



October 2017 Assessment Report: Undocumented Myanmar Nationals Influx to Cox's Bazar, Bangladesh



PHOTO: ADAM LAKE, IRC COMMUNICATIONS

Sectors: Multi-sector

Contact: Bobi Morris (Bobi.Morris@rescue.org), Elena Chopyak (Elena.Chopyak@rescue.org), Alex Gray (alex.gray@ri.org) & Kabir Mamun (kabir.mamun@ri.org)

Data Collection: September 29-October 3, 2017



Assessment Report: Undocumented Myanmar Nationals Influx to Cox's Bazar, Bangladesh

October 7, 2017

Executive summary

The International Rescue Committee (IRC) and Relief International (RI) carried out a multi-sector assessment between September 29 and October 3, 2017 with the aim of better understanding the priority needs of the influx of Undocumented Myanmar Nationals (UMN) – Rohingya – in Bangladesh, as well as the locations in which assistance is most needed from the humanitarian community. To date, an estimated 515,000 UMN have fled violence in Myanmar for Bangladesh.¹

With the influx of additional people seeking asylum, the makeshift settlements have expanded and the needs of the displaced population has changed as the demographics shifted. This needs assessment focused on recently arrived UMN in the four most affected Upazilas in Cox's Bazar: Ukhia, Teknaf, Ramu, and Cox's Bazar Sadar. The assessment used the following methods: cluster sampling to survey families, key informant interviews with medical and education professionals (notably, among the displaced population), observations in selected survey sites, health facility assessments, and a rapid market assessment in Cox's Bazar.

Of particular note, the findings include:

- The three most commonly reported needs were money (73%), household goods and non-food items (61%) and food (52%).
- Over 3/4 of the surveyed population relies on food security coping strategies, including opting for less preferred and less expensive foods (90%), reducing number of meals eaten in a day (69%), and restricting consumption by adults in order for small children to eat (68%). In addition, food consumption scores are extremely poor.
- Nearly one-third of families surveyed reported open defecation, and key informants noted the cleanliness of public latrines among major concerns in their areas of the sites surveyed.
- Nearly half of all pregnant women have not received medical care for their pregnancies and 41% of families with pregnant women do not know where to go for medical care for pregnant women.
- Observations during the assessment noted harmful practices in supporting survivors of gender-based violence (GBV), including men working in women's safe spaces, identifiable GBV sign posts without the necessary discretion required, and men exposing survivors to the community.

¹ International Organization on Migration. Bangladesh Rohingya Crisis Response. Situation Report. October 5, 2017. <https://reliefweb.int/sites/reliefweb.int/files/resources/IOM%20Bangladesh%20-%20Rohingya%20Influx%20Situation%20Report%20-%2005%20October%202017.pdf>

The following report outlines the methodology as well as key findings and recommendations for the sectors of health, WASH, education, cash assistance, protection, food security, and shelter and NFIs.

Introduction and Justification

On August 25, 2017, Myanmar began military counter-offensive operations after armed Rohingya militants, part of the Arakan Rohingya Salvation Army (ARSA), attacked border guard police, using improvised explosive devices (IEDs) and guns. Rohingya, or UMN, families fled the subsequent violence in Myanmar into Bangladesh. As of October 5, 2017, an estimated 515,000 UMN are said to have entered Bangladesh, increasing the total of displaced in Bangladesh to approximately 800,000. Prior to the events of August 25, there was already a Rohingya population in Bangladesh of between 300,000 and 500,000.² Conflict and human rights abuses in Rakhine state in Myanmar, where one million Rohingya account for nearly a third of Rakhine's population,³ have contributed to the displacement of the Rohingya into Bangladesh since 2012.

Only 33,000 refugees have received official refugee status in Bangladesh to date. Those with official status are hosted in two government-run camps, and the remaining UMN live in makeshift settlements and within host communities. Both existing camps and communities in Cox's Bazar - a port city in Bangladesh - are overwhelmed with the influx; humanitarian resources are strained, hindering aid to new arrivals.² To date, one other multi-sector assessment has been published, with data collection in early September, when the new influx accounted for less than 250,000 people.⁴

Relief International and the International Rescue Committee joined to conduct a second assessment, as the situation had evolved significantly since the last major assessment was published. As RI is one of the few actors approved to work in Cox's Bazar and has been active in the response to date, RI collaborated with the IRC on this assessment.

The aim of this assessment was two-fold: understand the needs and priorities of the new influx of refugees to inform rapid programming; and provide information for the humanitarian community, including donors, to mobilize more resources and actors.

Geographical Areas

The needs assessment focused on all UMN in the four most affected Upazilas in Cox's Bazar: Ukhia, Teknaf, Ramu, and Cox's Bazar Sadar. The complete list of locations and population numbers included in the sample frame, as well as the locations surveyed can be found in Annex A.

In these four most affected Upazilas in Cox's Bazar, there are five types of sites, including refugee camps, makeshift camps, an expansion site, spontaneous sites, and host communities. Prior to this current displacement, there were two refugee camps for registered refugees and four makeshift settlements hosting arrivals from a year ago.

² UNICEF July Bangladesh situation report <http://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20Bangladesh%20Humanitarian%20Situation%20Report%20-%20Influx%20of%20Rohingya%20-%202013....pdf>

³ Council on Foreign Relations, 'The Rohingya Migrant Crisis' January 12, 2017 https://www.cfr.org/backgrounder/rohingya-migrant-crisis?utm_medium=social_earned&utm_source=tw&utm_campaign=backgrounder&utm_term=rohingya&utm_content=083017

⁴ [Joint Needs Assessment Report. Data collection completed on September 13th.](#)

In the two weeks since the start of data collection for this assessment, new arrivals were moved by the Government of Bangladesh to several new makeshift camps and a new expansion site. It is comprised of 2,000 acres between the pre-existing makeshift camps of Kutupalong and Balukhali in Ukhia Upazila. Infrastructure and services, such as roads, water, sanitation, and health and social services, have not been established in all the new sites, and there are still groups of UMN scattered in host villages and spontaneous sites throughout the south of Cox's Bazar district. Most services have not been established across the expansion site or the new makeshift sites.

Methodology

Tools and Sampling

The assessment design had two aims: (1) provide a representative sample of families so results could be generalized across all UMN in the four noted Upazilas in Cox's Bazar district, and (2) understand variations between the types of sites where UMN reside, to prioritize locations for the humanitarian response.

To meet the first aim, a standard 30x7 cluster sample – the sample includes 30 clusters of seven families each, for a total of 210 families surveyed - was conducted using a population proportionate to size method. The cluster sample and method was carried out with the estimated population figures from the September 21, 2017 Round 5 of the International Organization for Migration's (IOM) Needs and Population Monitoring (NPM).⁵ The unit for the assessment was defined as "family" rather than as "household," as in some sites, several families shared one household. In addition, the assessment team identified 44 medical and education professionals among the newly arrived UMN for key informant interviews (KIIs) to gain qualitative data, including culture and current priorities of the population of concern. During the family survey, (female) assessors first requested to speak to a female adult in the family, and if she was unavailable or unwilling to be interviewed, a male assessor spoke with a male adult in the family. Seven families were surveyed in each cluster, or each geographic area as determined by the sampling method.

To find the first family (this must be done randomly to avoid bias) the survey walked to the middle of the survey location, threw a pen to determine the starting direction, and counted to a random number – generated for each cluster and each team, until the first family was identified. After the first family was identified and surveyed, the subsequent six families were the next six homes to the left after leaving the first family. The assessment was conducted using Kobo Toolbox (mobile data collection) on tablets and ArcGIS.

For the second aim to prioritize locations, surveyors conducted brief assessments of existing health services as well as observations of available sanitation, safe spaces for women and children and nutrition. A rapid market assessment was also conducted to understand the ability of local markets to supply the needs of the new arrivals. The table on the next page displays the types of tools used, number of forms completed, and locations or types of responses received.

⁵ IOM Needs and Population Monitoring. Round 5. September 21, 2017. <https://drive.google.com/file/d/0B-qpxdvn9n1WV3ZqWE9yenJfdms/view>

Tool	Total completed	Location/type and number
Family survey	210	Balukhali (84), Kutupalong makeshift and extension (77), Shamlapor (7), Leda (21), Neela (14), and Teknaf (7)
Observation form	30	Please see Annex A
Health facility form	22	Primary facility (14), secondary facility (8)
Key informant interview	44	Educators (28), Medical professionals (16)
Market assessment	16	Leda market (4), Balukhali market (4), Kutupalong camp market (4), Kutupalong market (along the camp) (4)

Limitations

The sampling frame and clusters were determined using population data and maps provided by IOM and UNHCR. By its nature, a cluster sample is only truly representative of the population when the data used to form the sample frame is accurate. While the IOM NPM data used was expected to be considerably closer to reality than typically available at this stage of an emergency, the population figures have not been verified at the household level and are thus not fully accurate. Therefore, any cluster sample conducted based on this data cannot be expected to be truly representative.

As the displaced population is mobile and the influx was rapid, population figures by location are constantly changing, making maps and population data quickly outdated. As the displaced population moved from some areas noted on the original map to makeshift or extension sites, the borders of the makeshift camps changed rapidly and continue to change. While the most up-to-date population numbers by location were used to choose the clusters the day before the assessment began, in those following three days populations residing in several sites were moved to the extension site, which is now being referred to as “Kutupalong plus.” As a result, in three of the sampled clusters, few or no UMN were available when the assessment team visited. These three clusters were reallocated to the expansion site. Amendments to the clusters selected were based on assumptions – informed by communication with the host community - of population movements. Surveyors located their assigned clusters using maps that may have been slightly outdated. Full details of how the outdated information affected the methodology can be found in Annex A.

Despite using a sample frame that included UMN from the previous year as well as new arrivals, nearly all families surveyed stated that they had arrived within the last month. As such, results are primarily focused on the needs for new arrivals.

As the survey was representative, results can be generalized to the full UMN population. A 95% confidence interval was calculated for all results and are available in Annex B. For simplicity the report includes confidence intervals for means (in the format: (lower CI, upper CI)) when relevant. For all percentages, margins of error were under 7% unless otherwise noted.

An assessment would normally include qualitative data, such as focus groups with women (and possibly men) to understand protection concerns and inform modalities for assistance. However, the sites did not appear to have safe, private spaces where focus groups could be conducted without drawing a large crowd, and thus, compromising the data as well as the participants’ safety. As a result, much of the information available regarding protection concerns comes from observation and secondary sources.

In addition, while the assessment questionnaires originally included information regarding access to cash and issues around safety and violence, all of these questions were removed due to concerns about the lack of privacy. In many cases there were no private locations to hold interviews. Thus, there were concerns that questions could either place respondents at risk, or risk re-traumatizing them when asking questions about violence, especially as there are no current services to assist them if they needed psychosocial support, for example.

Ethical Considerations

All assessors were trained on the importance of informed consent, and no interview was conducted with families or key informants without first receiving informed consent. No names or identification of any kind was collected from survey participants. Each survey team included at least one female assessor so that female adults in the family could only speak to a female surveyor.

KEY FINDINGS

Locations and Services

Existing facilities, including health facilities, schools, markets and waters points, were mapped using GPS within the geographic areas that the assessment team surveyed. The map of services in the areas surveyed provides information about the location and types of services currently available to the displaced population. Within the [online presentation](#) of the camps, makeshift settlements and expansion sites, individual data points about each location or facility are available and can be accessed by clicking on each. However, the services in the presentation do not represent a comprehensive mapping of the services available in all areas where the displaced population resides. The services mapped in the online presentation are those noted by the assessment team in the clusters surveyed for this assessment. The settlement outline for the service mapping presentation was provided by the Inter Sector Coordination Group (ISCG) via the Humanitarian Data Exchange.

Demographics

Interviewees at the family level were 60% female. The average family size is 6.8 (6.4, 7.2). However 22% of families are sharing their shelter with non-family members, making the global average household size 8.2 (7.4, 9.0). Of all respondents, 20% were considered elderly, while 3% were between the ages of 10 and 18 – the

remaining were over 18 but not among the elderly.⁶ Basic demographics at the family level can be seen in the table at right. Strikingly 87% families have at least one member with an identified vulnerability. Other vulnerable groups with a large representation in the population include the elderly (49% of families), breastfeeding (44% of families), pregnant (18% of families), and currently wounded (17% of families).

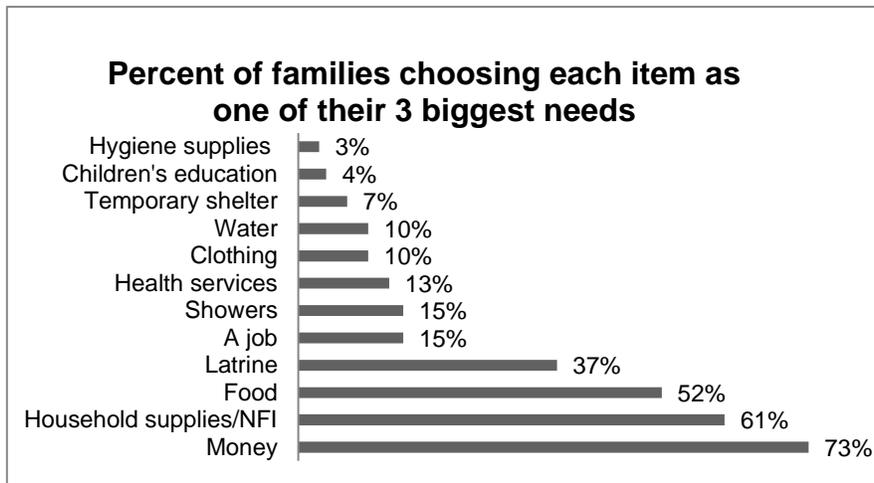
While the population has been characterized as mobile by news and humanitarian actors, 76% of families noted that they have stayed in the same settlement since arrival. When asked where they would like to settle in the future, 81% noted that they would like to stay where they are currently settled,

Demographic Data	Estimate
Family members who are female	52%
Household size	6.8
Families with at least one member who is:	
Elderly	49%
Disabled	12%
A separated child	1%
Currently wounded	17%
Pregnant	18%
Breastfeeding	44%
None of the above in the family	13%

⁶ The classification of “elderly” was determined by perception of the surveyor instead of by a numerical age.

11% mentioned they would like to return to Myanmar, and the remaining mentioned that they would like to move to different sites in Bangladesh.

When asked to prioritize the three most important needs of their family, the three most common responses were 'money' (73%), 'household goods/NFIs' (61%) and food (52%). The breakdown of all responses can be seen in the chart below.



Shelter and NFIs

The majority of new arrivals (68%) reside in tents, some live with host families (both Bangladeshi and Rohingya) (15%), while others rent space in someone else's home/land until they have their own accommodation (14%). Two percent are living in public buildings, while only 1% are sleeping in the open.⁷ While 80% mentioned that the location (either land or home) is free of charge, 18% are paying rent, while 2% exchange some form of good for shelter. The average monthly rent paid is 840 BKT (10.11 USD), with a median of 500 BKT (6.02 USD) (min: 200 BKT/2.40 USD, max: 4,000 BKT/48.20 USD).⁸

When asked about their top three housing concerns, 82% of families mentioned a lack of money, 70% were concerned with overcrowding, while 57% noted a lack of water and sanitation for the family. When asked to identify three priority items for distribution, kitchen sets (67%), blankets (65%) and floor mats (60%) were the most requested. Full results can be found in the chart to the right.

Top 3 Housing Concerns	
Lack of money	82%
Overcrowding	70%
Lack of water and sanitation	57%
Lack of cooking facilities	43%
Lack of NFIs	27%
Harsh weather conditions	12%
Security	7%
Privacy	1%
Other	0%

⁷ It is possible that the survey was biased against those who were sleeping in the open as the methods counted dwellings/tents as a means to identify families. While surveyors were trained to include families who did not yet have a dwelling, these families may have been less likely to have been surveyed.

⁸ All conversions to from BKT to USD were done using: <https://www.oanda.com/currency/converter/> on October 3, 2017.

Food Security

Using the standard measures for food consumption score (FCS) and the reduced Coping Strategies Index (CSI), the survey found severe concerns regarding food security. Only 6% of families had acceptable food consumption scores, while 62% had scores in the 'poor' range.⁹ Food diversity is severely limited, as rice is eaten five days a week, on average, while dhal, oil and vegetables are consumed twice a week, on average.

The severity of the food security situation is aggravated by the finding that 77% of families indicated a 'high' use of coping strategies, and only 4% with 'low to no coping'.¹⁰ The CSI is measured using five types of coping mechanisms, and the percent of families using each strategy at least once a week can be seen in the table at right.

Percent of families using this strategy at least one time a week	
Rely on less preferred and less expensive foods?	90%
Reduce number of meals eaten in a day?	69%
Restrict consumption by adults in order for small children to eat?	68%
Borrow food, or rely on help from a friend or relative?	60%
Limit portion size at mealtimes?	45%

Cash

Cash emerged as the clear priority for families; 73% noted that money is among their families' top three concerns. When asked about issues related to housing specifically, 82% of families stated that a "lack of money" is a priority housing concern. The need for cash is also echoed in the extremely poor food consumption and coping scores noted above.

Of all families surveyed, 81% noted that there are markets at an acceptable distance from them while 79% stated they can safely physically access the markets. Most of the families without safe physical access to markets or who are not within an acceptable distance to a market were located in Balukhali extension, Kutupalong makeshift camp, or Cakmarkul.

The assessment team completed market assessments with four vendors that sold prepackaged food items, small household goods, and/or produce in each of the following locations: Kutupalong market, along the road around the camp, Kutupalong camp markets, Balukhali, and Leda market.

All four vendors noted that their customers, both host and displaced people, use cash to purchase items. None of the vendors included in the survey have had customers who use mobile money or transfers, such as bKash. Half of the families surveyed had a family member who owns a working mobile phone.

All vendors, with the exception of one in the Kutupalong camp market, reported an increase in the daily average number of customers since last month. This is likely associated with the influx of people from Myanmar into the surrounding areas. Last month, vendors saw 20-100 customers each day, and are now reporting daily averages of 70-300 customers. With the exception of the vendors in Kutupalong camp, vendors reported increases in customer traffic from 25% to 250% since last month. All vendors in and outside of the settlements, with the exception of three, reported that the displaced population makes up over 50% of their customers. The table on the next page demonstrates the increase in the average number of customers by market area and the primary type of customer, host community or displaced population.

⁹ Standard thresholds for Bangladesh were used for the calculation (<28:poor, 28.5-42: borderline, >42: acceptable)

¹⁰ <4: low to no coping, 4-9: medium coping, >9: high coping.

Location	Average number of daily customers	Average number of daily customers last month	Percent change	Primary customer (over 50% of consumer base)
Leda Market	250	150	67%	Host
	70	45	56%	Displaced
	100	70	43%	Displaced
	300	150	100%	Displaced
Balukhali Market	100	40	150%	Displaced
	150	80	88%	Displaced
	150	100	50%	Host
	150	100	50%	Displaced
Kutupalong Camp	70	20	250%	Displaced
	150	60	150%	Displaced
	100	80	25%	Displaced
	150	150	0%	Displaced
Kutupalong Market	200	120	67%	Displaced
	250	100	150%	Displaced
	150	100	50%	Displaced
	250	200	25%	Host

Despite the nearly universal increase in daily customers, according to the vendors assessed, prices of staple items such as 1 kg of rice, cooking oil, dhal, and soap have remained relatively stable in the past month. The table at the bottom right displays the change in prices at the time of the assessment from the month prior to the assessment. There do not appear to be trends for the market types (camp or host) or market locations where goods have increased in price.

All vendors, with the exception of two in Kutupalong market, reported that they can restock supplies within a day of placing an order. The two exceptions reported requiring three days to restock. Most vendors depend on a mobile distributor, and most do not have warehouses or a location to store surplus stock. Twelve vendors cited cash flow and lack of stock storage or warehouse as impediments to maintaining their stock.

Despite the lack of storage space, limited cash flow, and an influx of displaced people, the vendors assessed reported they are able to keep up with demand. At the time of the assessment, only two vendors in Leda market reported they were out of stock of some items, such as soap, rice, oil, and shampoo.

All vendors with rice, soap, and oil in stock indicated that they had sufficient stock at the time of the assessment. Two vendors out of 11 reported that their stock of dhal was insufficient. Based on responses from vendors about levels of stock and current stock outs, it appears that the markets assessed have been able to respond to the increase in the number of customers and demand. Five (5) vendors were not sure how long it would take them to respond to increased demand, four (4) reported they could be prepared within less than a week, six (6) said they could respond to increased demand in one day, and one (1) stated they would need more than a week to respond.

	Rice (1kg)	Cooking oil	Dhal	Soap
Current price range (BKT)	38-45	80-105	30-80	10-40
Last month's price range (BKT)	35-40	80-105	30-80	10-40
Biggest increase in price (%) reported	14%	6%	14%	17%

The markets' limited functionality and family needs suggest that cash is a key priority for assistance. However concerns remain regarding safe distribution mechanisms, considering the lack of mobile phone coverage, a lack of photo identification (only 35% of families had ID), and a concerning lack of privacy and security within the sites themselves, making storage of cash a risk. Likewise, while markets are currently keeping up with demand, this reflects the influx of only the cash that refugees brought with them. It is unclear if all markets could continue to respond if affected populations had additional available cash.

Health

Thirteen percent (13%) of families noted health care as one of their top three priorities. The top health concerns reported by families and interviews with medical professionals among the displaced population are diarrhea, cough, and colds. In the two weeks prior to the survey, 73% of families had at least one family member with a strong cough, 82% with a cold, 31% with a skin disease, and 31% with diarrhea. When asked what the family would do if a member were ill, 73% would take the family member to a health facility, 15% would take the person to a community member with medical training, and 11% would do nothing.

Among the families surveyed, 18% reported having a pregnant woman in the family - of which 43% have received medical care for their pregnancies and 49% have not received care. The information that follows refers to only families with pregnant women. Thirty-two percent (32%) plan to deliver at home, 38% plan to deliver in a health facility, and 30% are not sure where they will deliver. Among the ten key informant interviews conducted with doctors and doctor assistants who practiced in Myanmar, eight stated that most pregnant women will give birth at home in Bangladesh, as they did in their home of origin in Myanmar. Forty-one percent (41%) reported that the pregnant women do not know where to go for medical care, 32% know where to go, and 27% were uncertain if they knew where to seek medical care. Nearly half of families reported that pregnant women have not received medical care for their pregnancy and nearly two-thirds are not sure where to seek medical care for pregnant women. These results point to a need for health messaging and services, as well as antenatal care and emergency obstetric care across the makeshift settlements.

Overall, 17% of families surveyed do not know where to find the closest health facility, 39% stated that the nearest facility is less than 1 km away, 32% stated the nearest is 1-2 km away, and 12% stated that the nearest is more than 2 km away.

Surveys were also carried out in twenty-two health facilities -14 primary and 8 secondary facilities- during the time of the family surveys. The table below demonstrates the services reportedly available in the facilities, with the most frequently mentioned services being family planning, emergency obstetric care.

Isolation Capacity (in the event of an outbreak)				Family Planning				Emergency Obstetric Care				Clinical Care for Sexual Assault Survivors			
Primary		Secondary		Primary		Secondary		Primary		Secondary		Primary		Secondary	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
5	9	5	3	11	3	6	2	9	5	8	0	9	5	6	2

WASH

Nearly three quarters of respondents (73%) stated that drinking water is consistently available in their areas, 25% of families noted that drinking water is inconsistently available, and only 1% of families stated that drinking water is not available at all. In terms of access, 11% have water available at the household, 69% walk under 500 meters to reach a water source, 17% walk between 500-800 meters, and 3% walk over 800 meters to reach water. Nearly half of all families surveyed (47%) use boreholes to access water. The majority (95%) do not treat their water. The table below demonstrates the other sources of water for the surveyed population.

Protected source	Unprotected source	Water trucking
(230) 78%	(33) 11%	(30) 10%

Over half of families (66%) use public latrines, 31% reported open defecation, and 3% stated that they use a household latrine. That nearly a third of the respondents reported open defecation indicates that there are serious public health threats in the makeshift settlements. The combination of poor sanitation, lack of treatment of water (95%), and health facilities with limited isolation and low overall capacity will exacerbate or potentially lead to disease outbreaks that will be hard to treat and manage. Out of the 44 key informant interviews carried out with medical and education professionals from the displaced population, 26 explicitly stated that the latrines were among their biggest concerns in their community.

Protection

Twenty-one of the 28 teacher key informants confirmed that they knew of at least one unaccompanied child in their site. Observation at the sites suggests an urgent need for child friendly spaces and education as children of all ages are seen alone or in groups both inside the camps and wandering outside the camps with no adult supervision.

Female family members were asked whether one of their female friends would seek help if they experienced violence. Only 46% said that they would seek help, 23% said no, and 31% stated that they don't know. Female respondents were also asked if a female friend who had experienced of violence would feel safe receiving medical treatment; however, there was no clear trend in their responses, as 26% said 'no', 37% said 'yes,' and 37% 'did not know.' While this assessment did not explicitly ask questions about gender-based violence, recent reports from the United Nations Population Fund and Al Jazeera indicate that many of the women fleeing from Myanmar have experienced horrific and widespread gender-based violence and trauma.^{11,12}

In terms of the current response and services being offered that address violence against women and girls, several concerns were observed during the assessment around harmful practices that do not meet international standards for supporting survivors. These included men operating in women's safe spaces, identifiable GBV sign posts without the necessary discretion required, and men exposing survivors to the community. When this occurs, there are life-threatening direct implications for women and girls from stigmatizing survivors, to placing them in harm of being rejected, or retaliated against, by their community or family. Since men are the perpetrators of the violence experienced, men operating in these spaces means these spaces and the services they provide are no longer safe, comfortable, confidential or accessible for women and girls.

¹¹ "Horrific accounts of sexual violence against Rohingya 'just tip of the iceberg'" UN News Center. September 2017. <http://www.un.org/apps/news/story.asp?NewsID=57764#.WddwRFuCzIV>

¹² "UN: 'Egregious' sexual violence reports emerge from Rohingya" Al Jazeera. September 2017. <http://www.aljazeera.com/news/2017/09/rohingya-refugees-accuse-myanmar-army-rape-170927105812065.html>

In terms of general protection concerns one key issue for UMN is lack of identification. UNHCR has biometric registration ongoing, but given the size of the influx, it is likely to take time before all families who want to register are able to do so. Likewise, families who have concerns with biometric registration may not have another option. Currently, 35% of families surveyed have at least one adult member with some form of photo ID. The lack of identification hinders access to services, such as potential cash distributions.

Another key protection concern is communication and information access; 50% of families had at least one mobile phone that was working in Bangladesh. Many of the new camp areas are remote, with no road access, and require over an hour of walking on foot to reach the main services or areas. This limits families who live in these areas from receiving information about distributions and other services. The remote nature of the new camps also hinders the humanitarian response to deliver services safely to vulnerable people, such as the elderly as well as pregnant women who may be unable to walk the long distances required to distribution sites and other service centers.

In addition, several concerns regarding coordination with military and military participation in assistance were observed during the assessment. Instances include but are not limited to: military refusing access of survey teams to the displacement sites unaccompanied by military;¹³ military forcing displaced persons along the roadside back into the camps using the threat of beating with sticks as a primary tactic; military participating in distributions using threats of violence (beating with a stick) for those who moved out of the designated area, forcing large groups to cram together and wait squatting on the ground en masse for the distribution to begin. While the military has long had involvement in the provision of aid to Rohingya in Bangladesh, and has expressed a desire to work with the humanitarian community in meetings attended by the IRC and RI teams, the above examples show that much work is still to be done to assure appropriate civil/military coordination and the protection and dignity of the affected persons.

Education

The majority of families (90%) would send their children to school if the opportunity was available, and 10% would not.

The assessment team carried out 28 key informant interviews with members of the displaced population who had worked as teachers in Myanmar. Twenty (20) noted that, in their communities, children are not attending school, as there are no schools (12), parents are unaware of the need to send the children to schools (5), and money or poverty is an impediment to attending schools (5).

Forty-nine (49) families reported having boys between the ages of 5-18 years (school going age), of which 42 families had boys in primary school and 3 families with boys in secondary school in Myanmar, before the displacement. Twenty-nine families reporting having girls between the ages of 5-18 years (school-going age), of which 23 families had girls who were going to primary school in Myanmar and 1 with female children going to secondary school.

As noted by the key informants and observed by the assessment team, schools – primary and secondary – are not available in the settlements for many school-aged children who have been displaced from Myanmar, particularly recently displaced children. These children will likely fall behind in their learning and may be more vulnerable to exploitation and other risks facing children in the settlements. Boys and girls may be exposed to child labor. Girls may face sexual exploitation by forced early marriage.

¹³ Note, while this happened on two occasions, no surveys were conducted with military present.

As schools provide a sense of normalcy and routine in the face of conflict and displacement, school-aged children will not be able to access services that can also serve as psychosocial support. According to the key informants, in Myanmar, some children went to school; however, some were unable to attend because of the fees required and/or government restrictions or discriminatory practices (7). One key informant noted that there was no secondary schooling available in his community in Myanmar.¹⁴

CONCLUSION AND RECOMMENDATIONS

Shelter & Non-Food Items

- While the priorities for distribution among surveyed families did not identify shelter materials as a primary need (as many families have recently constructed makeshift tents), they noted other NFI goods such as kitchen sets, blankets and floor mats. NFI actors should ensure kits contain these requested items rather than continuing to distribute tarps.

Food security

- As food consumption scores are extremely poor and the majority of the surveyed population relies on coping strategies, food distributions must reach the most vulnerable in the settlements and expansion site, including those who are recently arrived and far from the entry points or main roads of the sites. Food distributions must find a way to accommodate those who do not yet have a means of identification.

Cash

- The majority of the surveyed families identified money as a top need and markets appear to currently be resilient to the influx of people. An in-depth investigation of the feasibility of cash is recommended.
- However, as vendors confirmed mobile cash transfers are not used among surveyed markets and only 35% of UMN have photo identification and 50% of families have a family member with phones, further assessment of markets is needed to examine safe ways to get cash to people. This is an urgent priority.
- As one-fifth of families reported not being able to access markets, a market support intervention that brings markets closer to these families should be considered.

Health

- As nearly half of all pregnant women in families surveyed have not received medical care for their pregnancy and 41% do not know where to go for medical care - nearly a fifth of all families surveyed do not know where to go for medical care in general – there is a need to increase awareness of existing services.
- Further exploration into impediments to accessing health services, particularly sexual and reproductive health services, is necessary to ensure uptake. Women's safe spaces will be a critical area for women and girls to access information around health services and the referral pathway. So as not to identify survivors unduly, all women and girls should be informed of free service provision. GBV and health

¹⁴ Travel restrictions against Rohingya in Rakhine state have made attending middle and high school difficult for the Rohingya students, who mostly live in villages. Overcrowding in the schools that do exist is an impediment to learning, and many of the teachers are Buddhist and do not want to work in predominantly Muslim communities. Rohingya are also banned from attending Sittwe University. Myanmar's Rohingya deprived of Education. Al Jazeera. August 2014 <http://www.aljazeera.com/indepth/features/2014/08/myanmar-rohingya-deprived-education-201484105134827695.html>

responders need to consider how to safely and appropriately engage the community, especially women, to inform them of free medical care, which can be accessed for any type of wound or needed treatment.

- Health services must be made available in new sites, and integrated into existing non-health services to increase access. The limited capacity and presence of health facilities, particularly in the newly settled areas of the expansion and makeshift sites, will not be able to respond to public health crises, namely communicable diseases.

WASH

- Approximately 2/3 of the surveyed families use public latrines; however, 1/3 of families reported open defecation. Open defecation along with the reported lack of cleanliness of the public latrines poses a public health threat, and can exacerbate or cause an outbreak of cholera, diarrhea or other communicable diseases.
- Further investigation into the availability and cleanliness of existing latrines, as well as impediments to using latrines among those who openly defecate is necessary to ensure better sanitation and to avoid the spread of disease among the densely populated shelters in the settlements and sites.

Education and Child Protection

- In the absence of formal schools or while formal schools are set up, informal educational activities, that take into consideration the different daily activities, responsibilities and expectations of boys and girls can bolster learning, fill in learning gaps, and provide a sense of normalcy to children.
- Key informants indicated a need for child protection services, particularly for unaccompanied and separated children in the settlements. Integrating care for child survivors, case management, psychosocial support, and (informal and formal) education services into child friendly spaces and other services is needed.

Protection

- Due to high levels of violence against women and girls, there is a need for psychosocial support services, expressly for women and girls. Recognizing the lack of mobility women and girls experience in refugee and IDP settings, the integration of GBV response and prevention services with health services that have trained female Clinical Care for Sexual Assault Survivors (CCSAS) providers is necessary.
- There is a need to comprehensively train and hire female staff to provide services to women and girls, including at distribution sites and non-GBV service sites.
- All actors must strengthen the quality of GBV services and harmonize agency approaches to violence against women and girls to be in-line with international standards of practice as outlined by the Inter-Agency Standing Committee (IASC).
- All sectors must be accountable to the IASC Guidelines for Integrating Gender-based violence interventions in Humanitarian Action.
- There is also a need for the humanitarian community to further discuss and advocate as one body towards appropriate engagement with the military in all displacement sites. Key points of concerns include: freedom of movement for the displaced, unimpeded access to humanitarian actors, and training of military staff on safeguarding the dignity and protection of the displaced.

Annexes

- A. [Locations/Sample Frame](#)
- B. [Secondary Data](#)
- C. [Primary Data](#)