January 2021

COVID-19 takes social and financial toll on Cox's Bazar camp communities

Source: BDRCS

Since 2017, when some 700,000 Forcibly Displaced Myanmar Nationals (FDMNs) fled violence and persecution and took shelter in Cox's Bazar, the population of its 34 camps has swelled to 860,000 people. Fears of a deadly coronavirus outbreak prompted a swift government-issued lockdown in March 2020, with humanitarians having to limit operations to essential services only. As of 19 January 2021, there were 373 confirmed cases of COVID-19 among FDMNs and 10 recorded deaths.[1]

Restrictions and subsequent disruptions to services have had a devastating effect on camp populations, who are almost entirely dependent on humanitarian aid.[2] Loss of income and education, a rise in food insecurity, and breakdowns in social and interpersonal relationships have compounded existing vulnerabilities.

In October, Ground Truth Solutions (GTS) and the Bangladesh Red Crescent Society (BDRCS) with support from the International Federation of the Red Cross and Red Crescent (IFRC), conducted interviews with 315 FDMNs across 13 camps in Cox's Bazar in order to gauge their perspectives on information, behaviour, trust, and economic impact. We found that:

- Information needs are changing. Communities feel informed about the threat of the virus and how to protect themselves, but want more information on treatment options and vaccine development.
- Lack of space to distance or isolate, and limited access to water and hygiene items are making it difficult for people to adhere to preventative measures, no matter how clear the messaging is.
- The lockdown is taking a toll on social relationships, and parents are concerned about their children's emotional well-being.
- Many people are struggling to meet their basic needs, attributing this to loss of income, restricted access to markets due to restrictions, and physical health issues. Loss of income is the community's main worry, followed by movement restrictions.

Supported by:

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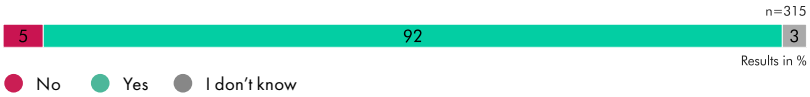
[1] WHO Bangladesh, "Rohingya Crisis Situation Report 1" (January 2021), https://cdn.who.int/media/docs/default-source/searo/bangladesh/bangladesh---rohingya-crisis---pdf-reports/sitreps/2021/who-cxb-situation-report-1-2021.pdf?sfvrsn=483648ca_7.

[2] ISCG, "COVID-19 Response Plan: Addendum to the Joint Response Plan 2020" (July 2020), https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/cov-id-19_addendum_rohingya_refugee_response_020720.pdf.

Information

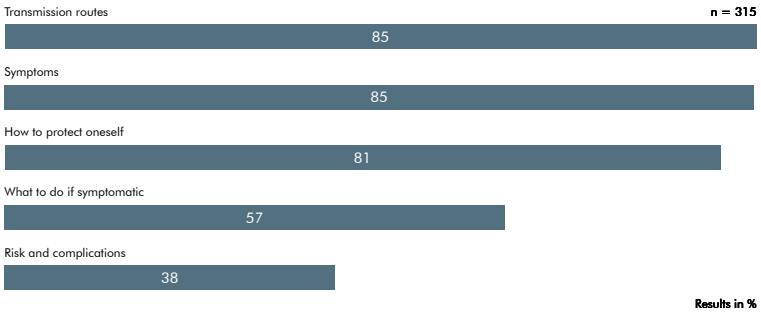
Risk communication and community engagement has been a central part of the COVID-19 response in Cox's Bazar, involving stakeholders at all levels – including the guest community – to encourage behaviour conducive to the containment of the virus. Findings suggest that this strategy is largely working: all key informants interviewed say their communities understand what COVID-19 is and most believe it to be very dangerous. But doubts over the severity of the pandemic likely persist. In August, community researchers in another study noted disbelief among some respondents on the existence of the virus, and scepticism around efficacy of lockdown measures.[3]

Do you have enough information on how to protect yourself from the virus?



The majority (92%) of respondents say FDMNs have received sufficient information on COVID-19, including on transmission routes, symptoms and prevention measures – and are aware that the virus is spread primarily through contact with infected people or animals, droplets, and contaminated surfaces. A WHO and UNHCR assessment similarly concludes good levels of knowledge.[4] But information needs appear to have shifted since the onset of the pandemic: people today want to know more about treatment options, vaccine development, and how to help prevent the virus from spreading further. They also want to be informed of changes to humanitarian assistance, including on shelter, nutrition, education, and livelihoods.[5]

What kind of information has your community received about COVID-19?



Despite high levels of awareness overall, communication challenges remain, and messaging doesn't seem to be reaching all locations or people equally. A third of key informants in Camp 18 say their communities are ill-informed. Women and girls, who have been more impacted by movement restrictions than men, are reliant now more than ever on male members of the family to relay important messages.[6] Limited access to telecommunications in the camps continues to prevent people from receiving information and engaging with feedback channels, while language is also a barrier. According to the latest Joint Multi-Sector Needs Assessment (J-MSNA), households not speaking Bangla or English feel less consulted overall, while some mechanisms – such as those requiring written forms – are inaccessible to people who are unable to read.[7]

"We are very grateful for the life-saving messages, but the frequency should be increased." – Elderly man, Camp 14

How do people in your community think the virus is spread?* (n=315)

87% Contact with infected people/ animals

78% Droplets from infected people

55% Contaminated objects/ surfaces

On what subjects is information still needed?* (n=315)

77% Treatment

53% Vaccine development

42% How to prevent virus spread

"To reach women, female NGO workers or female community volunteers should visit every house." – Woman, Camp 19

*Percentages do not total 100 because respondents could choose multiple options.

[3] PSRP, "Community Views on the Impact of COVID-19 in Rohingya Camps" (August 2020), https://www.politicalsettlements.org/wp-content/uploads/2020/09/COVID-Final-Report-1-min.pdf.

[4] WHO, "Rohingya Crisis Situation Report no. 31" (10 November 2020), https://reliefweb.int/sites/reliefweb.int/files/resources/who-cox-s-bazar-situation-report-31.pdf.

[5] ISCG, "J-MSNA Preliminary findings" (October 2020), https://reliefweb.int/sites/reliefweb.int/files/resources/bgd_2020_jmsna_preliminary_findings.pdf.

[6] BBC Media Action and TWB, "What Matters? Humanitarian Feedback Bulletin on Rohingya Reponse, Issue 44" (17 September 2020), https://translatorswithoutborders.org/wp-content/uploads/2021/01/What-Matters-Humanitarian-Feedback-Bulletin_Issue_44_English.pdf.

[7] ISCG, "J-MSNA Preliminary findings" (October 2020).

Effective two-way communication appears to be lacking. A recent study found people feel decisions are being made without their input, and accuse some organisations of taking more interest in capturing photos or distributing posters than providing help.[8]

Humanitarian organisations are the most frequently used (98% always or very often) – and most trusted (71%) – source of information on the virus. Government sources are where people turn next (77%) and then community members (63%). Traditional and social media are less common due to mobile phone restrictions, lack of phones and in some cases illiteracy. Very few people say they consult traditional healers for advice.

When asked how communication on the virus could be improved, communities say they want direct, frequent, face-to-face dialogue. But opportunities for in-person consultations have reduced, given a significant reduction in the number of humanitarian actors entering camps due to COVID-19 restrictions.

> "I don't understand messages given through miking+. I think visiting every house and ensuring that every person is informed will be more effective." – Elderly woman, Camp 17

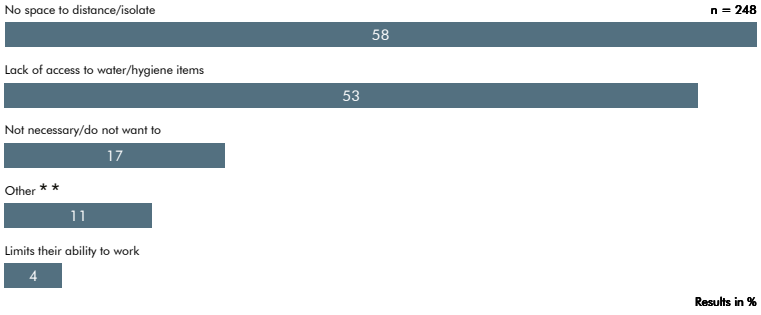
Behaviour

Our findings suggest that communities have been compliant with COVID-19 prevention measures. But while handwashing, wearing masks, and social distancing are considered vital, they are the most difficult guidelines to follow. More than half of respondents cite a lack of space and say that they don't have enough clean water and hygiene items. Some also mention that masks are uncomfortable and inconvenient.

Diminished access to clean water and sanitation was reported among 6% of households in the J-MSNA, and qualitative findings also revealed widespread concerns related to dirty or dysfunctional latrines and insufficient camp sanitation facilities.[9] Although the response allocates hygiene kits, community feedback collected by BBC Media Action (BBCMA) and Translators Without Borders (TWB) revealed complaints of insufficient quantity and distribution delays.[10]

Gender dynamics must be considered when analysing health-seeking behaviour. In a recent assessment by the multi-agency Gender Hub, women said they often need permission from men before making purchases related to COVID-19 prevention or consulting with health professionals.[11]

Why do community members find these measures difficult?



** The majority of respondents who selected "other" cited discomfort with wearing masks and difficulty adopting new habits.

Key informants say members of their community would seek in-person (89%) or remote support (51%) from health providers if experiencing symptoms of COVID-19. This on its own is positive, but some other reports suggest that health services provided by humanitarian agencies are generally viewed negatively due to distrust and scepticism about quality of care.[12]

What measures have people in your community adopted to protect themselves from the virus?* (n=315)

98% Handwashing/sanitation

89% Wearing facemask

82% Social distancing

What measures do you find the most difficult?* (n=315)

57% Wearing facemask

46% Social distancing

45% Handwashing/sanitation

> "I feel irritation when I wear a mask. We're not used to staying home all day long, so it feels difficult." – Mahji†, Camp 13

[8] PSRP, "Community Views on the Impact of COVID-19 in Rohingya Camps" (August 2020).

[9] ISCG, "J-MSNA Preliminary findings" (October 2020).

[10] BBC Media Action and TWB, "What Matters? Humanitarian Feedback Bulletin on Rohingya Reponse, Issue 44" (17 September 2020).

[11] ISCG Gender Hub, "In the Shadows of the Pandemic: The Gendered Impact of COVID-19 on Rohingya and Host Communities" (October 2020), https://reliefweb.int/sites/reliefweb.int/files/resources/advocacy_brief_in_the_shadows_of_the_pandemic_the_gendered_impact_of_covid-19_on_rohingya_and_host_communities.pdf.

[12] ACAPS, "Rohingya Response: Health behaviours and COVID-19" (3 April 2020), https://www.acaps.org/sites/acaps/files/products/files/20200403_acaps_rohingya_response_health_behaviours_covid_19_0.pdf.

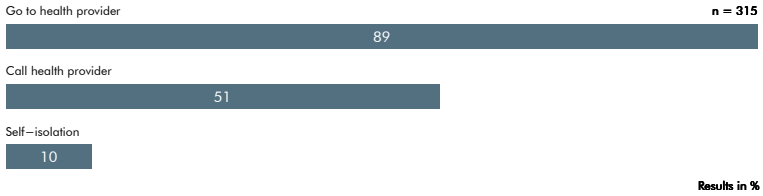
*Percentages do not total 100 because respondents could choose multiple options.

+ "Miking" refers to announcements made via loudspeaker mounted on motor rickshaws.

† Translating to "boatman" in English, the term "mahji" today refers to guest community leaders appointed by officials to maintain order in camps.

Long lines, insufficient medicine, and lack of specialised care drive people to seek services outside of the camps.[13] Those who would immediately contact a clinic say they would not feel prioritised by health staff, or fear contracting the virus at health facilities. Another survey suggests that similar fears are reportedly deterring families from going to clinics for routine immunisations.[14]

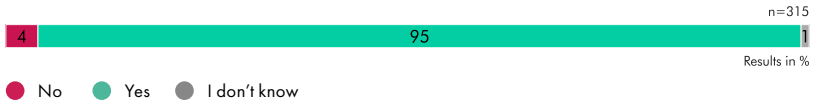
If people in your community experience COVID-19 symptoms, what do you think they would do?



Earlier in the response, community researchers in a separate study found FDMNs to have limited understanding of the benefits of COVID-19 testing and treatment, resulting in a reluctance to undertake either or both.[15] BBCMA and TWB noted people also feared being stigmatised or forced to separate from family if presented with a positive test result.[16] Encouraging behaviour change around these issues will require deeper understanding of the community's historical experiences around medical facilities, and a commitment to building or restoring trust.

Overwhelmingly, communities say that measures introduced have been effective, but respondents with a higher education level feel less satisfied. Among informant categories, imams are the most disapproving, as are those in camps 12, 18 and 19 compared to other locations.

Overall, does your community believe the measures introduced in your area will reduce the spread of the virus?



Economic impact

Most respondents (72%) tell us their communities are struggling to meet their basic needs, attributing this to loss of income, restricted access to markets, and physical health issues.

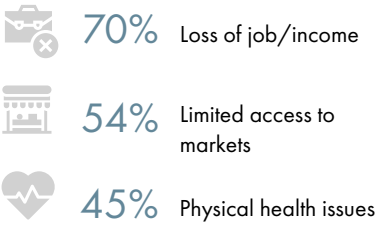
Unemployment rates among FDMNs in the labour force have increased from 36% to 77% since 2019, according to the World Bank.[17] A separate study found that more than a third of guest community men and women (43% and 34%, respectively) lost their incomes due to COVID-19 containment measures.[18]

Price hikes and fewer distributions have pushed many households into food insecurity. Without work or access to remittances, essential items not provided by the aid system – including shelter materials and clothing – have become more difficult to obtain.[19]

"If mahjis and others take responsibility to clean the block and keep social distancing, community members will stay free of the grip of this virus." – Woman with disability, Camp 19

"We hear that if someone is affected by the virus, the government will take him or her away, but no one knows where they are taken. Some say they are killed and their bodies are hidden...that is why many hide their symptoms out of fear." – Imam, Camp 13

Overall, what is your community's main concern about their economic situation due to the virus?* (n=315)



[13] BBC Media Action and TWB, "What Matters? Humanitarian Feedback Bulletin on Rohingya Reponse, Issue 46" (12 November 2020), https://translatorswithoutborders.org/wp-content/uploads/2021/01/What-Matters-Humanitarian-Feedback-Bulletin_Issue_46_English.pdf.

[14] WHO, "Rohingya Crisis Situation Report no. 31" (10 November 2020).

[15] IOM and ACAPS, "The stories being told: Rohingya report on the epidemic" (13 July 2020), https://reliefweb.int/sites/reliefweb.int/files/resources/covid-19_explained_-_edition_7_the_stories_being_told.pdf.

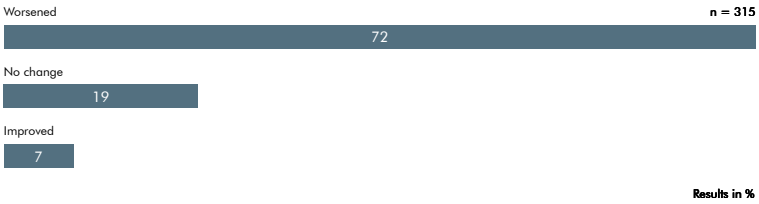
[16] BBC Media Action and TWB, "What Matters? Humanitarian Feedback Bulletin on Rohingya Reponse, Issue 42" (17 August 2020), https://translatorswithoutborders.org/wp-content/uploads/2021/01/What-Matters-Humanitarian-Feedback-Bulletin_Issue_42_English.pdf.

[17] World Bank Group, "Impacts of COVID-19 on Work and Wages in Cox's Bazar" (July 2020), https://fscluster.org/sites/default/files/documents/brief_5_labor_cxb_wb.pdf.

[18] ISCG Gender Hub, "In the Shadows of the Pandemic: The Gendered Impact of COVID-19 on Rohingya and Host Communities" (October 2020).

[19] Ibid.

Within your community, how has the ability to meet basic needs changed since the virus started spreading?

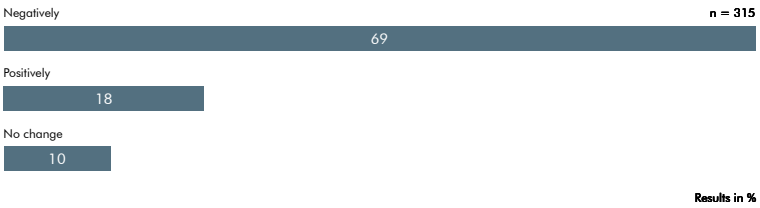


In the J-MSNA, 23% of households said they have limited food access and 66% have had to reduce spending on food,[20] despite there reportedly being no change in the caloric value of per capita assistance since 2019.[21] A World Bank analysis attributes this dissatisfaction to a shift in modality to fixed food baskets due to COVID-19, which has reduced variety and access to preferred items.[22] People are relying on less desired or more expensive items, reducing consumption, and borrowing from others to cope. Households without an adult male and those with members with a disability are more impacted.[23] Informants tell us loss of income is the community's main worry, followed by movement restrictions.

Protection

Most respondents (69%) say the pandemic has strained social relationships within their communities, specifically among family members and neighbours. Movement restrictions are preventing social gatherings, including funerals, marriage ceremonies, and communal prayers. Community researchers in a separate study found that Rohingya have been struggling to stay in touch with family who had gone to clinics, been put into isolation or sent to Bhasan Char.[24]

How do you feel the COVID-19 crisis has impacted relationships in your community?



The overall protection environment in the camps has significantly deteriorated. According to separate research, the limited presence of protection actors has created a vacuum in mediation and legal services, reportedly leading to a rise in negative coping mechanisms, including child labour, sexual and gender-based violence (SGBV), and heightened risk of human trafficking.[25] Guest community youth volunteers have also observed an increase in child marriage since the start of the pandemic, saying it is often seen as an alternative milestone to education or work.[26]

"Products are rotten due to being stored a long time because of the lockdown."
– Imam, Camp 13

What are people most worried about, in relation to COVID-19?* (n=315)

69% Losing income

46% Movement restrictions

31% Health/falling ill

31% Restricted access to food

*Percentages do not total 100 because respondents could choose multiple options.

[20] ISCG, "J-MSNA Preliminary findings" (October 2020).

[21] World Bank Group, "Impacts of COVID-19 on Food Security in Cox's Bazar: Food Consumption, Coping and Assistance" (July 2020), https://fscluster.org/sites/default/files/documents/brief_6_food-sec_1_wb.pdf.

[22] Ibid.

[23] ISCG, "J-MSNA Preliminary findings" (October 2020).

[24] PSRP, "Community Views on the Impact of COVID-19 in Rohingya Camps" (August 2020).

[25] ISCG, "2020 Mid-Term Review: Rohingya Humanitarian Crisis" (November 2020), https://reliefweb.int/sites/reliefweb.int/files/resources/2020_jrp_mtr_final.pdf.

[26] ISCG Gender Hub, "In the Shadows of the Pandemic: The Gendered Impact of COVID-19 on Rohingya and Host Communities" (October 2020).

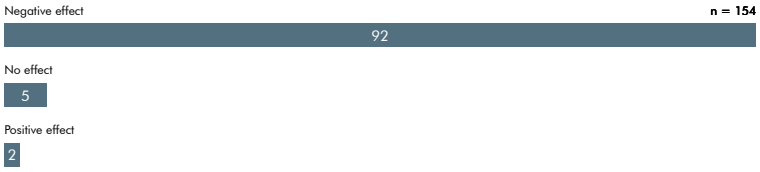
Inside the home, security risks have likely become more prominent due to an increase in domestic and intimate partner violence,[27] impacting vulnerable groups including women and girls, transgender people, and people with disabilities.[28] This has been further exacerbated by disruptions in gender-specific aid services due to the pandemic.[29]

While efforts to strengthen community-based protection and accountability to affected populations have allayed some concerns, challenges are likely to persist until regular services can be restored.[30]

Education and childcare

Among our sample, parents or caregivers of children between three and eight years old seemed more concerned about health than others. They lack information about creating good hygiene habits for their children's health, as well as how to support learning while centres are closed. The majority (92%) of parents and caregivers acknowledge that restrictions around COVID-19 are having a negative effect on their children's mental health. Around 70% say they need support for their child's emotional well-being.

Do you think restrictions around the virus are having an effect on your child's emotional/mental health?



Response actors are designing alternative modalities to facilitate distance learning, including radio and SMS,[31] but are unlikely to reach the 300,000 guest community children and youth who need education. A quarter (27%) of households in the J-MSNA have reported a reduction in education services since the outbreak, some saying they have stopped altogether.[32] A separate study found parents are worried their children are studying less and forgetting what they learned.[33]

Lack of guidance, support, and learning materials make it challenging for caregivers to facilitate remote schooling.[34] Girls are less likely than boys to follow a home-schooling curriculum due to obligations toward domestic and care work.

Learning centres in the camps are likely to reopen as COVID-19 restrictions ease and the rest of the country signals a return to school and academic activities.[35] When this happens, it is expected that the plan for more formalised education for children in the camps will be revisited.

"We cannot meet our relatives regularly, so our relationships are becoming worse." – Imam, Camp 11

Information needs of parents and caregivers* (n=154)

87% Child health and hygiene content

86% Educational content

39% Parenting tips

*Percentages do not total 100 because respondents could choose multiple options.

[27] ISCG, "COVID-19 Response Plan: Addendum to the Joint Response Plan 2020" (July 2020).

[28] Ibid.

[29] ISCG Gender Hub, "In the Shadows of the Pandemic: The Gendered Impact of COVID-19 on Rohingya and Host Communities" (October 2020).

[30] ISCG, "2020 Mid-Term Review: Rohingya Humanitarian Crisis" (November 2020).

[31] ISCG, "COVID-19 Response Plan: Addendum to the Joint Response Plan 2020" (July 2020).

[32] ISCG, "J-MSNA Preliminary findings" (October 2020).

[33] BBC Media Action and TWB, "What Matters? Humanitarian Feedback Bulletin on Rohingya Reponse, Issue 47" (2 December 2020), https://translatorswithoutborders.org/wp-content/uploads/2021/01/What-Matters-Humanitarian-Feedback-Bulletin_Issue_47_English.pdf.

[34] ISCG, "J-MSNA Preliminary findings" (October 2020).

[35] New Age Bangladesh, "Govt preparing to bring children to schools: PM" (13 December 2020), http://www.newagebd.net/article/124223/govt-preparing-to-bring-children-to-schools-pm.

Methodology

Sampling methodology

We designed the sampling strategy using UNHCR figures accurate at the time of research design: 860,175 FDMNs as of 30 April 2020. Due to safety measures and restrictions around COVID-19, key informant interviews were identified as the most practical methodological approach. Survey coverage was determined by BDRCS' access to camps. Camps are considered the primary sampling units and blocks secondary, with the assumption that the variables measured are homogenous among blocks and variability is expected among camps. Five key informant types were identified from each secondary sampling unit (blocks).

Surveys were collected from 63 blocks across 13 camps: 11, 12, 13, 14 Hakimpara, 15 Jamtoli, 17, 18, 19, 21 Chakmarkul, 22 Uchiprang, 26 Nayapara Extension, 27 Jadimura, and Nayapara RC. Coverage of all blocks within each camp was achieved, excluding 26 Nayapara Extension and Nayapara RC.[36] Given the sample size and focus on key informants, the survey results are only indicative of the situation in the selected locations and do not represent the perceptions of FDMNs as a whole.

Survey questions

Survey questions were designed in consultation with the WHO Global Risk Matrix,[37] the Global Humanitarian COVID-19 response plan,[38] and the IFRC. We identified four metrics to guide our questions: information, trust, behaviour, and economic impact. The survey tool was translated into Bangla by TWB and reviewed by BDRCS to ensure its quality and appropriateness to the context.

Participants

All participants were FDMNs over the age of 18 and belonged to one of five informant categories: imams, mahjis, the elderly, people with disabilities, and women. Respondent selection was conducted by camp focal points and BDRCS community engagement and accountability (CEA) network of community mobilisers and volunteers. In non-gendered key informant categories (elderly, people with disabilities), we aimed for a 50:50 gender representation of respondents. Personally identifiable information, including names and phone numbers, was not collected during any part of the survey.

Table 1: Sampling strategy, October 2020 with achieved numbers

Camp	Woman	Imam	Mahji	Older person	Person with disability	Total surveyed individuals
11	6	6	6	6	6	30
12	4	4	4	4	4	20
13	7	7	7	7	7	35
14	5	5	5	5	5	25
15	8	8	8	8	8	40
17	3	3	3	3	3	15
18	5	5	5	5	5	25
19	4	4	4	4	4	20
21	5	5	5	5	5	25
22	4	4	4	4	4	20
26	7	7	7	7	7	35
27	3	3	3	3	3	15
Nayapara RC	2	2	2	2	2	10
Total	63	63	63	63	63	315

[36] Surveys were collected in 7 out of 9 total blocks in Camp 26 Nayapara Extension, and 2 out of 8 total blocks in Nayapara RC.

[37] WHO, "Survey tool and Guidance: rapid, simple, behavioural insights on COVID-19," Table 1: Questionnaire – validation and value of variable and items included (2020), http://www.euro.who.int/__data/assets/pdf_file/0007/436705/COVID-19-survey-tool-and-guidance.pdf?ua=1.

[38] OCHA, "Global Humanitarian Response Plan COVID-19" (April–December 2020), https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf.

Next steps

The data collected supports our understanding of the needs of the displaced community from Rakhine. As well as being disseminated among response actors and coordinators, the information will be used to inform the Red Cross Red Crescent's Population Movement Operation (PMO) response and promote further inquiry. Findings will inform programme adjustments, including in the Health, PSS and WASH sectors. Key findings from this bulletin will be shared in a communicable language with the target group(s).

About this bulletin

This report presents findings from Ground Truth Solutions' (GTS) and Bangladesh Red Crescent Society's (BDRCS) quantitative surveys with 315 FDMNs across 13 camps in Cox's Bazar, Bangladesh in September and October 2020. This project was supported by IFRC.

Language of the survey

Surveys were conducted in Rohingya via simultaneous translation from Bangla script. BDRCS community mobilisers underwent a TWB-facilitated language training prior to data collection.

Data collection

Dates

Data collection took place between 6 September and 28 October 2020 by a team of eight BDRCS mobilisers.

Challenges and limitations

Gender balance: Due to cultural barriers, 50:50 gender balance among non-gendered key informant categories (elderly, people with disabilities) was difficult to achieve. Elderly women in particular were less willing to participate due to religious reasons, while others were dissuaded by their husbands or other male household members.

Selection bias: Findings may be susceptible to bias given that key informants were selected by camp focal points and BDRCS community mobilisers and volunteers. Efforts were made to recruit respondents from diverse groups – women, imams, mahjis, people with disabilities, and the elderly – in order to capture a broad range of perspectives.

Language: Given that there is no universally accepted written script for Rohingya, the survey was translated into Bangla. The enumerators, who are native Bangla and Chittagonian speakers, were expected to conduct the survey in Rohingya using simultaneous translation. As such, it is possible that not all surveys were conducted entirely in Rohingya, and some concepts were not communicated accurately. To mitigate some of these challenges, all enumerators underwent a Rohingya language training with TWB prior to starting data collection.

Courtesy bias: Since the enumerators were all local Bangladeshi aid workers, FDMNs may have been more hesitant to answer questions honestly. BDRCS mobilisers and volunteers had all previously been trained on the humanitarian principles – including impartiality and neutrality – and mitigated this bias to the best of their ability by providing a thorough explanation of the survey and its objectives, reassuring respondents that there are no right or wrong answers, and managing expectations by clarifying that participation would not result in immediate changes to the aid or services they receive.

Sampling: While our aim was to interview key informants in all blocks of the 13 camps sampled, movement and access restrictions resulted in coverage of 7 out of 9 total blocks in Camp 26 Nayapara Extension and 2 out of 8 total blocks in Nayapara RC.

Project partners

Ground Truth Solutions gathers perception data from affected people to assess humanitarian responses. Listening and responding to the voices of affected populations is a vital first step in closing the accountability gap, empowering affected populations to be part of the decisions that govern their lives, building relationships with communities, and localising knowledge.

The Bangladesh Red Crescent Society (BDRCS) is committed to provide timely, relevant, and actionable information to guest and host communities, to foster two-way communication and to promote an environment of greater trust to ensure that communities can participate and guide all sectoral interventions. Community Engagement and Accountability (CEA) is a critical component of the population movement operation (PMO) in order to build more sustainable capacities of communities, to support positive behaviour, and social change, and to help manage people's expectations about the Red Cross Red Crescent Movement.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, comprising 192 National Red Cross and Red Crescent Societies and 13.7 million volunteers working to save lives and promote dignity around the world. The IFRC's work focuses on four core areas: promoting humanitarian values, disaster response, disaster preparedness, and health and community care. Community Engagement and Accountability is one of its core components that aims to put communities at the centre of everything we do.

Author

Cholpon Ramizova

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For more information about GTS' work in Bangladesh, please contact Cholpon Ramizova, Project Coordinator: cholpon@groundtruthsolutions.org or Meg Sattler, Director: meg@groundtruthsolutions.org

For more information about BDRCS community engagement and accountability (CEA) work, please contact Md. Amirul Islam, CEA Coordinator, PMO, Cox's Bazar: amirul.islam@bdrcs.org.

For more information about IFRC community engagement and accountability in Asia Pacific, please contact Viviane L. Fluck, PhD, regional CEA coordinator for Asia Pacific: viviane.fluck@ifrc.org or for IFRC in Cox's Bazar, Bangladesh please contact Shariful Islam, CEA officer: shariful.islam2@ifrc.org.