



Myanmar Refugee Influx Crisis

Rapid Gender Analysis Report

CARE Bangladesh



Balukhali Makeshift Camp, Ukhiya
Cox's Bazar, Bangladesh
18 October 2017
(Version 3)

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Background

Between 25 August and 10 October 2017, an estimated 521,000 refugees from Myanmar have crossed the border from Myanmar to Cox's Bazar, Bangladesh following communal conflict in the Rakhine state of Myanmar¹. The numbers are likely to increase as people continue to cross the border and additional groups of new arrivals are identified².

As a humanitarian organization, CARE has a mandate to respond to emergencies and is well positioned to do so due to its history of emergency response in the country; a decade-long presence in the southeast region (including Cox's Bazar) through food security, disaster risk reduction (DRR), emergency response and women's empowerment programs; and established relationships with government stakeholders and NGOs.

CARE Bangladesh's first emergency response mission, comprising a seven-member team of multi-sector experts, including four female staff, arrived at Cox's Bazar on 15 September, 2017 to conduct a rapid needs assessment and rapid gender analysis to help prepare CARE Bangladesh's immediate and longer term response plan.

Objective of the Assessment

The objectives of the rapid gender analysis (RGA) were to understand the unique needs, capacities and coping strategies of women, men, girls and boys among the newly arrived Myanmar refugees and, consequently, to formulate recommendations for action for the different sectors.

Methodology

The Rapid Gender Analysis assessment was conducted in Balukhali Makeshift Camp at Rajapalong Union, Ukhiya Upazila, Cox's Bazar district.

Primary data collection methodologies included:

1. **Focus Group Discussions (FGD)**- Two FGDs were conducted with newly arrived refugees: one women's group and one adolescent girls' group
2. **Key Informant Interviews (KII)** - Six KIIs were conducted with community group leaders (*Majhi*), all men, appointed by local *Union Parishad* members. No evidence was found of the existence of any female community leaders.
3. **Household Questionnaire Tool** – Household questionnaires were used to collect primary data from 15 households. Special effort was given to reach women, including pregnant and lactating mothers, adolescent girls and boys, the elderly and the disabled.
4. **Direct Observation**- direct observations from the assessment team members were compiled and factored into the analysis.

Secondary data collection

See bibliography. With limited secondary data and information available from Cox's Bazar, secondary data and information from Rakhine State has also been used to demonstrate pre-existing

¹ Inter Sector Coordination Group (ISCG) Situation Report: Rohingya Refugee Crisis. Cox's Bazar. 10 October 2017

² Ibid.

characteristics and factors that could shape gender relations and dynamics of the same population in displacement.

Names of the RGA analysts: Rawnak Jahan, Technical Coordinator- Advocacy & Communication, Tipping Point and Rima Karim, Gender Learning and Development Coordinator, HRD&M

Local Partner: Coast Trust (local NGO)

Site visit/data collection dates: 15 – 17 September 2017

Demographic Profile

Before commenting on the demographic profile of the refugee population in Balukhali Makeshift Camp, it is worth noting some general characteristics of the population in northern Rakhine State. ACF 2015 provides that approximately 80% of the population are dependent on a mix of agricultural and off-farm activities and are engaged in farming, fishing, petty trade and collection and sale of forest products, to cover their basic needs. A large majority of these households (approximately 94% of Muslim communities and 78% of Rakhine communities) are landless and highly dependent on casual daily work opportunities. However, these work opportunities are mainly offered in the agriculture and fishery sectors and are highly seasonal, limiting regular income generation.

The ACF (2015) report also notes that, according to databases and base lines of ACF mental health and care practices component, psychosocial distress is very common among population in Maungdaw District³. Psychosocial and mental health distress is very high. Most mothers of humanitarian assistance participants suffer from general anxiety disorders and show symptoms of stress and depression. They also report a perception of limited control over their life with negative consequences for the individual, families and communities, such as deterioration of maternal and childcare and lack of capacities and resources for women to cope with daily-life problems. Maternal and childcare deterioration (due to mental health problems, high workload, high number of children, limited social support, lack of knowledge, isolation because the husband has left or been arrested, etc.) have negative consequences on risks of child mortality, morbidity, under-nutrition and health. In addition, poor socio-economic conditions, lack of food and limited access to health care have a strong impact on families and communities' capacities to cope, adding to stress and depression.

In general, the ACF 2015 report flags a refugee population that was already experiencing high levels of acute malnutrition with limited resources to address the situation. The report signals the need for humanitarian efforts in refugee sites to address women's needs, particularly in matters related to household food security and livelihoods, health childcare and access to water sanitation and appropriate hygiene practices.

The ISCG report of 17 October provides that 582,000 people have crossed the border into Cox's Bazar since 25 August.

Between 15 and 17 September, CARE Bangladesh conducted a rapid gender analysis (RGA) on the northeast side of Balukhali Makeshift Camp. This site has been identified as a possible target area for intervention.

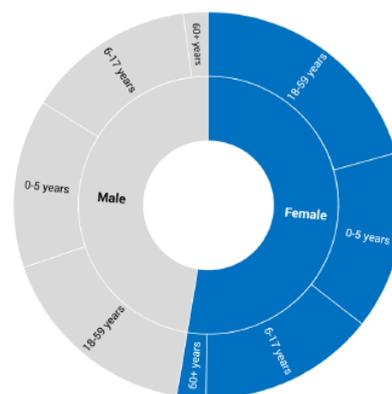
³ The ACF 2015 study carried out research in two townships of Rakhine State, Maungdaw and Buthidaung Townships.

Primary data collection from local stakeholders regarding an extrapolated 3,500 households - comprising an estimated population of 19,500 based on an average household size of six members⁴ - reveals a higher percentage of females (59%) compared to males (41%) and the following estimated sex- and age-disaggregated data of the newly arrived Myanmar refugee population:

Sex- and Age-Disaggregated Data (SADD)									
Children (age 0-5)		Children (age 6-18)		Adult (age 19-50)		Aged (50+)		Total	
Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
6,000	4,000	5,500	4,000	11,000	7,500	1,100	900	23,600	16,400
60%	40%	58%	42%	59%	41%	55%	45%	59%	41%
15% of total	10% of total	13.75% of total	10% of total	27.5% of total	18.75% of total	2.75% of total	2.25% of total		

While the age brackets differ between the CARE and IOM reports, the information above is roughly consistent with the IOM Needs and Population Monitoring Report of 21 September⁵, which reports a 53% female - 47% male split in the 23 displacement sites in Cox's Bazar surveyed.

Sex	Age	Individuals	Percentage	Total
Male	0-5 years	85,674	14%	287,989
	6-17 years	85,363	14%	
	18-59 years	104,383	17%	
	60+ years	12,569	2%	
Female	0-5 years	90,504	15%	319,746
	6-17 years	89,288	15%	
	18-59 years	125,338	21%	
	60+ years	14,616	2%	
			100%	607,735



The IOM report also provides the following information on the population: 3% pregnant and 7% lactating women; 29% children aged 6 to 17 years; 29% children under 5 years; 12% of households are headed by women; and 0.4% people have a disability. On this final point, given that the global rate of people with a disability is around 15% and in light of the fact that this population has experienced conflict, violence and displacement, the figure of 0.4% seems extremely low. As Handicap International, in partnership with UNHCR, is working in the camps and has undertaken a

⁴ REACH August 2015 cites the 2014 census data for Rakhine as finding that the average household size in the State is 4.4. A figure of six members per household may reflect the viable assumption that households subsume related and unrelated members such as unaccompanied children. On the other hand, IRC/RI (October 2017) reports that “[t]he average family size is 6.8. However 22% of families are sharing their shelter with non-family members, making the global average household size 8.2”.

⁵ It is important to note, as the IOM report points out, that a comprehensive registration system has still not been completed. Individual identification and information on the demographic breakdown is currently done through an extrapolation and estimation process. The NPM assessment provides an estimate at site level. The demographic profile is extrapolated from sample households at each site, selecting 10 households from a makeshift settlement or 10 households from the host community location, where there are more than 100 households. The results are extrapolated to provide the sex and age breakdown. The vulnerability profile is based on key informant interviews at site level.

number of assessments, it would be advisable to consult with them to understand a more accurate rate of people with a disability in the camps.

The IRC/RI (October 2017) assessment found that 87% families have at least one member with an identified vulnerability, which includes being elderly, disabled, wounded, pregnant, breast-feeding, and a separated child. 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).

In the CARE assessment, community leader respondents stated that about 20% of households have taken in unaccompanied children who have lost parents and are now in the care of relatives and other community members.

Findings and Analysis

Findings from primary and secondary data are given below to demonstrate sector-specific needs and different experiences of women, men, girls and boys as a result of the refugee influx into Bangladesh and subsequent settlement into makeshift camps.

Gender Roles and Relationships

Primary data:

- According to men and women respondents, before the crisis, women were typically responsible for care-giving, unpaid domestic work and supporting men as income earners.
- Male respondents reported having a diverse set of professions before the crisis including farming, teaching, small businesses (owning rice mills, shops) and jobs at NGOs. In addition, respondents reported that, in Myanmar, men had a variety of financial resources and assets; many owned land, livestock, rice mills, small businesses or were employed. On the other hand, women's ownership of land and assets is negligible with only a few saying they owned land, which they inherited from their father.
- In the camp, men collect relief and water. Women reported they collect water only when there was no man or adolescent boy, an invalid man and/or adolescent girls in the home.
- Adolescent girls, women and men reported that girls typically do not attend school and among those who do, they are usually from higher income families and even then, typically are pulled out after Grade 5. The community leaders, all men, reported to have completed at least secondary school education and their male children were all enrolled in schools or *madrassahs* in Myanmar before the crisis.
- Both before and after the crisis, the adult men of the family make decisions. In addition, religious leaders (imams) are also consulted on community matters.
- Community leaders, or *majhi*, appointed by local *Union Parishad* members are all men. Each is responsible for demographic data collection from 100 households; setting up WASH facilities; and resolving any GBV issues or other disputes.
- The movement of women within the camp is very limited. Women do not typically speak to men openly unless they are relatives or from their old neighborhood in Myanmar.
- Men are mobile within the immediate camp area but are not able to venture out further to seek employment because of close supervision of local law enforcement.

Secondary data:

- Women's role in decision-making is lower – some men attribute it to women's lower education level than men, as well as less life experiences. Inequality such as women's lesser participation and decision-making roles, restricted mobility, and being subjected to domestic violence, are believed by both men and women to be a matter of religion. (CARE Myanmar, October 2016)
- More broadly, in Rakhine State, women's political representation and civic participation is weak across all communities and almost non-existent for Rohingya women. No female parliamentarians were elected to the State Parliament in 2015 and only three were elected from constituencies to the Union Parliament in Naypyitaw. There are currently no female administrators (i.e. Village Tract, Township or District) in the State, though women do sometimes hold more junior civil service positions. While some women-focused civil society groups, including the Rakhine Women's Union and the Rakhine Women's Network, have sought to address gaps in women's empowerment and to generate public discourse on women's rights, they have had little influence on policymaking (Advisory Commission on Rakhine State, August 2017). However, it is important to note that Rakhine women's organizations do not represent Rohingya women.
- TNI 2016 notes while men comprise the highest number of casualties in the conflict, women experience sexual violence, human trafficking, other rights abuses and/or such indirect consequences as reduced access to clean water and health services, an increase in female-headed households and associated burden of responsibility for the household, as well as a denial of participation in peace initiatives.
- While addressing knowledge, attitudes and practices for disaster risk reduction (DRR) in northern Rakhine State, when asked about the impacts of and vulnerability to hazards, respondents reported that the most vulnerable population groups include elderly (reported by 81%), children (72%), poorer people (45%) and people with disabilities (45%). Only 19% of respondents identified women as vulnerable to hazards. In the case of both teenage girls and older women, the data suggest a lack of awareness of the dangers of natural disasters relative to other cohorts. The report concludes that older and younger women have a potentially higher level of vulnerability to natural disasters, which is an important point, given the relatively low proportion of people who perceive women to be vulnerable. (REACH, August 2015).

Gender-based violence

Primary data:

- Women and girls respondents reported being victims of GBV perpetrated by various armed and non-armed groups for many years but according to them, the frequency and brutality had increased over the last two years to an extent that they feared for their lives and had no choice but to escape.
- Both women and men respondents reported that there are women and girls in Balukhali Makeshift Camp who had conceived as a result of the rape and some had abortions after arriving in Bangladesh.
- Child marriage is common in the refugee community. Many female respondents between the ages of 13 and 20 years had children and some others are currently pregnant.
- All respondents reported personally knowing victims and survivors of other violence, including shooting, burning and mutilations, and/or being witness to such violence.

- The women and adolescent girls report that, in comparison to their previous situation in Myanmar, they feel relatively safe and secure in the camp.
- In the past eight months, CARE Bangladesh has been made aware by *Majhi* (community leaders) of eight incidences of rape and is working to ensure that we can provide the necessary services and referrals.
- Through interviews with both women and men, CARE Bangladesh has become aware that the practice in the camp is for GBV incidences to be reported to volunteers (one for every 10 households) or escalated to community leaders (one for every 100 households). It is further understood that, if the volunteer or community leader is unable to mediate, then the matter is further escalated to the member and Chairman of Union Parishad. The understanding is that the result is often not punishment for the offender but merely scolding the offender to “be warned and never do it again”.
- Male respondents cited being victims of constant harassment by the Myanmar army or Rakhine people. Some reported that their land was stolen from them and they had to pay tax to continue using their own land. In addition, many cited being mistreated for trying to extend their house on their own property because they had “no right to go beyond the limits outlined for them on the area map”. Some men said Muslim doctors were usually not accepted and called “fraud” and “fake doctors” by Rakhine people.
- Men and women respondents showed their national ID cards, which once termed them “Rohingya” but now use the term “Muslim” or “Bangali”. Interviewees reported being stopped at check-posts and having to pay bribes. The identity cards are a source of tension for the refugees.

Secondary Data:

- A knowledge, attitudes and practices study by the IRC in September 2016 in Sittwe, Rakhine State, revealed that the most common forms of GBV are intimate partner violence, forced or child marriage, sexual abuse, including rape and sexual exploitation, other forms of physical violence and health risks - exacerbated by poor access to care – of physical and psychological injury/trauma, STIs, unwanted pregnancy and unsafe abortions and the gendered risks of trafficking.
- Gender-based violence is prevalent across Muslim, Rakhine and Hindu communities, in which men are the primary perpetrators and women and girls are the primary targets. The primary intervention and support are family-based and, where community leaders are involved, the focus is on mediation rather than justice and punishment of the offender. Muslim men also face a high degree of harassment and discrimination from the government, which in turn often fuels tension and violence in the home, as men attempt to regain a sense of power and authority that was been taken from them in the public sphere (CARE Myanmar, October 2016).
- In OHCHR 2017, a survey of 204 persons found the following witness testimonies: 65% reported killings; 56% reported disappearances (“including persons having been “taken away” by the security forces and not heard of since”); 64% reported beatings; 43% reported rape; 31% reported sexual violence; 64% reported burning or other destruction of property; and 40% reported looting/theft of property. Many also reported having been personally victim to violence as follows: 13% reported having been shot or stabbed; 45% reported that a family member had disappeared; 47% reported that a family member had been killed; 44% reported having been

beaten; 13% (24% women) reported having been raped, including two girls; 28% of women reported having suffered other forms of sexual violence (a total of 52% of women reported rape of other forms of sexual violence); 50% reported that their own property had been burned or destroyed; and 37% reported looting or theft of their own property. The report notes that these figures likely represent an under-estimation of violations.

- Access to life-saving care is severely limited. First line treatment and referral for clinical management of rape services is not uniformly available across mobile emergency primary health care units (ISCG, Situation Report, 24 September 2017).
- Women and girls have no safe havens. Overcrowding in make-shift settlements and rapid population movement to spontaneous settlements is making it difficult for service providers to identify private, safe service points for GBV case management and psychosocial support services (Ibid).
- Distributions points are not safe, and women receiving aid have been targeted for theft, harassment, and assault. Congestion in settlements and camps continues to pose safety and security risks for children (Ibid).
- The IRC/RI assessment of October 2017 reports that observations during the assessment noted harmful practices in supporting survivors of GBV, including men working in women and girls' safe spaces, identifiable GBV sign posts without the necessary discretion required, and men exposing survivors to the community.
- The IRC/RI assessment report also provided that when 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 they would not, and 31% stated that they did not know. Female respondents were also asked if a female friend who had experienced of violence would feel safe receiving medical treatment and, here, there was no clear trend in their responses, as 26% said they would not, 37% said they would and 37% did not know.
- In October, CODEC, Save the Children, TAI and UNHCR carried out FGDs in six camps. They found that, in addition to existing cultural and religious constraints to movement, women and girls reported that a lack of appropriate clothing, the fear of harassment, trafficking and kidnapping, as well as the fear of losing their way further their movement. Respondents also reported that the lack of light is one of the main reasons why they are not comfortable going out at night or using showers and latrines.
- In a rapid protection assessment conducted in six camps in October, when asked about available services in place to help survivors of violence, none of the respondents indicated they knew where to find such support (CODEC et al).

Food Security and Nutrition

Primary Data:

- Households that have at least one male adolescent or adult have more knowledge of food aid distribution sites and more physical access to food aid.
- Women-headed households, the elderly and disabled men are less willing to go to road sides and crowded food distribution sites for food aid fearing risk of injury. These groups appear to lack information on how to get food aid tokens, where to go and who to consult. For women-headed households, the main sources of information are male relatives, neighbors and community leaders.

- As a coping strategy, women cited relying on male neighbors (both adult men and young boys) within their immediate surrounding as well as neighbors known from Myanmar, to fetch food and water from distribution sites.
- Pregnant and lactating mothers are particularly vulnerable – one interviewee was a nine-month pregnant mother who had eaten nothing the whole day, did not know where to access food and was more worried whether her husband would make it alive across the border than her own sustenance.

Secondary data:

- Amongst the new arrivals, 154,066 children under five years and 54,633 pregnant and lactating women require targeted food assistance including supplementary food. The ISCG Situation Report on the Rohingya Refugee Crisis, Cox's Bazar 24 September 2017 provides that 5.8 million food rations are required to meet people's emergency food assistance needs.
- 91,056 adolescent girls are in need of nutritional support (ISCG, 24 September 2017)
- The following point refers not only to food but to all distributions. CODEC et al (October 2017) found that, in their rapid protection assessment, respondents reported that the groups that face the most difficulties accessing support are those with restricted mobility, such as female-headed households with small children, pregnant women, the elderly and women without men in the family. All of these groups are reliant on male guardians or porters to access aid.

Livelihoods

Primary Data:

- Newly arrived educated men who can read and write in English and Burmese are finding no day labor work or other source of livelihood, and are monitored closely by local law enforcement to make sure that they stay in the camps. The little money they have carried from Myanmar is depleted quickly to purchase shelter items.
- Some refugees who arrived seven months ago are reportedly earning between 300 and 400 taka a month by building tents for newcomers. Currently, only men are involved in this work.
- Women are reportedly selling the little gold jewelry they have to purchase shelter goods.
- Both women and men reported that, in Myanmar, women do not earn any income. They also suggested that it is not women's role to earn income but rather that income-earning is men's role. Such statements appear to contradict secondary information and could indicate that both women and men devalue women's income generation efforts.

Secondary Data:

- In Rakhine State, instability, violence and the general lack of employment opportunities have encouraged significant out-migration by both Rakhine and Muslims, especially the better educated and resourceful among them. Many unskilled ethnic Rakhine laborers have left the state for the jade mines and garment industry. In addition, poverty and discrimination have encouraged tens of thousands of Muslims to emigrate. Women's labor force participation is low. Women workers face additional challenges such as unequal pay, including in the agricultural sector, lower levels of education and movement restrictions. Within the Rakhine community, more women than men migrate to find employment and where men do migrate, this increases the workload for women left behind (Advisory Commission on Rakhine State, August 2017).

Shelter/NFIs

Primary Data:

- It was observed that overcrowding is extremely common in the camp. In many cases, it was both observed and reported that seven people often live in areas of approximately 40 sq. ft., which demonstrates the cramped and difficult conditions that many refugees face.
- Men, women, girls, boys and infants live together in one undivided space, impacting the refugees' privacy, dignity and safety.
- Men cited they are spending most of the money they have brought with them to purchase tarpaulin and bamboo to build shelters with the help of refugees who arrived to the camp some months ago, as well as to buy utensils and cookware for cooking and collecting water.

Water, Sanitation and Hygiene (WASH)

Primary Data:

- There is a limited number of toilets in the whole camp, most of which are not separated for men and women. Respondents reported that there are often queues of up to 1.5 hours to use the toilets. More female compared to male respondents reported this as being problematic, as open defecation is more of an issue for women than men. Some households report that they have built makeshift toilets within their home for women and girls to use.
- Some women reported they are deliberately not eating available food to avoid the need to use the toilet, which puts their health at risk.
- In the camp, women refrain from going to the toilet at night, partly out of cultural belief that they should not go out at night, and partly because of fear of security. There is no light at night to help their passage to the toilets, which are often a long distance away.
- Some respondents report that they have put a tarpaulin border next to their kitchen space to shower. This is unhygienic as washing and bathing are all being done next to food preparation. Soap is available only through purchase.
- Many women who had arrived to the camp 15 days earlier said they had only used the showers twice in the whole time because of unavailable facilities or initial lack of knowledge of the facility's whereabouts.
- Women reported that they feel ashamed to walk in front of men to go to the showers. They put on *burqas* and go in groups to the shower. Women reported that, in Myanmar, they did not normally go in front of men and usually had a separate shower area within the boundary of their home.
- Observation during site visit on 11 October: As had been reported in a number of sector meetings, very few people and no women and girls were observed to be using the latrines in the camp. There is significant evidence and reports of open defecation in areas around the camp.

Secondary Data:

- A GenCap 2015 survey of eight villages, IDP camps and settlements in Rakhine State found that it is primarily women, adolescent girls, girl children and, to a small extent, older women who are responsible for household activities requiring water collection, handling and use, including bathing, cleaning latrines, washing clothes, cooking and washing dishes.

- The GenCap survey also found that women’s participation in decision-making structures in villages was virtually zero. In IDP camps supported by one INGO, camp management committees had agreed that women could be appointed as invitee members. In about half of the IDP camps and settlements surveyed, there were Women’s Committees and/or Women & Girls’ Centers; again, these appeared to be initiated by INGOs. Male respondents often advised that, according to “tradition”, only men are involved in decision-making.
- In terms of bathing practices, a clear pattern of segregation emerged in the GenCap survey (2015) whereby males tend to be outdoors and females indoors while children can bathe both outdoors and indoors. In this survey, women suggested either female-only communal bathing facilities where they could also wash clothes or a covered extension to each family shelter where women could bathe and wash clothes privately.
- Another finding in the GenCap report (2015) was that, while women and adolescent girls were provided through WASH programs with disposable sanitary pads rather than washable ones, to the date of the survey, they had not been given the means to dispose of the pads safely and with dignity. As a result, women and adolescent girls, tended to hide used pads until they were a distance from the shelter and to burn or bury them.
- Specific to the refugee camps, CODEC et al (October 2017) conducted focus group discussions in six camps and found that, in all sites, women and girls indicated they do not feel safe using latrines, even during the day. Toilets are not segregated and are often far away from their shelters. As a result, women and girls said that they prefer to wait until it is dark. “Afraid to go too far or into the forest in the dark, many resort to open defecation close to their shelter”.
- In the same assessment (CODEC et al, October), respondents in all of the sites assessed reported challenges in accessing clean water. People resort to drinking water from unsafe sources such as paddy fields, puddles or hand-dug shallow wells. In two sites, the respondents indicated that water shortages are causing friction with the host community and within the refugee community.

Sexual and reproductive health (SRH)

Primary Data:

- Women are used to using washable cloths during menstruation in Myanmar. In the camp, women and adolescent girls are resorting to reusing rags. Observation during a site visit on 11 October: Given the overcrowding and congested nature of the camps, there are no private facilities or spaces for women and adolescent girls to wash and dry their cloths.
- Women and men have limited knowledge of family planning. Interviews revealed that younger women knew relatively more about birth control; however, some believed that it “damaged their health” so they did not continue its use.
- Religious sentiment is strong as women and men both cite pregnancy as “God’s wish” and believe that God will help them feed and provide for their children.
- In general, women report that they have little influence over how many children they have.

Secondary Data:

- Amongst the new arrivals, there are an estimated 24,000 pregnant and lactating women who require maternal health care support (ISCG, 24 September 2017)

- SRH services and GBV support are priority areas particularly given the high proportion of women among the newly arrived refugees (Ibid)
- The CARE Myanmar/Wu study of 2016, revealed a very varied picture of women's rights and access to sexual and reproductive health (SRH) services across the area of the survey. The issue of SRH, including family planning, differs between ethnic/religious communities. The three communities' experience of family planning and reproductive health differs from one another. While the financial aspect of child rearing is one of the key concerns for married couples, and for them to take up family planning, only the Rakhine women have the most control over the type of contraceptives as well as birth spacing. The biggest barrier for Hindu women and men is the lack of knowledge about birth control. On the other hand, Muslim women face the biggest challenge in terms of reproductive rights and access to birth control.
- Rakhine State has a higher child mortality rate than the national average with only 19% of women give birth in professional health facilities (compared to 37% nationally). The immunization coverage in the state is among the lowest in the country and there have been multiple outbreaks of vaccine-preventable diseases over recent years. In a 2016 state-wide study, 52% of respondents said they do not have access to adequate health care (Advisory Commission on Rakhine State, August 2017).
- An IRC/RI assessment in October 2017 found that nearly 50% 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.
- The IRC/RI assessment also found that, of the families with pregnant women, 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 10 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. The medical personnel also reported that 41% of 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. As the report concludes, "[t]hese results point to a need for health messaging and services, as well as antenatal care and emergency obstetric care across the makeshift settlements".

Risks and Threats

- The little money and food that the newly arrived refugees have brought with them from Myanmar is depleted within weeks of arrival. Without any source of livelihood, there is a risk that refugees will resort to negative coping strategies and that there will be increased tensions within households and communities. Without any source of livelihood, there is an impending risk of crime for survival. Many men who were interviewed expressed frustration with the lack of opportunities to work.
- With the least access to food, shelter, medical facilities, information, and with relatively restricted mobility, women, girls, unaccompanied children, the elderly and the disabled are the most vulnerable groups among the refugees.

- With no proper camp management structure or justice system, women and girls, particularly adolescents and young married women, are at constant threat of many forms of gender-based violence, including sexual violence, early marriage and trafficking.
- Domestic violence is expected to increase as a result of difficult living conditions, lack of food and resources and available livelihood options.
- Early marriage is also expected to increase in the aftermath of this crisis as dowry will be one means to cope against food and resource scarcity. Less mouths to feed will mean reducing family burden. More data is required on this issue and will need to be monitored closely.

Recommendations for Actions

Given its organizational focus on women and girls, CARE has a special duty to ensure that its response to the Myanmar refugee crisis that prioritizes and promotes their distinct needs.

The following recommendations have been informed by the analysis above and developed to support the CARE Bangladesh team to implement practical actions to integrate gender across their humanitarian programming.

AREA OF FOCUS/SECTOR

General (decision-making, participation, and partnership)

- It is reported that adult men of the family and male religious and community leaders are the main decision-makers in households and the community respectively. With an increase in the number of female-headed households, it is critical that gender-balanced assessment teams consult with women and that special efforts are made to locate and to speak with women and girls who, for cultural and social reasons, may be less visible and/or willing to speak.
- Men are mobile within camp area but are not able to leave the camp to seek employment because of close supervision by local law enforcement. Accordingly, men may face a degree of isolation and potential harassment, which in turn may fuel tension and violence in the home.
At the same time, the movement of women within the camp is very limited and women do not typically speak to men unless they are relatives or from their old neighborhood in Myanmar.
It is important, therefore, that assessment and project teams include female staff who will be better placed to speak with female refugees. In addition, all humanitarian programming must recognize and enable rather than undermine the participation of women and girls in decision-making processes. All assessments, implementation activities, monitoring and evaluations and IDP committees must involve women meaningfully. If this proves difficult due, for example, to cultural and social issues around women's mobility and availability, liaise with local women's organizations to understand what special accommodations are required to facilitate their participation and incorporate these accommodating measures.
- While some sex- and age-disaggregated data is available, in the absence of a comprehensive registration of all refugees, it is not always complete and is often contradictory. In such a rapidly changing situation, the data must be updated constantly. It is, therefore, essential that all humanitarian programming activities, including assessment, implementation and monitoring and evaluation, collect sex- and age-disaggregated data at a minimum and disability-disaggregated data insofar as is possible.

- While initial assessments and this initial RGA provide important information on existing gender roles and relations and the distinct assistance and protection needs, capacities and coping strategies of women, girls, boys and men, the analysis must be updated constantly in order to ensure that programming is targeted accurately and effectively. Ensure that all programming activities collect and analysis data and information on women, girls, boys and men and that this information is shared with the team member(s) responsible for updating the gender analysis.
- Partner with women’s organization or, in their absence, with organizations that have a focus on women’s empowerment and gender equality, to understand the needs, priorities and capacities of female refugees and to deliver appropriate and adequate services to them.

Gender-based violence (GBV)

- Liaise with all GBV service providers and actors in Balukhali Makeshift Camp to map the response services available and, if not already available, together develop referral pathway(s) – for medical, psychosocial and legal care - for survivors. Ensure that all CARE staff and partners are briefed and aware of the protocols for referring survivors who may disclose to them.
- Ensure that all CARE staff and partner staff and volunteers have been briefed on and are aware of their responsibilities related to the prevention of sexual exploitation and abuse and have signed the Code of Conduct and the PSEA (Prevention of Sexual Exploitation and Abuse) Policy (if available). Ensure that a briefing on GBV, including PSEA, is included in all staff orientations.
- A working group under the UNFPA-led GBV sub-sector has developed technical specifications for establishing WFSs – ‘Safe Spaces for Women and Girls (SSWG): Standardization and Technical Guidance – How to set up a SSWG in practice’. The guidance is available on the GBV Sub-sector’s page on the humanitarianresponse.info portal at <https://www.humanitarianresponse.info/en/operations/bangladesh/document/safe-spaces-women-and-girls-technical-guidance>.

Food security and nutrition

- Through the channels for communication and formats of information – written, pictorial and/or oral - ensure information about food distributions reach female- and child-headed households.
- Establish food distribution mechanisms that ensure that vulnerable households, such as female- and child-headed households, households with sick, elderly or disabled people, are prioritized and reached. Take any additional measures required to facilitate this, including providing porter services, seated and shaded waiting areas, etc.
- Ensure distributions have adequate security and registering and queuing systems so that distributions are conducted in a safe and orderly fashion.
- Ensure that post-distribution monitoring systems are sensitive to potential abuse of women and any other people who are not able to collect food themselves. In this regard, ensuring that monitoring teams are gender-balanced, ask questions in a discreet manner to understand any challenges or problems encountered in collecting and transporting food.
- Provide targeted nutrition support to pregnant and lactating women, children under five years, older people and people with disabilities.

- At distribution sites and in all messages to the communities, provide information to women about the location of Safe Spaces for Women and Girls (SSWGs)/Women Friendly Spaces (WFS) where they can breastfeed infants or assist older people or people with disabilities in feeding.
- Provide feedback/complaints mechanisms at the distribution points and ensure that all refugees are informed of their entitlements and the existence of the mechanism and their right to use it freely without fear of any negative consequences.

Livelihoods

- In this first phase, assess the skills and capacities of women and men within the area of intervention and liaise with other local and international actors in the livelihoods sector to understand what efforts and programming are planned. Ensure that the discussions include equal and appropriate opportunities for women.

Shelter and NFIs

- Identify and support female-, elderly- and child-headed households to construct/establish shelters, monitoring the situation carefully to ensure that there is no risk of exploitation and abuse, including sexual exploitation and abuse.
- If relevant to the Shelter/NFIs rather than the WASH team, distribute hygiene kits that include menstrual hygiene materials. Ensure that the proper washing/disposal facilities are in place in the area, that women are aware of their location and that they offer women safe and dignified washing/disposal. Refer to the guidance and standards on the contents of dignity kits provided by the GBV sub-sector Working Group at <https://www.humanitarianresponse.info/en/operations/bangladesh/gender-based-violence-gbv> or refer to the Sub-sector Coordinator, Saba Zariv at zariv@unfpa.org.
- If relevant to the Shelter/NFIs rather than the WASH team, provide households with women and adolescent girls soap and a sealable bucket for to use for their night time ablutions.
- Establish or refer women to established safe spaces for women and girls where they and their young children can congregate safely and privately.

Water, Sanitation and Hygiene (WASH)

- Existing toilets must be rehabilitated and new toilets provided urgently. In order to alleviate the *immediate* need, ensure at a very minimum that segregated facilities for women/girls and men/boys are available before carrying out more detailed safety and accessibility audits for additional sanitation facilities.
- Recognising the different roles that men and women play with regard to water, sanitation and hygiene, as well as the sensitivities regarding women and girls' personal hygiene issues in particular, WASH teams – including female staff – should conduct safety and accessibility audits separately with men and women, including adolescent girls, older women and men and women and men with disabilities, to understand each group's needs and concerns around the location and design of WASH and sanitation facilities.
- Rehabilitate existing and provide additional toilet and wash facilities that are located and designed in line with the feedback received during the safety and accessibility audits, ensuring

that segregated toilet and wash facilities are available for women and men in locations that are deemed to be safe and accessible.

- If queuing for water and sanitation facilities remains an issue, take additional measures to facilitate this, including providing seated and shaded waiting areas, arranging porter services for water collection, etc. for the elderly, people with a disability and pregnant women.
- If relevant to the WASH rather than the Shelter/NFIs team, distribute hygiene kits that include menstrual hygiene materials. Ensure that the proper washing/disposal facilities are in place in the area, that women are aware of their location and that they offer women safe and dignified washing/disposal. Refer to the guidance and standards on the contents of dignity kits provided by the GBV sub-sector Working Group at <https://www.humanitarianresponse.info/en/operations/bangladesh/gender-based-violence-gbv> or refer to the Sub-sector Coordinator, Saba Zariv at zariv@unfpa.org.
- If relevant to the WASH rather than the Shelter/NFIs team, provide households with women and adolescent girls soap and a sealable bucket for to use for their night time ablutions.
- In consultation with a gender-balanced WASH Committee or, in its absence, with female and male IDPs, including older women and men and women and men with disabilities, design and establish confidential complaints and feedback mechanisms and ensure an acceptable response time to the feedback and complaints received.
- Promote the establishment of secure WASH facilities that are close to people's shelters and which are shared and managed among a limited number of families. Provide (solar) lights around WASH facilities (CODEC et al, October).

Sexual and Reproductive Health (SRH)

- With only 19% of women - compared to 37% nationally - giving birth in professional health facilities, it is very likely that refugee women may not seek out health facilities for their maternal health needs and information on the availability of such services and what they offer may have to be disseminated around the camp.

As nearly half of all pregnant women in families surveyed by IRC/RI (October 2017) have not received medical care for their pregnancy and 41% do not know where to go for medical care – nearly 20% 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.

IRC/RI (October 2017) also puts forward that further exploration into impediments to accessing health services, particularly SRH services, is necessary to ensure uptake. Safe spaces for women and girls (SSWG) will be an important space for women and girls to access information and available referral pathway.

- With the lowest immunization coverage in the country and multiple outbreaks of vaccine-preventable diseases over recent years among the Rakhine population, reproductive, maternal and child health (RCMH) services should gear up to address this situation.
- Recognize that the different ethnic/religious communities' experience of family planning and reproductive health differs from one another and ensure that the full range of family planning services available in Rakhine State is now available in the camp. In addition, ensure that information on the availability of services and facilities and what they offer are disseminated

widely and are available to women and adolescent girls from all communities in places, languages and formats that will be accessible to them.

- Refer to the guidance and standards made available through the SRH Working Group's Google Group.
- Refer to the guidance and standards on the contents of dignity kits provided by the GBV sub-sector Working Group at <https://www.humanitarianresponse.info/en/operations/bangladesh/gender-based-violence-gbv> or refer to the Sub-sector Coordinator, Saba Zariv at zariv@unfpa.org.

Limitations

Data collection using questionnaires and following formats (in the subject assessment) – Due to the trauma that the refugees have faced in and fleeing from Myanmar, it was too difficult collect quantitative data. Instead, the CARE team relied on transcriptions of recordings of interviews and photos (with their permission), which was more respectful of the interviewees' desire to freely express their experiences.

Interviewing boys (in the subject assessment) - While men, women and adolescent girls are available for interviews, it was much more challenging to find boys to interview. There was a visible lack of them at all times and many were busy trying to bring back food from distribution sites at the time of the visits.

Area coverage (in the subject assessment) – Data was gathered from a specific area of the camp, which accommodates Muslim communities, and reflects a sample demographic instead of total camp area coverage. This was to satisfy immediate response needs. Further assessment and analysis will be required to understand the evolving needs of women, girls, boys and men of all ages.

Language barrier and cultural beliefs (in the subject assessment) – The CARE team had translators from the local partner, Coast Trust. Though they were able to understand most of the language of the Myanmar refugees (it shares similarities to the Chittagong dialect), many words were unknown to the translators, which impeded some understanding. Moreover, the cultural norms and beliefs among the refugees are such that getting women to talk about sensitive topics, such as menstruation and family planning was very challenging.

Registration (in general) - At the time of writing, a comprehensive registration system has still not been completed though UNHCR/MDMR is currently undertaking a 'family counting exercise' and IOM/MOHA is also currently undertaking registration at the individual level. The IOM Needs and Population Monitoring Reports have been based on an extrapolation and estimation process to establish individual identification and information on the demographic breakdown.

Focus group discussions (in general) – CARE and other organizations have reported the challenges in collecting qualitative data in the refugee camps. As IRC/RI (October 2017) assessment report states, "[a]n 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".

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