unable to eat fresh food” a 15-year-old girl explained (Guglielmi et al. 2020a).

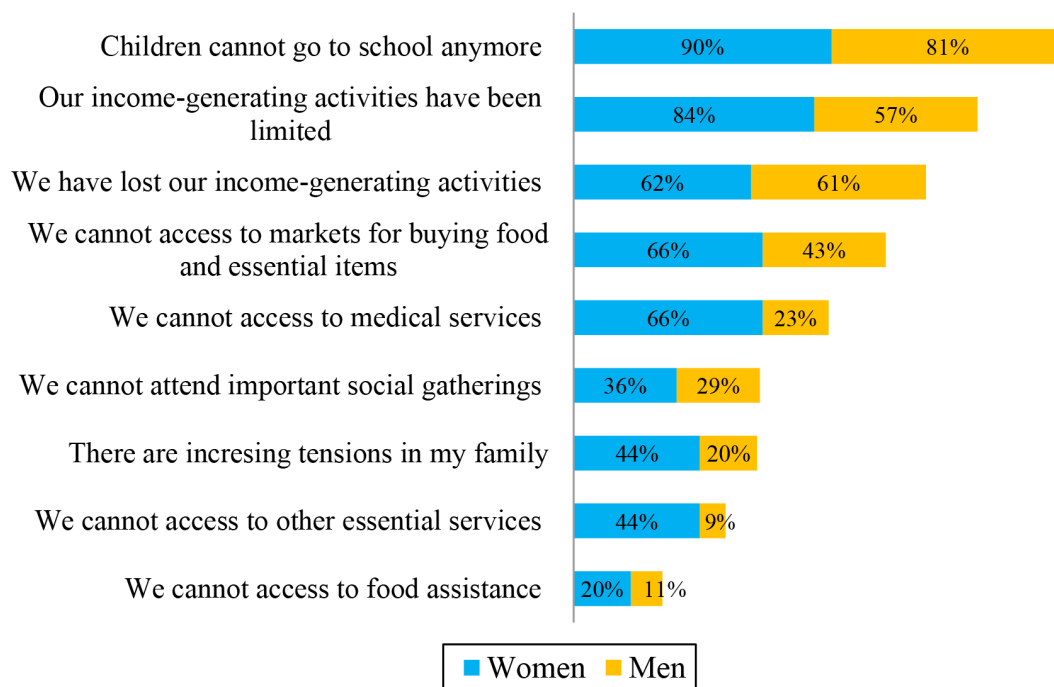


Figure 3: Effects of lockdown on Rohingya refugees.
Source: ISCG (2020).

The government has strict employment restrictions in place that govern how many individuals can participate in cash-for-work programmes in Rohingya camps at any given time. There are no traditional labour markets, such as those found in host communities, where controlled self-sufficiency and livelihood activities are carried out (World Bank 2020). A small fraction of the Rohingya is self-employed and earns a fixed wage, or they are enrolled in humanitarian aid programmes that pay for technical life-skills training, small companies, or street hawking.

Women who predominantly work in the informal economy have been hurt the worst. COVID-19 confinement limitations are said to have limited the income of 36% of Rohingya women (ISCG, 2020). According to the “Refugee Influx Emergency Vulnerability Assessment” (REVA 4) findings, Rohingya refugees sold valuables such as jewellery at a 4% greater rate than the prior year (iMMAP 2021). According to CARE International, single female-headed households are unable to meet their basic needs due to a lack of income and interruptions in the distribution of non-food entitlements (iMMAP 2021) (see Figure 3).

JRS and Caritas Bangladesh built the Multi-purpose Child and Adolescent Centre (MCAC), which trains and develops women leaders. H, a female Rohingya leader, created and distributed reusable face masks around the community. She created a programme at the MCAC and trained adolescent girls in vocational programmes. The children were given hundreds of face masks. She even provided free facemask stitching sessions to Rohingya women and children who were not involved in the MCAC initiative. Paid volunteering at the MCAC gave the leader (H) financial security, allowing her to purchase her own sewing machine to meet the needs of her family while also serving her community (JRS 2021). Frontline Negotiations also continued tailoring and sewing sessions while maintaining physical distance. Trained women and adolescent girls were able to continue their education while sewing masks for their towns and families (CCHN 2020). Over 2.8 million reusable facemasks were distributed in all 34 Rohingya camps by the humanitarian partners and each person over five years received two masks. This mask distribution not only protected refugees from the spread of coronavirus but also helped more than 2,480 tailors of the refugee and host community to earn their livelihood (Reliefweb 2020b).

Health Impacts

The COVID-19 pandemic has significantly impacted global population health, particularly among vulnerable groups like refugees (Elisabeth et al. 2020; Brito 2020; Brickhill-Atkinson and Hauck 2021). The Rohingya refugees have endured a negative impact due to a variety of factors. Because a significant proportion of migrants are female and teenagers, their health is a critical concern that must be addressed. The Rohingya women and children are already in peril due to their separation from their house-heads (husbands or fathers) (Tay et al. 2018), and the COVID-19 has exacerbated

their position. The health impacts of COVID-19 on Rohingya refugee women and adolescents are investigated in three broad contexts in this section: physical health, sexual and reproductive health, and mental health, as well as the variables they value.

Because the Rohingya women and children live in overcrowded conditions in makeshift shelters with inadequate sanitation, the camps are a breeding ground for COVID-19 epidemics (Banerjee 2019). Since the state-wide lockdown began, resources have been scarce from the government and outside entities, causing healthcare delivery to be hampered. This will have a direct impact on the disastrous outcome of COVID-19 as well as the clinical suffering of other disorders. Adult women with chronic illnesses such as chronic liver disease (CLD) and chronic kidney disease (CKD) suffer considerably since diagnostic and therapeutic interventions are not readily available in their rural communities.

According to previous surveys conducted before the age of the COVID-19, infectious diseases (57.1%) and waterborne and vector-borne ailments were the most common among Rohingya youngsters (Islam et al. 2019; Riley et al. 2020; Tahir et al. 2021). The national lockdown resulted in a significant decrease in routine vaccination and Expanded Programme on Immunization (EPI) coverage across the camps. As a result of the suspension of the outreach effort, EPI vaccine coverage in Ukhiya and Teknaf has dropped to 6% or less (ACAPS 2020). According to the World Health Organization (WHO), the current low level of immunisation coverage could result in a vaccine-preventable disease (VPD) outbreak (WHO 2021). The pandemic's influence on pre-existing medical concerns is almost certain to worsen now. Because of their filthy living conditions and scarcity of supplies, the children are on the verge of a twin pandemic with diarrheal ailments, tuberculosis, and dengue fever. According to a December 2017 WHO situation assessment, a diphtheria outbreak has already killed 27 Rohingya minors (WHO 2017). Food insecurity was also mentioned in the Cox's Bazar Panel Survey interviews as a result of reduced rations and lower household income (Guglielmi et al. 2020a).

Furthermore, girls are 63% more likely than boys to go hungry. According to UNICEF mass screening data, moderate acute malnutrition and children at risk among Rohingya children increased from 6.8% and 5.4%, respectively, to 7.9% and 11.1% (UNICEF 2020). Malnutrition is expected to rise in the long run as a result of the food crisis. Therefore, the number of infectious diseases affecting children and adolescents would be at an all-time high (Guglielmi et al. 2020b).

Non-communicable diseases, on the other hand, such as diabetes and hypertension, are claimed to be particularly widespread in the Rohingya population, owing to high-risk factors such as smoking, smokeless tobacco, indoor air pollution, and so on (Harvard FXB and BRAC 2018; WHO-SEAR 2018). The situation is likely to worsen in the aftermath of the epidemic. Mistry et al. (2021) looked into the challenges that elderly Rohingya people had in accessing medicines and standard medical care during the COVID-19 pandemic in Bangladesh. They found that approximately one-third of participants had difficulty obtaining medicine or standard medical care.

After the first pandemic lockdown, certain studies discovered that the Rohingya population had fewer child marriages but are predicted to rise over time (Guglielmi et al. 2020b). According to a focus group discussion with Rohingya volunteers hosted by Centre for Peace and Justice (CPJ) and BRAC University, the prevalence of underage marriage has increased as a result of the camp administrators' diminished presence (Olney et al. 2019; ISCG 2020). A United Nations-led study has also observed that child marriage is on the surge in Bangladesh's Rohingya refugee camps since various youth programmes and children services were closed during the pandemic, making it even harder for them to receive assistance (Karim 2020). This is a significant health risk factor for women and girls, as they are more likely to catch sexually transmitted infections, have obstetrical difficulties (such as perinatal death and obstetric fistulas), and suffer from mental illnesses such as depression and post-traumatic stress disorder (PTSD) (Equality Now 2019). According to a report published by the ISCG in October 2020, the COVID-19 epidemic is making it more difficult for women and children to access critical healthcare services like sexual, reproductive, and maternal health (Joarder et al. 2020; ISCG 2020).

Regardless of refugee status, adolescent mothers are more likely to have preterm and low-birth-weight children (Nour 2006). Sexually transmitted diseases (STDs) that go untreated can cause congenital issues such as premature delivery, congenital infections, and blindness. The limited availability of antenatal care (ANC), emergency obstetrics, and neonatal care (EmONC) may have an impact on the pregnancy's outcome. The absence of ANC and EmONC can significantly increase maternal and perinatal morbidity and mortality.

SGBV is the top cause of depression, anxiety, and stress among women in the Rohingya community (Riley et al. 2020). According to Samaj Kalyan O Unnayan Shangstha (2020), women are expected to have significant stress and mental health issues as a result of the increase in GBV, domestic responsibilities, and financial challenges in the COVID-19 epidemic. Overall, the available studies show a high predominance of a variety of mental health issues including the symptoms commonly associated with PTSD and depression. The number is far higher in comparison to other communities subjected to mass displacement (UNHCR 2021). In addition to the existing hurdles, resource constraints such as poverty, food insecurity, and unemployment may aggravate the problem. When children and adolescents are removed from their school environment, they become more prone to worry and stress, which hinders their capacity to adapt to a new situation (Brickhill-Atkinson and Hauck 2021; Graber et al. 2020; Hajjar and Abu-Sittah 2021). It is found that 31% of the Rohingya community is concerned about growing ill, and 92% of parents believe the lockdown has impacted their child's mental health (Ground Truth Solutions [GTS] et al. 2021). Suicide and other types of self-harm are likely to increase if these conditions persist for an extended period of time.

Inequality between Rohingyas and the host population can cause strife and instigate social clashes, resulting to anxiety and PTSD. As a result of their traumatic experiences, Rohingya women and teenagers are more likely to suffer from PTSD, depression, somatic complaints, and other functioning issues (Hossain and Purohit 2018; Riley et al. 2017). This terrible event, together with homelessness, has already been recognised by Save the Children UK as a tremendous breeding ground for children's mental health crises (Beech 2017). Because of the paucity of mental health resources in the camp region as a result of the COVID-19 lockdowns, follow-up non-compliance, treatment dropout, and relapse rates among the most vulnerable women and children are likely to soar (Table 1).

Table 1: Health impacts of COVID-19 on Rohingya women and adolescents.

Classes of health	Early impacts	Late impacts
Physical health	<ol style="list-style-type: none"> 1. Rapid spread of COVID-19 with increasing mortality. 2. Impaired other health services turn into sufferings for other chronic diseases patients (e.g., malignancy). 3. High chances of dual pandemic (COVID-19 and other communicable diseases such as tuberculosis, dengue, diarrheal diseases). 	<ol style="list-style-type: none"> 1. Malnutrition, immunodeficiency, respiratory tract infections. 2. Increased non-communicable diseases such as diabetes, hypertension, and so on.
Sexual and reproductive health	<ol style="list-style-type: none"> 1. Increased child marriage resulting in impaired child health. 2. Limited access to antenatal care in pregnancy and other reproductive healthcare services. 	<ol style="list-style-type: none"> 1. Increased maternal and neonatal mortality and morbidity such as intrauterine growth restriction (IUGR)
Mental health	<ol style="list-style-type: none"> 1. Anxiety and stress followed by depression. 2. Incompliant follow-up and treatment discontinuation. 	<ol style="list-style-type: none"> 1. Suicide and other self-harm practices. 2. Crime involvement. 3. Relapse of psychiatric illness.

Source: Authors.

CONCLUSION

The catastrophic consequences of COVID-19 for the socioeconomic and health aspects of Rohingya women and adolescent groups warrant prompt attention. The varying emotional and socioeconomic consequences of COVID-19 may need a comprehensive response, which may be the only approach to protect these vulnerable groups.

First, the government should provide adequate equity in the distribution of fundamental necessities, such as food security and other material demands, to safeguard disadvantaged populations from abuse or prejudice. Humanitarian organisations should broaden their services to meet the unique requirements of women and adolescents, such as psychosocial support and teleconsultation.

One of the most effective techniques for preventing GBV is to empower women via education, training, and preparing them to participate in local labour markets. Given that economic dependency on a partner is a risk factor for domestic violence and exploitation, providing all women and young adolescents with a broad range of quality education or vocational training would improve job opportunities and, as a result, quality of life.

The authors advocate for improved access to healthcare, focusing on adolescent and child health, reproductive health, and mental health facilities, while frontline personnel are provided with the best possible protection. As a result, women, particularly single mothers, female heads of households, and children under the age of five, will have easier access to community health and mental health services. Health facilities, such as essential treatment and supplies for sexual and reproductive healthcare (including contraceptive and menstrual hygienic management kits), should be widely accessible, along with instructions on how to use them on a regular basis. A substantial number of female counsellors would be required to encourage Rohingya women and children to seek medical help when necessary.

Stakeholders should prioritise women's participation in self-sufficient activities such as pottery, cottage products, and the creation of masks and reusable menstrual pads. Furthermore, with rising concerns about research on gender-equal family dynamics, GBV, child marriage, and the long-term impact of adolescent pregnancies, home-schooling for children should be resumed. National and international partners should collaborate to improve community involvement among Rohingyas, host communities, and the government in order to provide the most comprehensive, efficient, and safe response possible for the vulnerable. International organisations and world leaders and the government of Bangladesh should work together to return Rohingya people to their home country as soon as possible so that they can live a better life and avoid the hardships of COVID-19.

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