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Article

Assessing gender-based violence among Rohingya refugees during COVID-19: A qualitative study in Bangladesh

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Abstract

Rohingya refugee women in Bangladesh are now at higher risk of gender-based violence (GBV) due to COVID-19. This qualitative study examines socio-cultural, economic, and structural aspects affecting Rohingya women's GBV throughout the pandemic. This study employed phenomenological research design and purposively hired 15 health workers-Health coordinators, Care workers, and Mental health counselors to get the experiences of the survivors. According to thematic research, the following factors may enhance IPV and other kinds of GBV: They are the levels of lockdown, economic factors, and restrictions on support services respectively. Some of the limitations highlighted by focus group members when a study was freely rebuilt and enlarged were; gender norms stand traditional gender norms, mobility and mobile communication as barriers to reporting and receiving support. Disruptions in basic GBV services were especially traumatic since survivors who needed psychosocial and medical support stayed with their abusers. The findings suggest culturally competent and gender-sensitive interventions and public health policies to sustain GBV-related services in emergencies. Policies drawn include telemedicine, cultural suspicion under patriarchal thought leadership, and survivor-oriented support systems. Displacement, self-reported health, and systems relevant for violence prevention for women refugees are presented in the provided study.

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Introduction

The Rohingya people have become a victim to the largest humanitarian crisis of the 21st century, where more than one million Rohingya women and children from Myanmar are now living as refugees in Bangladesh (UNHCR 2020). In Cox's Bazar, Bangladesh, the risk of gender-based violence (GBV) remains a major protection concern among Rohingya refugees, exacerbated by poor living conditions and barriers to essential services. This has become more challenging as the COVID-19 pandemic has deepened existing vulnerabilities and brought exposure to all forms of violence. Rohingya women have reported multiple forms of GBV,

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including sexual violence, domestic abuse, and trafficking, both before and after displacement. These have been worsened during the COVID-19 pandemic through disrupted protective systems and lowered humanitarian organizations' operational capacities (Amnesty International, 2021). Also, refugee status by augmenting gender disparities affects Rohingya women and girls in health crises globally in ways that require further analysis of their experiences.

Bangladesh has taken the tremendous challenge of accommodating the forcibly displaced Rohingya population especially in Cox bazar camps where about 80% of humanitarian interventions are found. Lockdowns and movement restrictions during COVID-19 have not only exacerbated stress, overcrowding, and trauma within the camps but have also limited GBV survivors' access to support systems, such as medical care, counseling, and legal aid. Furthermore, some key components of multisectoral GBV services like safe spaces and skill development programs were deprioritized during the pandemic (Shahnoor et al., 2022). COVID-19 cases have emerged as a new challenge and a looming threat in the context of the extreme deprived Rohingya refugees existing in Bangladesh. Disruptions to health-care and decreased access to reproductive health services threaten the lives of women and girls to pregnancy-related complications and lifelong damage (ACAPS, 2020). Moreover, social norms in the Rohingya community, such as strict gender roles and restrictions on women's mobility, have further reinforced GBV as a normalized, under-reported issue (Guglielmi et al., 2020). Intimate partner violence (IPV), often considered a "family matter," is rarely reported due to cultural and systemic barriers. COVID-19 Lockdown and Bangladeshi refugee camps has significantly limited the humanitarian aid workers' accessibility to embrace the refugee camps the overall services provided by 80% of the workers were face-to-face (Guglielmi et al., 2020).

Globally, the COVID-19 crisis has been particularly hard on women and girls in humanitarian crises. According to the UNFPA (2020), the pandemic fueled an alarming increase in GBV incidents worldwide, particularly in refugee camps where overcrowding, stress, and economic insecurity are prevalent. Measures aimed at controlling infection have proven vital in reducing the spread of infections but at the same time are maker for causing non-communicable diseases affecting women and girls by locking them down and reducing their service strength and ability to access protection services. Findings from other refugee contexts reveal that GBV survivors often face challenges in accessing timely medical care, emotional support, and legal assistance, which are essential for recovery and justice. There are also other assailants such as Child Marriage which has been deepened by Covid 19 pandemic reduces girl's future prospects and deepens her isolation (Cox's Bazar Panel Survey 2019). Global evidence demonstrates the importance of adopting multi-sectoral approaches to GBV prevention and response, including access to safe spaces, counseling, and skills development. Nonetheless, the delivery of these services has been significantly affected during the humanitarian crises during the pandemic.

Despite significant research on GBV in humanitarian settings, there remains a limited understanding of the compounded impact of the COVID-19 pandemic on GBV among Rohingya refugees in Bangladesh. Previous studies have focused on GBV prevalence and protection challenges in Cox's Bazar but have not fully explored how the pandemic has influenced survivors' access to services, as well as the emerging gaps and best practices in GBV interventions (Guglielmi et al., 2020). In addition, whereas prior work confirms that education disruption and rising stress among children and adolescents including those in

Cox's Bazar refugee camps, little research offers a qualitative examination of how COVID-19 prevention measures have also heightened GBV threats & undermined support systems for Rohingya women.This study fills this important research niche by examining the prevalence of Gender Based Violence among the Rohingya refugee women during the COVID-19 pandemic**.** The broad objective of the study is to asses gender-based violence among Rohingya refugees during COVID-19 and the specific objectives are given below:

1. To asses the social, cultural and structural factors that worsen the risk of GBV among Rohingya women and girls during COVID-19.
2. Determining the prevalence of GBV among Rohingya women and girls during COVID-19.
3. To evaluate the current measures offered to GBV survivors in the Rohingya refugee camps in the era of COVID-19 and suggest enhancements.

Through achieving these objectives, this paper seeks to proffer recommendations that shall lead to availing policy change, enhancing responses to GBV and advancing other literature pertaining to the protection of vulnerable persons in humanitarian crises. The study contributions have the potential to enhance the existing knowledge base on the interaction of COVID-19 to GBV in Rohingya refugee camps and concrete recommendations for enhancing the coping capacity and the psychological well-being of Rohingya women and girls.

Vitamin D, a fat-soluble steroid hormone, is essential for preserving optimal blood levels of calcium and phosphorus. It promotes bone mineralization and is considered an important determinant of bone health through calcium absorption and parathyroid hormone secretion (Mahmood et al., 2017). Vitamin D is synthesized in vivo when solar ultraviolet B (UVB) radiation interacts with 7-dehydrocholesterol, a precursor molecule in the skin. While endogenous production accounts for approximately 90% of total vitamin D in healthy individuals, dietary intake and supplements also contribute significantly. However, activities that minimize sun exposure can lower vitamin D levels (Sowah et al., 2017).

Method

Qualitative phenomenological research should use case studies for the Rohingya refugees. Since our investigation was centered on the interpretive paradigm, qualitative research was ideal for the study. Quantitative research focuses on how information is perceived and life's reality understood. Qualitative research also expansion on interesting ideas (Forbes, 2015). We used an interpretative paradigm to understand Rohingya Refugees' GBV during COVID-19.

As the study area was Bangladesh, data was collected from Cox's Bazar, where the health workers were found, to provide insights and meaningful information on the GBV. Case Study provided a detailed picture of Rohingya Refugee GBV. Case study is a qualitative approach of acquiring data comprising thorough individual interviews with limited participants to investigate their viewpoints on a particular subject, program, or issue (Boyce & Neale, 2006). Purposive sampling was used to choose 15 case studies or in-depth interviews with health practitioners who directly worked with Rohingya refugees in different situations.

We used semi-structured questionnaires for getting response from health workers on the context of GBV of Rohingya Refugees during COVID-19. Semi-structured interviews can be better to look into people's inner motives and fulfill our main goals of this study (Catterall, 2000). Besides semi-structured interviews help us to get additional significant information regarding the study question (Hillebrand & Berg, 2000).

Results or Findings

Demographic Profile of Respondents

Table 1. Demographic information of the respondents

Respondents	
n =	15
Respondent gender	
F=	9
M=	6
Respondent age	
25–34 years old	6
35–44 years old	7
45–54 years old	2
Over 55 years old	0
Respondent nationality	
Bangladeshi	15
Position of respondent when assisting Rohingya refugees	
Health coordinator	4
Project manager	3
Care worker	5
Mental counselor	1
Other	2

The study involved 15 participants (9 women and 6 men). The majority of participants were between the ages of 25 to 44, with six responses aged 25 to 34, seven aged 35 to 44, and two aged 45 to 54; none were over 55 years old. All contestants were Bangladeshi nationals. Health coordinators (n = 4), project managers (n = 3), care workers (n = 5), mental health counselors (n = 1), and others (n = 2) all assisted Rohingya refugees in various ways.

Theme Analysis

Thematic analysis is a technique followed by Braun and Clarke used to analyze qualitative data by carefully examining a data set and identifying recurring patterns in the underlying meaning of the data, ultimately leading to the identification of themes (Braun & Clarke, 2006).

Challenges in Providing Services During Response

Health care professionals said that the total number of survivors officially reporting or visiting their centers to receive services has declined, despite the apparent rise inGBV instances. Prior to COVID-19, numerous stakeholders had observed little use of GBV services in the refugee camps. Nonetheless, it appears that the epidemic has caused a further decline in the use of services.

> There was a significant decrease. Normally, this figure is not particularly high, but during the COVID period [when the pandemic first started], I would estimate that in one or two months.

> There was nothing at all. We therefore question whether this case has truly been reduced. One of my presumptions, I suppose, is that this type of thing never really stopped.

> Since November 2019, a health coordinator has been involved in the Rohingya response.

The COVID-19 pandemic reduced health workers' ability to offer necessary services, resulting in fewer reported incidents.

> We instructed that only essential services would run in the camp, and service providers should bring their staff people down. 20% of the campers.... We intended to minimize the spread.
>
> I have been serving as an Assistant Camp in Charge (CiC) in Rohingya camps since 2018.

Impact of COVID 19 on Gender-Based Violence (GBV)

The COVID-19 epidemic significantly affected gender-based violence (GBV) among Rohingya refugees, increasing pre-existing vulnerabilities and introducing new issues. The economic pressure resulting from the pandemic exacerbated tensions within households, resulting in an increase in domestic violence. The loss of livelihoods resulted in men, unable to support their families, frequently directing their frustrations towards women and children.

> Men experienced anger and frustration due to their inability to work, and regrettably, women bore the brunt of that anger.
>
> I have been serving as an Assistant Camp in Charge (CiC) in Rohingya camps since 2019.

This pattern mirrors global trends observed in humanitarian circumstances during COVID-19 (UNHCR, 2021; WHO, 2021).Moreover, healthcare professionals highlighted that pandemic restrictions affected GBV response services, constraining survivors' access to medical care, psychosocial support, or legal aid.

> The services we could provide were limited during COVID—many survivors endured their struggles in silence.
>
> I have been providing services since 2018 in this particular camp.

Studies have shown that the lockdown and movement restriction in refugee settlements made the identification and response to gender-based violence cases difficult (Chynoweth, 2020; Jahan & Alam, 2020).

The Effects of Public Health Measures

The Refugee Relief and Repatriation Commissioner (RRRC) directed service providers to ensure social stability. Distancing and health care professionals discussed how constraints affected the services they provided, the quantity of patients they could see, and the delivery methods.

> If we are to do it staying inside three feet distance. Avoid allowing more than five persons at a time. We are responsible for maintaining the outside crowd as well.
>
> Over three years of experience providing sexual and reproductive health (SRH) services to Rohingya refugees.

Intimate Partner Violence (IPV) and Sexual and Gender-Based Violence During the COVID-19 Pandemic in the Camps

Health care providers reported an increase in GBV cases and believe the government of Bangladesh has implemented measures to avoid it. COVID-19 restrictions, which kept people indoors, contributed to an increase in gender-based violence.

> This could be due to their sedentary lifestyle at home. Since 2018, I have worked as a gender-based violence prevention and response officer with Rohingya survivors.

Respondents, however, have noted that other factors have taken a hit due to the government-imposed lockdown and service restrictions. It is associated with IPV factors such as economic pressures, mental health and substance use were also considered (Roesch et al., 2020).

Cultural and Social Norms

The cultural and social norms within the Rohingya refugee community significantly contribute to the persistence of gender-based violence (GBV) and inhibit survivors from accessing support. Participants emphasized the pervasive patriarchal ideologies that place women in inferior positions, thus legitimizing violence as a mechanism of control and discipline.

> Violence is perceived as a private family issue, leading many women to believe it is their destiny to suffer in silence.
>
> I am a social worker and volunteer in Cox's Bazar since 2018

This perception is consistent with findings by Chynoweth (2019), who highlighted that cultural stigmatization of GBV results in silence and underreporting among refugee women. Moreover, conventional gender roles and expectations intensify the issue. Women and girls are frequently regarded as custodians of family honor, where any act of defiance or perceived misconduct may lead to punishment or shame for the family (Freedman, 2016). Religious and cultural leaders exert significant influence in refugee camps, and their perspectives on gender-based violence can affect community attitudes and responses. Some leaders have contributed positively to the mitigation of violence, whereas others reinforce detrimental norms. The dual role of cultural gatekeepers in humanitarian contexts has been observed, as they can either facilitate or hinder efforts to address gender-based violence (Jahan & Alam, 2020).

Issues Related to Communication and Execution of Telehealth Services

Health providers had difficulty communicating with patients and were limited by restrictions of their mobile networks that affected their ability to coordinate and deliver counseling, survivor outreach, and other critical services and referrals. Respondents reported that Rohingya refugees—along with Rohingya staff and volunteers found in Bangladesh camps could not legally own SIM cards because of internet and telecommunications restrictions imposed by the Government of Bangladesh before COVID-19 (Dhaka Tribune, 2019). The challenges associated with this service delivery method in refugee camps included internet connectivity issues, restricted access to mobile phones particularly for women and the absence of safe spaces, among other factors.

> The survivors face a significant issue: the inability to utilize mobile phones. The Camp in Charge (CIC) has imposed an embargo prohibiting contact with survivors via mobile phones. While numerous organizations engage in such communication, we adhere strictly to the established guidelines to avoid exacerbating any issues.
>
> A Gender-Based Violence prevention and response officer engaged with Rohingya survivors since 2018.
>
> During phone counselling, there are instances where a proper network connection is unavailable. That was a significant point. At times, we experienced inadequate network connectivity, which hindered effective communication.
>
> A clinical psychologist has been working with Rohingya refugees since 2017.

While communication was limited, many organizations worked hard to continue service delivery remotely. Gendered access to communications limited telehealth access.

Discussion

This study's findings highlight the substantial influence of the COVID-19 pandemic on gender-based violence (GBV) among Rohingya refugees in Bangladesh, demonstrating a combination of pre-existing vulnerabilities and newly introduced systemic barriers. In accordance with global trends, extended lockdowns, economic hardship, and mobility limitations resulted in a rise in gender-based violence, concurrently diminishing survivors' access to critical services (Roesch et al., 2020; UN Women, 2020). Previous studies have shown that crises intensify gender inequalities, especially among displaced populations, as societal tensions disproportionately affect women and girls (Freedman, 2016; Chynoweth, 2019). The economic pressures resulting from job losses related to the pandemic were often identified as a catalyst for intimate partner violence (IPV) in this study and in other humanitarian contexts (Jahan & Alam, 2020). Struggles with men who are unemployed are often beset by frustration, leading to violence against women and children, confirming earlier studies that show that economic dependence in patriarchal structures makes women vulnerable to abuse (Roesch et al., 2020; Peterman et al., 2020). This study highlights the powerful role cultural and social norms play in allowing for the continuation of GBV. Patriarchal ideologies existing within the Rohingya community considered violence a private or allowable matter, thus discouraging women from seeking help, participants reported. Chynoweth (2019), and Freedman (2016) note how cultural ostracization and honor codes often serve to silences survivors, and produce an ecosystem where gender-based violence is pacified. Cultural gatekeepers, namely community and religious leaders, appear to both maintain and to reduce gender-based violence (GBV). These findings are consistent with evidence from other refugee settings, which emphasizes the impact of leaders on attitudes towards reporting and intervention (Jahan & Alam, 2020; UNHCR, 2021). Pressing service provision challenges made the problem worse. Respondents said pandemic restrictions social distancing and lockdown measures significantly reduced access to medical, psychosocial and legal services. This is supported by international research findings reporting that services responding to gender-based violence were categorized as non-essential during the COVID-19 pandemic, while cases of violence increased (ISCG Secretariat, 2021; WHO, 2021). Survivors were isolated by poor mobility and restrictions on access to telecommunication systems in the camps, with others in need of shielding their outreach efforts. These findings corroborate prior critiques of the telehealth model in humanitarian contexts that argue gendered constraints, including women and girls' lack of access to mobile devices, restrict women's ability to be able to reach out for support (Human Rights Watch, 2020; Dhaka Tribune, 2019). These results highlight the importance of public health interventions in restricting service provision. Health directives meant to limit the virus inadvertently hampered survivors' access to aid. Respondents reported that stringent movement restrictions, personnel cutbacks, and social distancing protocols significantly impaired service providers' ability to recognize and deal with GBV cases. Similar patterns were documented in other refugee populations, where restrictive measures negatively affected already limited GBV response systems and further isolated survivors (Roesch et al., 2020; UN Women, 2020). My research has confirmed the links between health crises, displacement and structural inequities that heighten the risks of gender-based violence for refugee women. The results are consistent with existing literature on violence against

women in humanitarian settings and highlight the importance of designing gender-responsive, culturally appropriate, and flexible interventions (Peterman et al., 2020; Jahan & Alam, 2020). Providing systems of support to survivors requires flexible service delivery models that account for emergencies like COVID-19, as well as active partnerships with cultural influencers to challenge harmful attitudes and ensure that survivors can access the resources they need.

Conclusion and Implications

This study highlights the increased impact of the COVID-19 pandemic on gender-based violence (GBV) within the Rohingya refugee population, illustrating a complex interaction of systemic, socio-cultural, and health system challenges. The findings indicate that the pandemic increased existing vulnerabilities, such as economic stress, isolation, and limited access to services, while simultaneously reinforcing damaging cultural and social norms that silence survivors. Healthcare workers observed a notable decrease in the use of GBV services, intensified by lockdown measures, limited mobility, and communication obstacles, especially affecting women. This study emphasizes the necessity for interventions that are flexible, culturally sensitive, and responsive to gender, particularly in crisis contexts. Humanitarian actors must prioritize the integration of GBV services within comprehensive health and social support frameworks to ensure continuity during emergencies. Engaging cultural and religious leaders is essential for challenging detrimental gender norms and promoting reporting and support-seeking behaviors. Future interventions must prioritize enhancing access to technology and telehealth services, ensuring equitable benefits for women, who frequently face exclusion from mobile device ownership. Policy reforms must target the structural inequalities present in refugee contexts, including limitations on communication and mobility, to enhance access to services and foster survivor-centered responses in future crises.

Declarations

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References

ACAPS-NPM Analysis Hub. (2020). *COVID-19 & secondary impacts Cox's Bazar Bangladesh*. 5 July 2020.

Amnesty International. (2021). Rohingya refugees face increased risk of gender-based violence during COVID-19. https://www.amnesty.org/en/latest/news/2021/08/rohingya-gbv-covid/

Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews*.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Catterall, M. (2000). The use of semi-structured interviews in educational research: A review of the literature. *Educational Research, 42*(2), 182-192.

Chynoweth, S. K. (2019). "More than one million pains": Sexual violence against men and boys on the Central Mediterranean Route to Italy. *Reproductive Health Matters, 27*(1), 43-56.

Chynoweth, S. K. (2020). The shadow pandemic: Gender-based violence during COVID-19. *UNHCR*. www.unhcr.org

Dhaka Tribune. (2019, September 2). BTRC asks mobile phone operators to stop services in Rohingya camps. *Dhaka Tribune*. https://www.dhakatribune.com/bangladesh/communication/2019/09/02/btrc-asked-to-stop-cell-phone-services-at-rohingya-camps

Dhaka Tribune. (2019, September 11). BTRC suspends 3G, 4G services in Rohingya camp areas. *Dhaka Tribune*. https://www.dhakatribune.com/bangladesh/rohingya-crisis/2019/09/11/btrc-suspends-3g-4g-services-in-rohingya-camp-areas

Forbes, D. (2015). *Qualitative research: Methods and data collection techniques*. Routledge.

Freedman, J. (2016). *Gendering the international asylum and refugee debate*. Palgrave Macmillan.

Guglielmi, S., Jones, N., Muz, J., Baird, S., Mitu, K., & Ala Uddin, M. (2020). Age and gender-based violence risks facing Rohingya and Bangladeshi adolescents in Cox's Bazar. *Policy Brief, Gender and Adolescence, Global Evidence*, London.

Hillebrand, W., & Berg, B. (2000). Semi-structured interviews: A practical guide for researchers. *Journal of Qualitative Research, 10*(4), 233-245.

Human Rights Watch. (2020, March 26). Bangladesh: Internet ban risks Rohingya lives. *Human Rights Watch*. https://www.hrw.org/news/2020/03/26/bangladesh-internet-ban-risks-rohingya-lives

ISCG. (2018). *Protection sector working group: Rohingya refugee response—Key findings and recommendations*. Inter-Sector Coordination Group (ISCG).

ISCG Secretariat. (2021). *2021 Joint Response Plan Rohingya Humanitarian Crisis (January-December)*. https://reliefweb.int/sites/reliefweb.int/files/resources/2021_jrp_with_annexes.pdf

Jahan, N., & Alam, M. (2020). Barriers to reporting GBV in Rohingya refugee camps. *Journal of Refugee Studies, 33*(4), 905-920.

Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., & van Gelder, N. (2020). Pandemics and violence against women and children. *Center for Global Development Working Paper, 528*.

Roesch, E., Amin, A., Gupta, J., & García-Moreno, C. (2020). Violence against women during COVID-19 pandemic restrictions. *BMJ, 369*, m1712.

Shahnoor, C., Thomas, M., Lindsey, G., Ranit, M., Chloe, P., & Isabel, F. (2022). Health professionals' perspectives on the impact of COVID-19 on sexual and gender-based violence (SGBV) and SGBV in Rohingya services refugee communities in Bangladesh. *BMC Health Services Research, 22*, 743.

UNFPA. (2020). *COVID-19 impact brief*. https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

UNHCR. (2020). *Global trends: Forced displacement in 2019*. United Nations High Commissioner for Refugees. https://www.unhcr.org/globaltrends2019/

UNHCR. (2021). *Global trends: Forced displacement in 2021*. https://www.unhcr.org

UN Women. (2020). *COVID-19 and ending violence against women and girls*. www.unwomen.org

UN Women. (2020). *The shadow pandemic: Violence against women during COVID-19*. https://www.unwomen.org

WHO. (2021). *COVID-19 and violence against women: What the health sector/system can do*. https://www.who.int