Situation Analysis: Health Care and Protection Services for GBV Survivors among the Rohingya (Forcibly Displaced Myanmar Nationals) Community in Cox's Bazar

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List of acronyms

CIC	Camp-In-Charge
FDMN	Forcefully Displaced Myanmar Nationals
FGDs	Focus Group Discussions
GBV	Gender Based Violence
GBVIMS	GBV Information Management System
GNSPU	Gender, NGO and Stakeholder Participation Unit
GO	Government Organization
HEU	Health Economics Unit
ICSG	Inter-sector coordination group
IDIs	In-depth Interviews
IHE	Institute of Health Economics
IMC	International Medical Corps
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IRB	Institutional Review Board
IRC	International Rescue Committee
KIIs	Key Informant Interviews
MOWCA	Ministry of Women and Children Affairs
MSF	Médecins Sans Frontières
OCC	One-stop crisis center
OCCs	One-stop crisis cells
RRRC	Refuge Relief and Repatriation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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Executive summary

1 Background and objective

Following escalation of violence in Myanmar during 2016-17, more than one million Rohingya individuals (referred to as Forcibly Displaced Myanmar Nationals or FDMNs by the government of Bangladesh) have fled to Bangladesh and started living in makeshift settlement camps in Cox's Bazar, Bangladesh. The majority of the arrivals are women and girls, and many of them were reported to have faced physical abuse and sexual violence, including gang-rapes, in Myanmar. A vast majority of women of reproductive age has suffered some degree of gender-based violence (GBV) while fleeing the atrocities which had a lingering effect for many and many reportedly continue to suffer. This influx also has had some spillover effects in the host communities putting the host communities in a higher risk of GBV. The government of Bangladesh was initial responder. However, both national and international NGOs extended their supports later. Though there is some conjecture surrounding the extent of GBV in the FDMN and host communities, government sectors' response to the GBV, the impact of influx on the host communities are in place, these issues are not well documented. Without a proper understanding of the aforementioned problems, an effective planning and actions concerning those issues is not possible. Therefore, it is essential to understand the overall situation of GBV both in host and FDMN communities and their underlying causes and the current challenges in service provision.

Institute of Health Economics (IHE) was commissioned to conduct a study by the GNSPU unit of Health Economics Unit with a view to ascertaining the current extent of GBV burden, the services availability for GBV survivors including health care services and how these interventions are leaving impact in the lives of the GBV survivors. The key objective of this study was to assess the overall situation of GBV survivors in FDMNs settlement camp and GO-NGO response towards them, with specific objectives of identifying the extent of burden, availability of services, coordination among service providers and level of access.

2 Methodology

The study mainly performed an analysis of overall situation of the GBV survivors among the FDMN (Rohingya) community. This analysis consisted of a desk review of available literature, service protocol documents, data and reports, followed by field activities, and one-day consultative workshop at the district level with presence of GO-NGO stakeholders. The field research activities included: Key Informant Interviews (KII) with the GBV service providers and stakeholders, Focus Group Discussions (FGDs) with GBV service providers and representatives from both FDMN and host communities, In-depth Interviews (IDIs) with GBV survivors from FDMN community; and health and psychosocial service facility observation. The one-day consultation workshop was conducted to share and validate the key research findings with the focal points of GBV sector actors (GO-NGO-INGO-UN bodies) and local government representatives. Guidelines and checklists for KIIs, IDIs and FGDs were developed based on the GBV assessment and situation analysis tool by UNFPA, IMC, Global Protection Cluster and Australian Government Aid Program and the Gender-Based-Violence

Tools Assessment Manual by the Reproductive Health Response in Conflict Consortium and modified to capture Bangladesh context.

The study protocol, tools and methodology were submitted to the Institutional Review Board (IRB) of Institute of Health Economics (IHE) in Bangladesh for review and ethical approval. Informed consent was taken from the participants prior to enrollment into the study and interviews. The confidentiality and anonymity of the study participants was strictly maintained.

3 Findings

a) Nature and Scope of the reported GBV cases in FDMN community

Physical assault (battering) is the most common GBV concerns encountered by Rohingya women and girls, indicative of the rampant but unfortunately somewhat acceptable domestic violence in the FDMN community. Denial of the access to resources of FDMN women by the male counterpart was also reported, and in most cases this phenomenon was attributable to the polygamy practices. While secondary data (official records) suggests that the proportions of sexual violence (e.g. rape), early marriage and child sexual abuse are relatively small, the respondents reported larger prevalence of GBV in FDMN community; and these violence are highly under-reported due to the stigma associated with them and lack of awareness about the available GBV services.

b) Information about the GBV survivors

Almost all of the of survivors in FDMN camps are females with adults being the majority. Although the girls and women in the FDMN community are considered to be at the greatest risk of GBV, the disabled, separated and unaccompanied children (both male and female), single mothers, and widows were identified as the most vulnerable groups for GBV, particularly for domestic violence, forced/child marriage, and exploitation and trafficking.

c) Nature and Scope of the reported GBV cases in host community

The GBV incidents in the host community are reported to be on the rise following the FDMN influx. Like the FDMN community, domestic violence is also found to be the most prevalent form of GBV in the host community; the underlying factors being early marriage, dowry, polygamy, or by drug addicted husband or members from in laws house. Increasing income of people was found to be one of the potential factors for this rise of violence, as it influences the tendency of polygamy, especially among the lower income group. As a whole, majority of the GBV survivors are adult female, while the survivors of sexual abuse are mainly children of both sexes; the commonly affected age group is 5-13 years.

d) Causes and contributory factors for GBV

Polygamy is found to be a common underlying factor for GBV in both FDMN and host communities. Polygamy practice is culturally acceptable in FDMN community and a leading cause of domestic violence, abandonment, denial of resources and forceful divorce. The malpractices of FDMN communities are being inflicted upon the host communities, as evidenced by the increasing rate of multiple marriage and divorces in the latter. The poor living condition, i.e. overcrowding, congested premises, lack of extensive outdoor lighting, lack of

WASH facilities, lack of shelter and privacy in the FDMN camps exposes the community to the risks of physical insecurity and abuses. Poverty and financial insecurity are catalysts for both domestic violence and sexual assault. A lack of resources to support the household, limited opportunities for employment and the idleness of men contribute to GBV in FDMN community. Together with the loss of livelihoods and absence of opportunities, huge uncertainty regarding future cause frustrations among men and women, resulting conflicts in the households, demanding of dowry/ bride price, domestic violence and subsequent divorce, which makes female headed households more vulnerable to other forms of GBV. Deeply rooted discriminatory attitudes and practices, social norms further exacerbate GBV in FDMN. The patriarchal nature of Rohingya society and a long tradition of having low status for girls and women result in extreme male domination with women continually oppressed and underrepresented. In addition, the lack of police presence in the FDMN camps at night causes deterioration of the security and law and order situation. Insufficient police capacity to respond to GBV cases, a lack of adequately trained officers and few female police, knowledge of and confidence in the formal system, all prohibit women from reporting. Inadequate follow up and failures to prosecute GBV cases according to the law of Bangladesh contribute to an environment of impunity that marginalizes survivors, discourages reporting and help seeking behavior. Complaints of sexual exploitation and abuse by Mazhis were also reported by some respondents. While there has been some progress in the access to education, still the opportunity of education especially for the adolescents is very low and so young girls are more likely to be dropped out of school and get married early. As a result, the opportunities to continue their education and develop their knowledge and skills severely remain limited with implications for their reproductive health, education and long-term livelihoods.

e) GBV service provision and gaps

As part of the GBV response, humanitarian actors are providing various services to support GBV survivors in FDMN community, such as, psychosocial and mental health services, health services, legal, security and protection services, and basic needs services. However, the coverages of the services are not uniformly distributed, with several settlement camps having little or no coverage of essential minimum GBV services such as, case management, access to psychosocial services, health, clinical management of rape, legal counselling and safe spaces for women and girls. While majority of GBV survivors received psychosocial, health services and basic need services, the provision of police and security, safe house/shelter and mental health services in the FDMN camps are underwhelming. Among the Bangladeshi host communities, approximately 85% of areas have severely limited access to GBV service provision. This may be attributable to the fact that the priority of the GBV actors is to render GBV services in the FDMN community; only one-third of the GBV sub-sector program partners provide GBV response and prevention services to the host community. Nevertheless, the Multisectoral program on Violence Against Women under MOWCA plays the major role in providing services to GBV survivors both in the host community and the FDMN community. The program offers a range of services like medical treatment, psychosocial counseling, legal support and rehabilitation services to the GBV survivors from both FDMN and host communities through One-stop crisis center and One-stop crisis cells run in collaboration of 11 other ministries. According to service utilization record of MOWCA, all of the GBV survivors

from the host community reporting at the OCC received medical treatment and around two-third received counselling service. Legal service appears to be underutilized in the host community, and affected by the stigma associated with case reporting, the fear of loss of confidentiality, uncertainty about future life etc. There is a critical shortage of safe home/ shelter services for the GBV survivors in the host community.

Conclusion and recommendations

The findings revealed that GBV cases are highly prevalent, though potentially to be under-reported, in both the communities. While majority of the GBV survivors received clinical care, psychosocial and basic needs services, a large proportion of survivors have had unmet need of mental health, child protection, legal assistance and security/shelter services. The study also finds that there is a paucity of information about services rendered by the INGO/NGO and multilateral agencies as a whole. In addition, information regarding available services to children and male survivors and GBV prevention strategies are also insufficient. While effective preventing and responding to GBV requires both the coordination and commitment from a wide range of actors, a lack of coordination between the humanitarian actors and the government of Bangladesh is conspicuous.

The study put forward some recommendations to better address the GBV issue both in FDMN and host communities. Key recommendations include improving the protection and security situation of FDMN women and girls through fencing around the camps, ensuring effective protection services during night time, and improving WASH facility and increasing the lighting facility; strengthening the GO-NGO collaboration and coordination and ensuring stewardship of the government in all activities along with proper data sharing mechanism; introducing camp-centric judicial services (similar to village courts) for the FDMN communities and strict enforcement of law; improving access to GBV and health facilities through establishing more facilities within or close to the camps that provide GBV related services and encouraging service utilization; and strengthening community participation in developing solutions to GBV.

Chapter 1: Background and objectives

1.1 Background and rationale of the study

Nearly two years since August 2017, more than a million Rohingya, identified as Forcibly Displaced Myanmar Nationals (FDMNs), have fled the brutal violence in Rakhine state of Myanmar and sought refuge in southern Bangladesh district of Cox's Bazar[1]. Such unprecedented influx has resulted in a situation of statelessness and acute vulnerability for the affected people. Despite being a limited resource country, Bangladesh government has shown highest degree of humanity to provide immediate shelter to the distressed people. Subsequently in no time, the humanitarian communities from across the world has stepped in to support GOB to help mitigate a critical humanitarian emergency. The response is also designed to support the host Bangladeshi communities most directly affected by the influx and improve their ability to cope with the strains of hosting a refugee population.

It has been reported that an estimated 52% of the total arrivals are women and girls[2]. A vast majority of women of reproductive age has suffered some degree of gender-based violence (GBV) while fleeing the atrocities, and for many this suffering had lingering effects and continued. Already marginalized and vulnerable, they are bearing the impact of the crisis.

The government of Bangladesh was initial responders, even though both national and international NGOs extended their supports later. Several interventions from GO/NGO/INGO are in place to address GBV issues among the FDMN community. The providers are operating at various locations and extent within and outside camp area in the region[3]. However, if an effective coordination and synergy across the providers are not maintained, a full potential of these interventions will not be possible to reaped, and this coordination is very crucial to create an enabling atmosphere for GBV survivors.

The Gender, NGO and Stakeholder Participation Unit (GNSPU) under MoHFW, has prepared Gender Equity Action Plan 2014-24. The Gender equity action plan has targeted to achieve health sector response to gender based violence as part of essential service package. All activities under health care services are obliged to ensure strict adherence to the core principle of gender equity.

Although some editorials in the journals and newspapers, limited scale studies related to the impact of Rohingya influx on the challenges of public health provision are evident, no comprehensive studies are documented. For instance, Rahmand (2018) identifies the ongoing challenges of the health sector which includes: i) overburdened government health care facilities at (Sadar Hospital in Cox's Bazar and Teknaf and Ukhia upazila health complexes &

1 RRRC Family Counting 2018.
2 Self-reliance Situation of Host Communities in Cox's Bazar, UNHCR, 2018
3 Inter-sector Coordination Group Situation Report on Rohingya Refugees, November 2018

PHC), ii) severe acute malnutrition, iii) inequitable access to services due to new arrivals, and iv) communicable disease risks due to crowded living conditions, inadequate water and sanitation facilities and low vaccination coverage. Similar conclusion is drawn in Ahmed and Rahman (2017) and Hasan-ul-Bari and Ahmed (2018) and Hossain et al (2018). Though there is some conjecture surrounding the extent of GBV in the FDMN and host communities, government sectors' response to the GBV, the impact of influx on the host communities are in place, these issues are not well documented. Inter-sectoral Cordination Group (ISCG) publishes quarterly situational analysis of GBV for FDMN communities which provides an account on the types of GBV and their aggregate measures. Even though these reports are useful to understand the overall situation, the underlying causes, details on service availability and impact on the host communities cannot be uncovered with this report. Nordby (2018) studies GBV issues in the FDMN communities where the author finds that like other refugee camps around the world, GBV is widespread FDMN camps; gender norms, unequal power relations between male and female, community leaders and women, broken family due to the atrocities faced in Myanmar, lack of reproductive health services, and camp amenities create opportunity for the perpetrators to do GBV related crime. Although this study gives a good account on the types of GBV and underlying causes, to do so this study relies only the online data source and consultation with a very few academicians instead of going to the field. Therefore, the study was very limited in its scope. Akter & Kusakabe (2014) also study GBV in Cox's Bazar and find that male dominance, lack of income earning opportunity by male which forces female to be involved in informal activities including sex-trade, unequal power relation between male and female causes GBV in the FDMN communities and similar findings are observed through perpetrators' narratives by Subramaniam (2017). Women and children especially girls are the main victims of GBV both inside and outside the home and by their families, communities and outsiders. Most of studies were carried out before the recent influx, and limited to one camp only, and therefore they are not generalizable and may not correctly represent the current context. Without a good understanding of the aforementioned issues, an effective planning and actions concerning those issues is not possible. However, due to lack of relevant data availability the situation in the camp areas, and the adherence to the protocol in those camps are largely undiscovered. Most importantly, there is a dearth of a comprehensive study which covers situational analysis along with GO-NGO's response, impact on the host communities, and level of coordination between government and other partners, and this knowledge gap hinders the better policy formation for both FDMN and host communities of those areas.

In order to ascertain the current extent of GBV burden, the services available for GBV survivors including health care services and how these interventions are making difference in the lives of the GBV survivors, GNSPU commissioned Institute of Health Economics to conduct a research that would not only provide some insight and knowledge in this gap thus creating evidence base for policy advocacy for GBV integration in the existing humanitarian sectors but also contribute in improving the overall GBV situation by proposing feasible solutions.

1.2 Objectives of the study

The key objective of this study was to assess the overall situation of GBV survivors in FDMNs settlement camp and GO-NGO response towards them.

Specific Objectives:

- To assess the magnitude of burden of GBV survivors and their health consequences (Number of new cases, repeat/follow up cases, number of cases received CMR, number of cases provided PFA)
- To ascertain changes in service modalities towards adopting gender sensitive approaches in both GO-NGO providers in the area (Installation of Women Friendly Spaces, care providers trained on CMR, designated service provision for female clients i.e. separate queue, proportionate gender equity among care providers to encourage utilization of services by GBV survivors)
- To determine the level of access and utilization of services by both host and FDMN communities
- To identify coordination among mainstream actors in GBV (service mapping, inter sector coordination, referral pathways)

1.3 Conceptual issues/Operational definition of GBV

The overarching aim of this study was to assess the overall situation of GBV survivors in FDMN settlement camp and GO-NGO response towards them with specific objectives of identifying the extent of burden, availability of services, coordination among service providers and level of access and utilization of services. To operationalize the study some clarification is needed with regard to definition of GBV.

GBV is a very broad term, and for operationalizing the activities, the service providers use various definitions. Hence, a clear operational definition is necessary to pinpoint the scope of the current study. For this study, we provided a clear operational definition based on the definition used by recognized national/international organizations as well as based on the current practices in Bangladesh. Swedish International Development Cooperation Agency (SIDA) defined gender-based violence (GBV) as any harm or suffering that is perpetrated against a woman or girl, man or boy and that has a negative impact on the physical, sexual or psychological health, development or identity of the person. The cause of the violence is founded in gender-based power inequalities and gender-based discrimination. Many actors,

including the UN, use the term "violence against women" interchangeably with GBV. United Nations Declaration on the Elimination of Violence against Women adopted by the General Assembly in 1993 articulated the definition of gender based violence as any act of violence 'that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'. Gender-based violence includes:

Battering	Intimate partner violence (including marital rape, sexual violence, and dowry/bride price related violence)	Feticide
Sexual abuse of female children in the household	Honour crimes	Early marriage
Forced marriage	Sexual harassment	Intimidation at work, in school and elsewhere
Commercial sexual exploitation	Trafficking of girls and women	

In 1995, the U.N. expanded the definition to include: violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery, forced pregnancy, forced sterilization, forced abortion, coerced or forced use of contraceptives, and prenatal sex section and female infanticide.

Like the GBV definition, the standardization of GBV types also appeared to be complex and different from one context to another. The classification of GBV incidents varies greatly from agency to agency, from office to office, and even from case worker to case worker. This often results in difficulties in the collection and analysis of GBV data across field offices or agencies. For example, what one individual may classify as rape another may classify as domestic violence; what one organization may classify as forced marriage another organization may classify as sexual assault. This variation between and within organizations may affect the accuracy of GBV data and the effectiveness of inter-agency information sharing and coordination. To mitigate the terminological issues, the UN Population Fund (UNFPA), the International Rescue Committee (IRC), and the UN High Commissioner for Refugees (UNHCR) developed a new GBV classification tool that standardized how GBV incident types are defined by using a set of six core types of GBV. The six core GBV types described in the GBV classification tools are following:

Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

2. Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks.

3. Physical Assault: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that re*sults* in pain, discomfort or injury.

4. Forced Marriage: the marriage of an individual against her or his will.

5. Denial of Resources, Opportunities or Services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc.

6. Psychological / Emotional Abuse: infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

The GBV classification tool is widely used by the GBV service providers around the world, particularly by the GBV Information Management System (GBVIMS)[4] partner agencies. In accordance with the global GBVIMS reporting system, the GBV sub-sector actors in Bangladesh also follow the same classification tool for recording of GBV data. Therefore, we will consider the six core types of GBV as described in the GBV classification tools for discussing the GBV situation in FDMN community in this report. In addition, though not included as the core types of GBV, the following incidence will be analyzed to explain the context of the GBV cases as per the instructions of the GBV classification tool:

- ✓ Intimate Partner Violence (often referred to as "domestic violence")
- ✓ Child Sexual Abuse
- ✓ Early Marriage
- ✓ Sexual Exploitation / Transactional Sex
- ✓ Sexual Slavery
- ✓ Harmful Traditional Practices

[4] The GBVIMS is an inter-agency partnership between the United Nations Population Fund (UNFPA), the International Rescue Committee (IRC), and the United Nations High Commissioner for Refugees (UNHCR), in consultation with the Inter-Agency Standing Committee Sub-Working Group on Gender and Humanitarian Action and the Gender-Based Violence Area of Responsibility Working Group of the Protection Cluster. The GBVIMS Global Team was established in 2007 in response to the need for a standardized information management system to manage GBV incident data in humanitarian contexts. Currently, the GBVIMS initiative is overseen by a Steering Committee made up of representatives from the IRC, UNHCR, UNFPA, UNICEF, and International Medical Corps (IMC).

Chapter 2: Methodology

The study performed the following research activities:

i. Desk research (literature review)
ii. Field activities:
    a) Key Informant interviews (KII) and facility observation
    b) Focus group Discussions (FGDs)
    c) In-depth interviews (IDIs)
iii. One day consultative workshop with relevant persons from GO-NGO-INGO-UN bodies

Table 1 in annex 1 provides the summary of research activities.

2.1 Desk research (literature/document review)

The study team conducted literature review to understand the overall situation as well as to identify different stakeholders of GBV related issues and explore the capacity and extent of support services available for the GBV survivors before and after the influx. A variety of documents, reports, research papers on the status of women in the refugee camp was reviewed. In addition, different components of the existing services and their adherence to GNSPU policy papers, access and referral pathways for the beneficiaries were assessed. The literature review also explored the care seeking behavior of the beneficiaries and barriers to access the services. Special emphasis was given to the counselling and related materials used for providing services for GBV survivors.

At the beginning of the assignment, the review plan was developed in consultation with GNSPU which defined specific selection and exclusion criteria, including search terms. The literature review included existing literatures (reports and publications) produced during 2017 onwards. Materials reviewed encompass published scientific journal articles, technical reports, evaluations, case studies, presentations at technical meetings, working papers and briefings, service provision guides, counselling materials, and other write-ups.

The review involved searching electronic databases including: PubMed, Medline, WHOLIS (KMS), SCOPUS, and the Cochrane Library. Web sites of the relevant entities were also reviewed for materials, including national governmental entities; national research institutes, foundations and councils, as well as professional associations; UN/multilateral system agencies and donors funding related work in Bangladesh; and national and international NGOs. Most importantly, the study thoroughly reviewed the protocol developed by GNSPU of Health Economics Unit. Although this document is meant for service providers, it covers wide of issues pertaining to the GVB spanning from the definition to the legal issues, high court rulings, recent amendments.

2.2 Field Activities

2.2.1 Key Informant Interview and facility observation

In order to obtain a detailed understanding of services being offered for GBV survivors and their adherence to GNSPU policy guidelines, KIIs were conducted with the GBV service providers and stakeholders. The KIIs also provided an insight into the barriers to access the services, areas of improvement and sustainability of services. The KII respondents were functional heads of public and UN/NGO/INGO providers and also local public representatives. It included Refugee Relief and Repatriation Commission (RRRC) officials, Chief Coordinator and field coordinator of Ministry of Health and Family Welafre (MoHFW) Coordination center, health managers such as Civil Surgeon, UH&FPOs of two upazilas in Cox's bazar, coordinator of One-stop crisis center (OCC) at Cox's bazar district hospital, FDMN camp administrative officials (i.e. Camp-in-charge), program/project focal points of UN/NGOs/INGOs working on the GBV sector and public and private healthcare providers, psychosocial service providers and legal service providers serving the GBV survivors in the FDMN settlement camps and outside. In addition, the local public representatives, i.e. Upazila Chairman, Chairman and female member of Union Council, Upazila Nirbahi Officers (UNOs) and Officers-in-Charge (OCs) at local police stations were also interviewed in order to capture the views of host communities on the GBV services. The guideline used for KIIs have been provided in the Annex 2.

Along with the interviews, the study team visited several GO-INGO-NGO-UN facilities within and outside the FDMN settlement camps to observe the provision of health and psychological services to GBV survivors. The facilities visited were the One stop crisis center at Cox's bazar district hospital, one-stop crisis cell at Teknaf Upazila Health Complex, Ukhiya Upazila Health Complex, Baharchhora union health and family welfare center, IOM health center, MSF health post, BRAC health post, women and children friendly spaces and trauma counseling centers of MOWCA at the office of the camp-in-charge in selected FDMN camps.

2.2.2 Focus Group Discussion

Focus group discussions were conducted to explore views and experiences of GBV service providers and representatives from both FDMN and host communities. Alongside, themes/issues identified through KIIs were further discussed with the FGD participants. A detailed plan for focus group discussion was developed in consultation with GNSPU. Total 5 FGDs involving 6-12 participants in each group were conducted with service providers from GO/NGO/INGO/ UN bodies and multilateral organizations (i.e. psychosocial counsellors from MOWCA, agency focal persons of protection sector from UN bodies and INGO/ NGO/ multilateral organizations), *Mazhis* (community leaders) of FDMN settlement camps and host community representatives. The exact locations and framing for the groups were decided in consultation with GNSPU. The checklists used to conduct the FGDs have been provided in the Annex.

2.2.3 In-depth Interview

Considering the sensitivity of the topic and stigma associated with GBV issues, IDIs were conducted with the GBV survivors instead of FGDs from FDMN community to explore their views and experiences of utilization of health and GBV related services. The list of potential respondents was collected from the Camp-in-charge offices of selected FDMN camps, Upazila Nirbahi Officers (UNOs) and Officers-in-Charge (OCs) at local police stations. A strong level of privacy and confidentiality has been maintained during the interviews.

2.3 One day consultative workshop

A 1-day consultation workshop with focal points of providers and local elected representatives was organized at Upazila Health Complex of Ukhiya, one of the two upazilas of Cox's Bazar that hosted the fled FDMN community. Along with key stakeholders of two upazilas, RRRC and camps, high officials and key persons of GNSP Unit of Health Economics Unit were also present in the workshop. The objective of the workshop to share and validate the key research findings.

2.4 Data collection instruments (DCI)

Guidelines and checklists were developed for KIIs, IDIs and FGDs based on the GBV assessment and situation analysis tool by UNFPA, IMC, Global Protection Cluster and Australian Government Aid Program (2012) and the Gender-Based-Violence Tools Assessment Manual by the Reproductive Health Response in Conflict (RHRC) Consortium (2004) and modified according to Bangladesh context. In addition, standard protocols/guidelines were used for the consultation meetings and workshops. The data collection instruments are listed in Annex 2.

1.4 Ethical considerations

The study protocol, tools and methodology were submitted to the Institutional Review Board (IRB) of Institute of Health Economics (IHE) in Bangladesh for review and ethical approval. Informed consent was taken from the participants prior to enrollment into the study and interviews. The confidentiality and anonymity of the study participants was strictly maintained throughout the study.

Chapter 3: Findings

3.1 Situation overview

3.1.1 Dwellings of FDMN in Cox's bazar, Bangladesh

Rohingyas are a Muslim minority who reside in Rakhine state, Myanmar. For decades, the Rohingyas have lived in Myanmar and have been subjected to denial of citizenship and ethnic and religious persecution in Myanmar. Hundreds of thousands have fled to other countries in Southeast Asia, including Malaysia, Indonesia, and Philippines, the majority have escaped to Bangladesh. Since the 1970s Rohingya people have been coming to Bangladesh from Myanmar, with large exodus occurring in 1978 and 1991-1992, when over 200,000 Rohingyas entered in Bangladesh each time. In 1992, two official refugee camps, namely Kutupalong (in Ukhiya) and Nayapara (in Teknaf) camps, were built for hosting the registered[5] Rohingya refugees and still exist today. Following escalation of violence in Myanmar during 2016-17, Bangladesh experienced the largest influx of Rohingya people into the land. According to the UN Refugee Agency (UNHCR), more than 743,000 Rohingya, officially regarded as FDMNs by GoB, have fled to Bangladesh since 25 August 2017. It is estimated that there are 1.1 million FDMN people living in Bangladesh now. Most of FDMNs are living in the makeshift settlement camps in Ukhiya and Teknaf upazilas of Cox's bazar districts. There are about 34 settlement camps the FDMNs reside in currently, including the above-mentioned two camps. . Table 2 provides key statistics of FDMN community.

Table 2: Dwellings of FDMN in Bangladesh

Dwellings of FDMN	Number of Rohingyas (%)
In 27 Camps	905754 (79.22%)
Outside the camps	231798 (20.27%)
Host communities	5812 (0.51%)
Total number of Rohingya in BD	1143364
Number of FDMN arrived since August 25,2017	743000
Registered by Govt. UNHCR till July 31, 2019	482081
Percentage of refugees hosted by Bangladesh in relation to world's total refugees	4.7%
Total Refugees in the world	24326894

Source: UNDP/Inter Sector Coordination Group (ISCG) Situation Report, July 31, 2019/Bangladesh

More than 50% of the FDMNs are below 18 years of age, another 42% are aged 18-59 years (Figure 1). Figure 2 depicts the demographic characteristics of FDMN community based on UNHCR population fact sheet, which shows that majority of the FDMNs are female and half of them belong to 12-59-year age groups.

[5] Up until 1992, the Rohingya population arriving in Bangladesh were officially registered as refugees by the GoB.

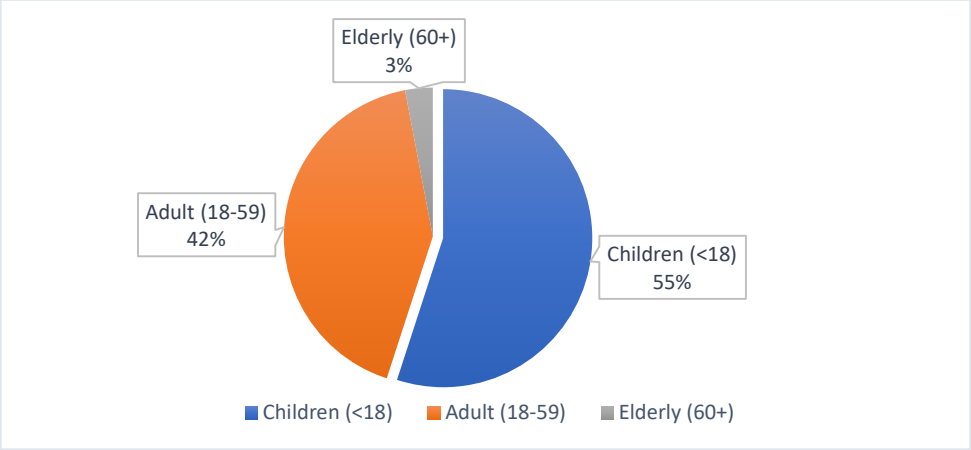

Figure 1: Age distribution of FDMN community living in settlement camps and host community (n= 909000) (Source: Bangladesh Refugee Emergency Population Factsheet by UNHCR, 15 June 2019)

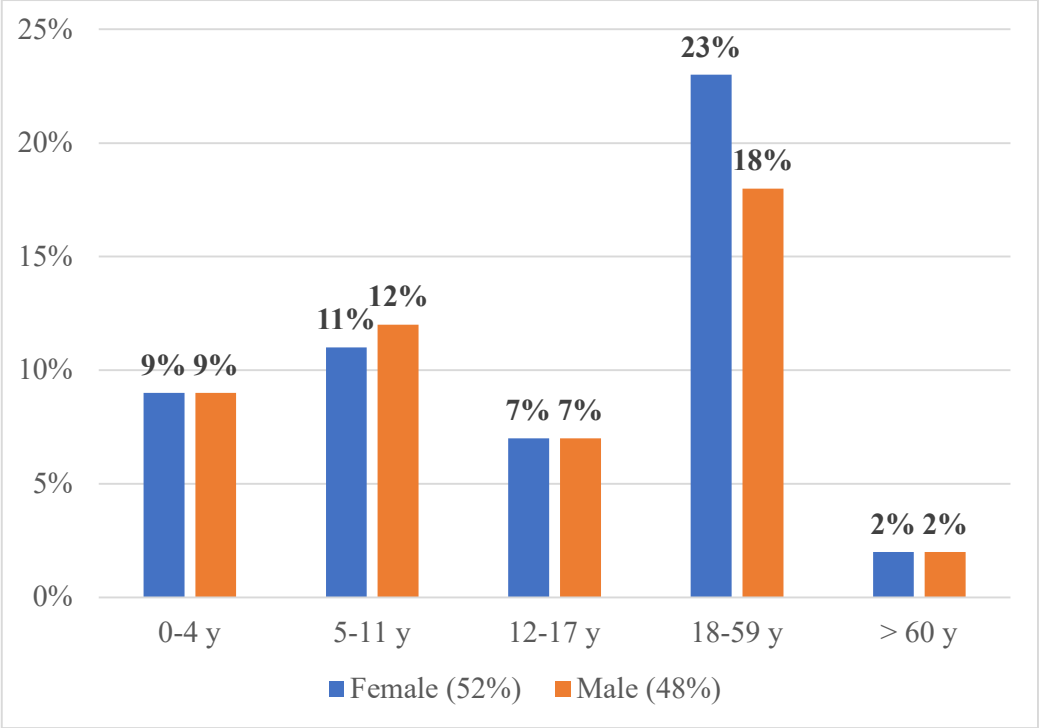

Figure 2: Demographic breakdown among FDMN (Source: Bangladesh Refugee Emergency Population Factsheet by UNHCR, 15 June 2019)

3.1.2 Humanitarian response to FDMN crisis by GoB and UN bodies/ INGO/NGO/ multinational agencies

The government of Bangladesh (GoB) has responded generously throughout FDMN crisis. From the very beginning of the latest crisis, GoB has kept its border open to fleeing Rohingyas, thus saving the lives of almost a million of FDMNs, spared no effort to help despite its limited resources and continues to lead the humanitarian response in close collaboration with the humanitarian agencies. The people of Bangladesh continue to show exceptional hospitality in the face of human tragedy on a massive scale. Following the influx, the office of the Refugee

Relief and Repatriation Commissioner (RRRC)[6], under the Ministry of Disaster Management and Relief (MoDMR), was mandated to coordinate all activities related to the provision of humanitarian aid (water, sanitation and hygiene, shelter, health, education, food security and nutrition services) and relief for the FDMN community (Vincent and Sapkota, June 2018). The directorate general of health services (DGHS) under Ministry of Health and Family Welfare (MoHFW) is among the first government entities to reach out to the FDMNs and provide lifesaving healthcare services. The DGHS has been providing healthcare services to Rohingya refugees settled in two registered camps, Nayapara and Kutupalong and local community in the surrounding area since 1992. Following the recent influx, the DGHS established health posts and primary health centers in 12 camps and further extended the services in 4 more camps. During the acute emergency phase (August 2017-August 2018), the DGHS deployed 12 health teams (8 in Ukhiya and 4 in Teknaf) in static health camps consisting of Medical Officers, Sub-assistant Community Medical Officers (SACMOs), Senior Staff Nurses and Technician etc. through deputation from across the country to provide essential lifesaving services, while the support staffs were managed from local communities. Till date, 293 doctors, 186 nurses and 224 SACMOs[7] have been posted by DGHS in FDMN settlement camps and served the FDMN community in various duration, from 1-3 months; about 1259 community health workers have been recruited for outreach activities. As of November 2019, DGHS is running 16 health posts (HPs) and 5 primary health centers (PHCs) in FDMN settlement camps. Initially, UNICEF provided logistic support to the health posts (for example, tents and medical supplies), later the World Bank contributed in the construction of the health posts, delivery of human resource, logistics and medical supplies through International Organization for Migration (IOM). The Management Information System (MIS) of DGHS has created a separate database for FDMNs in the District Health Information Software version 2 (DHIS-2) named DHIS-2 FDMN Server for better monitoring of health situation, improving disease surveillance, mapping disease outbreaks and analyzing health interventions. In August 2017, DGHS coordination center was established to oversee the health service provision activities and provide support to the government health staff, which later became the MoHFW coordination center in 2019 and is being funded through World Bank support to Civil Surgeon's Office. The MoHFW coordination center consists of 22 officials, 17 posted in Cox's Bazar and 5 in Dhaka, and is headed by Chief Coordinator.

The other government bodies involved in providing humanitarian assistance include but not limited to the department of public health engineering (DPHE) under the Ministry of Health and Family Welfare (MoHFW), Armed Forces Division, Ministry of Home Affairs (MoH), Ministry of Women and Children Affairs (MOWCA), Ministry of Local Government, Rural Development and Cooperation (MoLGRD), Ministry of Land (MinLand), Law and Justice Division under the Ministry of Law, Justice and Parliamentary Affairs (MinLaW), Department of Social Services (DSS) under the Ministry of Social Welfare (MoSW), Ministry of Environment, Forest and Climate Change (MoEF), Ministry of Foreign Affairs (MoFA), office

[6] The office of the Refugee Relief and Repatriation Commissioner (RRRC) is a government body responsible for the provision of humanitarian assistance for Rohingya refugees in Bangladesh, with the support of the United Nations (UN) and the international community. The RRRC was established in 1992 following the arrival of an estimated 250,000 Rohingya Muslims who fled across the border into Bangladesh from Rakhine State, in Myanmar. The RRRC office is located in the Cox's Bazar district of Bangladesh, approximately 390 km south-west of its capital city, Dhaka.

[7] http://103.247.238.81/webportal/pages/controlroom_rohingya.php

of the Deputy Commissioner and Civil Surgeon in Cox's bazar (Joint Response Plan for Rohingya Refugee Crisis, January-December 2019).

Along with the government agencies, a variety of UN bodies, national and international NGOs has been operating to provide life-saving protection and assistance to FDMN community. These agencies are organized into 12 thematic Sectors and Sub-Sectors namely Protection, Health, WASH, Food security, Nutrition, Education, Site management and site development, Shelter and non-food items, Energy telecommunication, Communication with communities, Logistics, Coordination as well as Working Groups that focus on cross-cutting issues (e.g. Protection, Gender in Humanitarian Action, Communicating with Communities). The activities of these humanitarian agencies (list is given in Table 3 in Annex 3) are coordinated by Inter-sector coordination group (ICSG)[8], which are supposed to work closely with the office of RRRC. Figure 3 in Annex 4 presents the FDMN response coordination mechanism. The following sub-section of the report provides a brief account of GBV sub-sector and health sector.

3.1.2.1 GBV sub-sector

The Gender-Based Violence (GBV) Sub Sector coordination structure in Cox's Bazaar was established in May 2017. Since 25 August 2017, this structure has been reinforced and expanded to respond to the needs of the massive influx of the FDMNs in Bangladesh. The GBV Sub-Sector ((led by UNFPA) operates alongside the Child Protection Sub-Sector (led by UNICEF) within the Protection Sector (led by UNHCR). The Sub-sector participates with other humanitarian sectors in the Inter-sector Coordination Group (ISCG).

The Gender-Based Violence Sub-Sector in Cox's Bazar is comprised of more than 28 standing member (27 implementing partners and 24 program partners, list provided in Table 4 in Annex 5) organizations; including, UN (5), INGO (12), NGO (7) and government bodies (RRRC, MOWCA, DGHS, DSS), operating in the Rohingya refugee camps and the surrounding affected host community locations. The sub sector works to prevent and respond to Gender-Based Violence through strengthening community-based GBV programming. The key strategic objectives of the Sub-Sector and main activities of the sector actors are given in Table 5.

Table 5: Strategic objectives and activities of GBV Sub-Sector

Strategic objectives of GBV Sub-Sector	Main activities of GBV Sub-Sector
- Ensuring access to quality multi-sector GBV response services for survivors - Building capacity of GBV service providers and other stakeholders to deliver quality care in line with best	- GBV awareness raising - Women's empowerment program - Psychological support - Dignity kits[9]

[8] The Inter-Sector Coordination Group (ISCG) is the central coordination body, hosted by IOM and UNHCR, for humanitarian agencies serving FDMNs in Cox's Bazar, Bangladesh.

[9] Dignity kits are packages comprising the basic necessities that displaced women and girls require to maintain feminine hygiene, dignity and respect in their daily lives, in spite of displacement. The packages include menstrual hygiene supplies, soap, clothes, a flashlight and a whistle.

practices and minimum standards for humanitarian settings - Enabling active participation of affected communities in GBV awareness raising, response, prevention and risk mitigation - Enhancing GBV risk mitigation across humanitarian sectors and with the government - Strengthening co-ordination and planning for sustainability of the GBV response	- Capacity building for community members - Capacity building for service providers - Youth/adolescent targeted program - Engagement of men and boys - Risk mitigation

In 2018, Gender Based Violence Information Management System (GBVIMS) was created to promote best practices in the collection, storing, management and sharing of GBV data generated through services delivered to GBV survivors in humanitarian settings (as per the above mentioned global GBVIMS protocol[10]). In Cox's Bazar it is currently implemented by 12 Data Gathering Organizations (DGOs) in the FDMN humanitarian response and affected host community. In June 2018, GBV IMS deployment process was rolled out that included assessment of GBV case management organizations, capacity building on GBV case, GBVIMS design and testing, and development of an Information Sharing Protocol (ISP). A total of 15 organizations including UNFPA, UNHCR and UNICEF, 12 GBV case management organizations signed the GBVIMS ISP in October 2018. As per the ISP, signatories must commit to engaging in ethical and safe GBV data collection and sharing that protects survivors and their families whilst facilitating GBV inter agency coordination. Aggregated statistical data collected by the DGOs is shared with the GBVIMS interagency coordination team for analysis, and the team produces a consolidated monthly report and further consolidated reports quarterly. For this study, data from two GBV IMS reports for October-December 2018 quarter and January-March 2019 quarter was analyzed.

3.1.2.2 Health sector

[10] The GBVIMS includes:
- GBV Classification Tool: provides definitions for a set of six core types of GBV that enables uniform terminology for GBV data collection. The tool uses a standardized process to reliably classify reported incidents of GBV by the core type of GBV that occurred.
- Intake and Initial Assessment Form: ensures that all GBV actors using this standard intake form are collecting a common set of data points in a consistent format. The form allows for local and institutional customization.
- Incident Recorder: an Excel database designed to simplify and improve data collection, compilation and analysis.
- Inter-Agency Information Sharing Protocol Template: provides a framework to guide the creation of a customized Information Sharing Protocol based upon guiding principles on the safe & ethical sharing of GBV data and best-practice.

In response to the humanitarian crisis following the recent influx in August 2017, at least 65 national and international agencies joined their hands to render emergency health services to FDMN community, thus the Health sector was formed (Health Sector Bulletin#9, Rohingya Crisis in Bangladesh, May 2019; Rahman, 2018). The Health sector is led by the World Health Organization (WHO)[11] since 1 October 2017 and currently there are more than 100 health partners known to be operating under this sector, including 62 international partners, 49 National NGOs, and 8 UN agencies (Health Sector Bulletin no. 10: Rohingya Crisis in Cox's Bazar, Bangladesh, July 2019). The list of health sector partners is given in Table 6 in Annex 6.

The sector is responding to the population needs through provision of health services in camps as well as strengthening of the health system as a whole through supporting existing health facilities, the health workforce and the surveillance system. The total estimated population in need which the health sector is targeting is 1.24 million including new arrivals, existing refugees, host community and contingency. Till date, the health sector has responded to the needs through health service delivery in more than 262 static and mobile health facilities in both Ukhiya and Teknaf, with a further 18 planned or under construction. The health sector partners are running 140 health posts in the camps; as well as 36 primary health centers of which 29 are running 24/7 services and 8 hospitals[12]. Besides, several government-run health facilities in the host community (including 10 community clinics, 6 union-sub-centers and 6 Health and Family Welfare Centers, Ukhiya and Teknaf upazila health complexes and Cox's Bazar District Hospital) are supported by the partners with human resources, renovations and medical supplies. The RRRC is running Refugee Health Units (RHUs) in two registered FDMN settlement camps, namely Kutupalong in Ukhiya and Nayapara in Teknaf, for providing healthcare to FDMN community, as well as for coordinating all the activities by health sector actors. The other activities of the health sector are listed in Table 7.

Table 7: Activities of Health Sector

Establishing expansive community health worker networks and developing risk communication materials
Ensuring availability of essential medicines and other supplies through logistics support
Maintaining a strong disease surveillance system
Delivering vaccination campaigns and strengthening routine immunizations
Improving morbidity/mortality reporting from health facilities and from the community
Strengthening laboratory diagnostic capacity
Monitoring and improving water quality in health facilities
Capacity building of medical personnel
Preparing for disease outbreaks

[11] World Health Organization also represents the health sector during Inter-Sector Coordination Group (ISCG) meetings in Cox's Bazar and also acts as the secretariat for the Emergency Coordination Committee set up by the government to lead the health response. Information management is handled jointly by IOM, UNFPA and WHO.

[12] http://103.247.238.81/webportal/pages/controlroom_rohingya.php

Overall, the health sector partners are coordinated under the leadership of Civil Surgeon's Office of Cox's Bazar, the DGHS Coordination Center and the WHO. The health sector has adopted a three-tiered coordination structure at District, sub-district (upazila) and camp-levels. At the District level, a strategic advisory group[13], constituting the main health sector partners, serves an advisory role to the health sector coordinator based on priority needs. Under the health sector coordination there are several active working groups with strong representation from the health sector partners. These groups evolve based on current needs, and meet at differing frequencies depending on the priorities. At present, the active working groups include:

a) Mental Health and Psychosocial Support (MHPSS) (chaired by IOM and UNHCR)
b) Sexual and Reproductive Health (SRH) (chaired by UNFPA)
c) Community Health (chaired by UNHCR and co-chaired by CPI)
d) Epidemiology and Case Management (chaired by WHO)

In addition, coordination of support to the District hospital (Sadar) continues through the Sadar Roundtable meetings and upazila level health sector coordination meetings. To ensure three levels of coordination, field coordinators were recruited to strengthen the linkages with the field-level activities. At a camp level, camp-level focal points are assigned from health partner agencies, for better two-way information sharing under the guidance of the Health Sector Field Coordinator. Field coordinators participate in relevant upazila and camp level meetings and the health camp focal points represent health sector in the camp-level CIC meetings.
The health sector actively collaborates with the Nutrition, WASH and Logistic sectors. In addition, to promote integrated care and guide implementation of the actions, the health sector convenes a group of GBV, CP, SRH, Community Health and Mental Health and Psychosocial Support technical working group leads.

3.2 GBV burden in FDMN and host communities

3.2.1 Nature and Scope of the reported GBV cases in FDMN community

Gender based violence is widespread and pervasive in FDMN community. While focus group discussions (FGDs) and key informant interviews (KIIs) revealed that many forms of GBV are endemic, but overall the types of GBV found to be most prevalent as shown in GBV IMS quarterly reports were: physical assault (battering), psychological abuse, denial of resources, opportunities and services, rape, sexual assault and forced marriage (Figure 4). Any incident involving GBV can often involve more than one form of violence (i.e. a survivor can be exposed to battering, sexual abuse and psychological abuse during the course of an incident). The exact nature and scope of GBV in FDMN community is difficult to measure given the high level of underreporting, especially for forced marriage and sexual violence. This is due to the risk of social stigma and lack of social support associated to sexual violence that survivors

[13] Strategic Advisory Group (SAG) was established comprised of WHO, the MoHFW and selected health partners such as BRAC, IFRC, MSF, IOM, UNFPA and UNHCR

might face as some of the rape survivors have previously been rejected by their husbands and in some extent the community. This is supported by comments from focus group discussions with Mazhis: ***"If it is disclosed that a woman's modesty was outraged, no one in the community will accept her for marriage."***

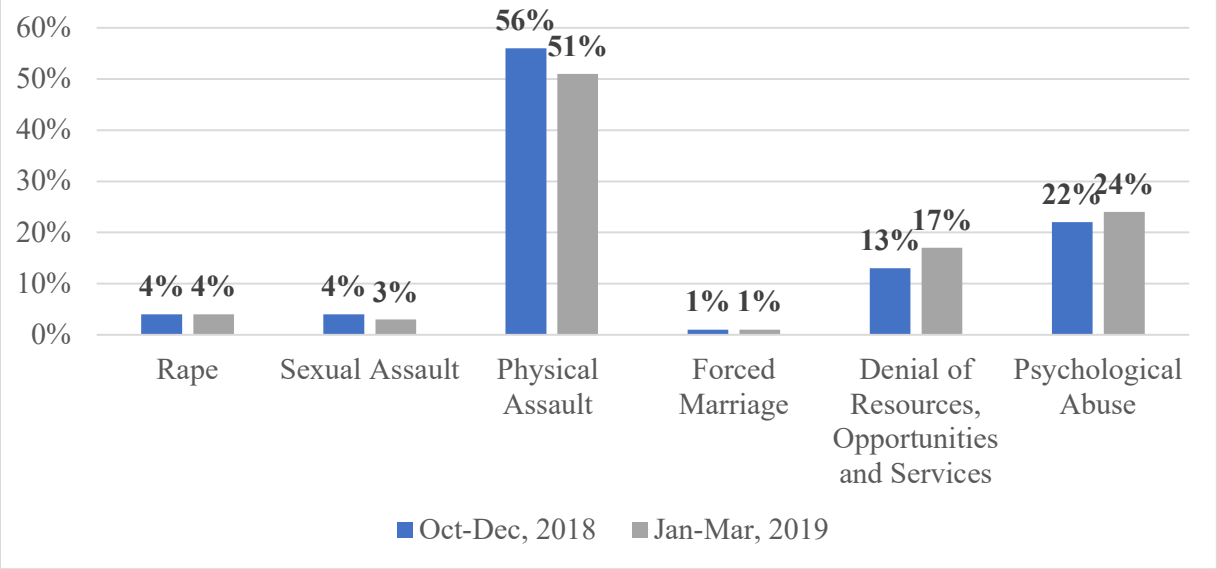

Figure 4: Proportion of reported GBV cases (Source: GBVIMS by UNFPA Quarterly Factsheet 2019, January-March)

Physical assault (battering) appears to be the most common GBV concerns encountered by Rohingya women and girls, indicative of the rampant but somewhat acceptable domestic violence[14] in the FDMN community. The GBV IMS quarterly report by UNFPA revealed that 74% of the total reported GBV cases were perpetrated by intimate partners[15], which was also evident in the FGDs and interviews. Apart from wife/ partner battering, battering of girl child by the household members, battering of women by in-laws and neighbors were also reported. Some of respondents mentioned of survivors presenting to the service providers with grievous hurt (fractured limbs, injured eyes and ears) and psychological illnesses due to extreme corporeal beating. Common contributing factors to domestic violence were linked to poverty, unemployment, dowry, polygamy, extramarital affairs, misinterpretation of religious beliefs, substance abuse, lack of resources, lack of education and lack of women empowerment.

[14] Any abuse perpetrated within the premise of the family against an intimate partner or any other family members. It can be in the form of physical, sexual, emotional, economic, reproductive, spiritual or psychological actions or threats or stalking/monitoring. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound.

[15] Includes current or former spouses (legal and common law), non-marital partners (boyfriend, girlfriend, same-sex partner, dating partner). Intimate partners may or may not be cohabitating and the relationship need not involve sexual activities.

Case study 1
A 30 years old women named Lotifa (pseudonym), fled to Bangladesh with her husband and three children in 2017 due to brutal violence by Myanmar army. Her husband Mr. Abul (pseudonym), 35 years old, had extra marital affairs with a girl when they lived in Myanmar. He continued that relationship after coming to Bangladesh and married her. After that, he stopped contacting with his wife and providing financial support. While demanding financial support, she had been continuously physically assaulted by husband. She sought care from hospital located inside the camp area and got required services. She complained to the Mazhi with a view to getting protection services. But her husband did not pay any heed to the Mazhi and then she complained to the CIC office. The CIC handed him over to the assigned officials from Bangladesh Army in the camp area. The army officials treated her in their ways. Now Mr. Abul stopped assaulting his wife physically, started providing financial support occasionally and is living with two of his wives.

Denial of resources for FDMN women was reported, for example where husbands refuse to provide support such as care and food for their wives and children, especially after marrying a second wife. Women also reported men pressuring them to hand over their food cards, taking women's earnings, denying their wives the freedom to work outside, denying their access to essential relief services and information, and denying girls access to learning centers.

Case study 2
Roksana (pseudonym), female, 40-year-old, fled to Bangladesh from Bunidaung, Northern Rakhine state in August 2017, with her husband and in-laws. Her husband, Shah Alam (pseudonym), 65 years old, was previously married and has children with the first wife. Roksana doesn't have a child with her husband. She has been subjected to physical assault and emotional abuse many times by Shah Alam. When they lived in Myanmar, she was not allowed to have her meal before she fed her step children. During flight, her husband abandoned her and she lived on the road for three days, without any food and shelter over her head. Later, she was discovered by Bangladesh Army, who helped her reunite with her in-laws. She continued to live with her husband and in-laws in a FDMN settlement camp in Ukhiya. Shah Alam has had several extramarital affairs within the camp and has been forcing her to divorce. Roksana used to get a beating every time she refused to divorce. About a year ago, he hit her so hard that her ears bleed. As she went to the MSF run primary health center for treatment, the duty doctor informed the Army about her condition. The Army personnel summoned Shah Alam, fined him and took undertaking from him that he wouldn't beat her wife in future. For the last 7-8 months, he has been involved with a woman from a different camp and staying in that camp with a hope to marry her, leaving Ruksana behind. In his absence, Roksana was frequently battered by her in-laws. Recently, he has started to coerce Roksana again for divorcing him. He has snatched her ration card, depriving her of relief items. Upon resistance from her end, he accused her of infidelity and produced divorce certificate in front of the Mazhis. He also claimed that he already had paid the Denmohor, whereas he never paid it. Roksana could not comprehend the writings on the divorce documents due to her poor literacy. She lost all contact with her father and brothers in Myanmar, and had no one in her support

in the community. Helpless, she went to the office of the CIC for justice. She was promptly referred to the Mental Health Service Center run by MOWCA for necessary services. Her case is now under investigation.

The most observed harmful traditional practices[16] within the FDMN community is early marriage[17], which is still underreported compared to the other reported GBV types. According to the GBV IMS quarterly report (January-March 2019), the prevalence of child sexual abuse in FDMN community was 2%. Interestingly, the health services providers interviewed in this study reported that child sexual abuse[18] was one of the most common types of violence that the survivors receive services for. A focal person of a health sector partner informed that they receive 7-8 cases of child sexual abuse survivors per month on an average.

The survivor report available at one stop crisis center, Cox's Bazar District Hospital also suggested, though highly underreported, child sexual abuse was not uncommon in FDMN community (Table 8). One of KII respondents said, ***"Child sexual abuse is a tip-of-the iceberg phenomenon. No one usually reports until the abuse is severe. Most of the cases of child sexual abuse we received lately were brought in unconscious state, imagine the level of torture the children had undergone!"***

Table 8: Total GBV survivors from FDMN community reporting to One-stop crisis center at Cox's bazar district hospital (referred cases) and Services Report of January-2017 to August- 2019

Age	Physical Assault	Sexual Assault	Burn	Total
0-18	06	26	00	**32**
18+	14	12	00	**26**
Total	**20**	**38**	**00**	**58**

The GBV IMS report of October-December 2018 revealed that from September 2017 to December 2018, 204 cases of human trafficking and exploitation have been identified and abetted. About 65% of the victims are women and girls under 18 years old who experienced exploitative and forced labor, unsafe sex and abusive working conditions. It was widely reported that forged travel documents are being produced to facilitate trafficking abroad and abduction of adolescent girls with the purpose of forced marriage and prostitution. The KIIs also corroborate with this finding. Some of the key informants revealed that the geographical location of the most of the settlement camps (in between the hills with dense forest and the Bay of Bengal) adds on to the vulnerability to trafficking. After abducting someone, the trafficker

[16] Are defined by the local social, cultural and religious values where the incident take place
[17] Is defined by the age of the survivor (below 18 years) at the time of the incident of forced marriage
[18] Is defined by the age of the survivor and includes different forms of sexual violence (rape, sexual abuse)

can escape simply by sailing away or can hide in the hills; making it difficult to track them down.

About 71% and 84% of the reported GBV incidents occurred in the survivors' home in October-December 2018 and January-March 2019 respectively (Figure 5). Water points, latrines and toilets are indicated among the spots of GBV risk, with 1% of the reported GBV incidents occurring at water points. However, the findings of KIIs and FGDs revealed that the proportion might be higher, as women face significant harassment from men at water points as well as on the way to and from the water points. According to the Joint Response Plan for Rohingya Humanitarian Crisis (2019), 49% of girls and 40% of women reported feeling unsafe using latrine facilities, 40% and 34% respectively for bathing facilities. Also, the number of water points, toilets and bathrooms is inadequate in the camps, thus these facilities are shared by multiple households. As a coping strategy, women try to avoid crowds by collecting water at dawn and dusk, going to makeshift bathing areas within their living shelters and not using latrines at night.

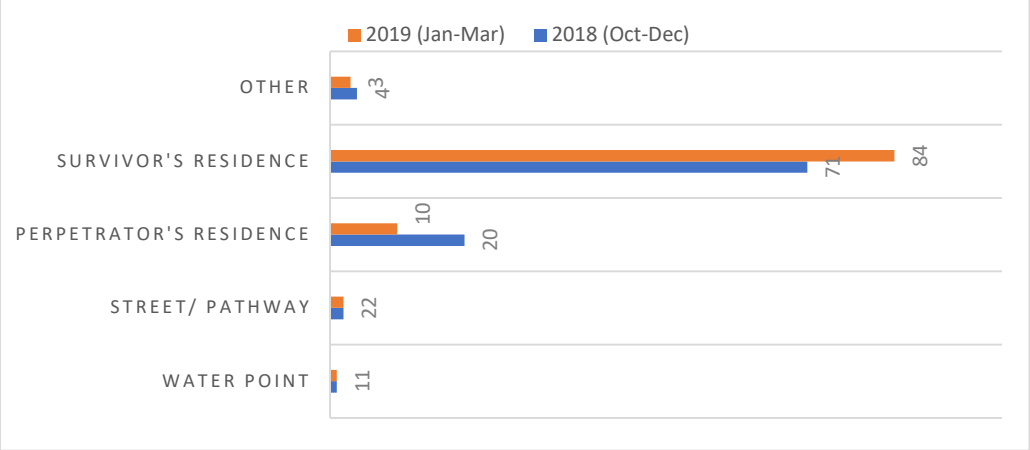

Figure 5: Location of GBV incidence (Source: GBVIMS by UNFPA Quarterly Factsheet 2019, January-March)

Nearly 50% of the reported GBV incidents were perpetrated during the night (Figure 6). The findings of KIIs and FGDs also revealed that the majority of the GBV incidence reported took place at night time. This could be explained by many different factors. Most of the men, who are the main perpetrators of the reported GBV incidents, spend the day outside and only come back home at night. Furthermore, lack of outdoor lighting, administrative support, security patrols and the absence of humanitarian actors in the camps at night increase the risks of GBV for women and girls compared to day time.

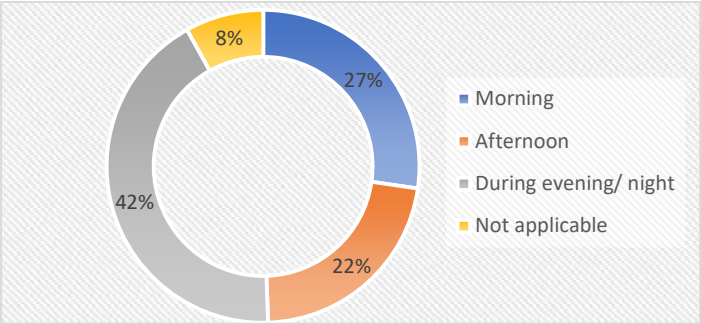

Figure 6: Incident time of day (Source: GBVIMS by UNFPA Quarterly Factsheet 2019, January-March)

3.2.2 Information about GBV survivors in FDMN community

About 98% of survivors in FDMN camps are females (adults in their majority). Male survivors represent only 2%, which could be due to the limited access for the men and boys. Key informant interviews with service providers revealed lack of services for male survivors as the GBV interventions are focused on women and girls mainly. Whilst children (<18 years) represent 55% of the total FDMN population, they represent 6% of the GBV survivors. Some of the KII respondents involved in GBV service provision mentioned that the child survivors were usually 7-11 years old. Figure 7 illustrates the age distribution of the GBV survivors.

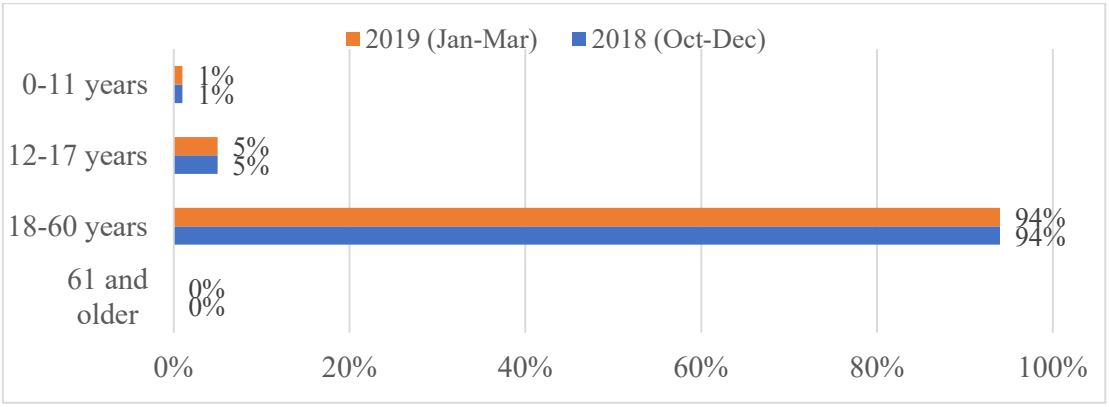

Figure 7: Age distribution of GBV survivors in FDMN community (Source: GBVIMS by UNFPA Quarterly Factsheet 2019, January-March)

Although the girls and women in the FDMN community are considered to be at the greatest risk of GBV, the disabled, separated and unaccompanied children (both male and female), single mothers, and widows were identified as the most vulnerable groups for GBV, particularly for domestic violence, forced/child marriage, and exploitation and trafficking. According to the GBV IMS quarterly reports, about 3% of the reported GBV incidents were perpetrated against these group of people, which is likely to be underreported.

3.2.3 Nature and Scope of the reported GBV cases in host community

To understand the nature and scope of GBV cases in host community, the study conducted several key informant interviews with stakeholders (including coordinator of OCC, clinical psychologists of MOWCA, GK, UNFPA), focus group discussion with clinical psychologists.

Most of the GBV cases received were from children of age 5-13 years. All the male children survivors were below 12 years and female are below 18 years. Assaults among the adults has also risen over the last three years. Domestic violence is more prevalent due to early marriage, dowry, polygamy, or by drug addicted husband or members from in-laws' house. Increasing income of the people was identified to be one of the potential factors to the rise of violence, as it influences the tendency of polygamy, especially among the lower income group. The perpetrators were of middle age, even elderly people of age >60 years or very young of age 12-13 years. In most cases, parents brought the children to OCC for seeking care and support. In some cases, neighbors also brought the survivors, especially in case where women beaten by husband. Survivors who works in NGOs or are employed came by own selves. The psychological coordinator usually supervises the whole process of service in OCC. She counsels the patients as well as the attendants through several sittings. Table 9 provides a detailed GBV cases reported to the OCC from January 2017 to July 2019 among the host community.

Table 9: Total GBV survivors and Services Report of January- 2017 to July- 2019 (Host community)

Age group	Physical Assault	Sexual Assault	Burn	Outdoor Victims	Total	Counseling	Thana/Court Case	Mediation	Processing	Not interested to take legal action
0 - 18	23	238	0	288	549	879	672	98	60	**509**
18 +	438	187	4	158	787					
Total	**461**	**425**	**4**	**446**	**336**	**79**	**672**	**8**	**0**	**509**

3.2.4 Causes and contributory factors for GBV

3.2.4.1 Underlying factors for GBV in FDMN camps

- Polygamy practices: Polygamy practices are found to be prevalent in the FDMN communities and that has increased coming to Bangladesh. Myanmar did not permit them having more than one wife, and now in Bangladesh it is difficult to enforce Bangladeshi law. And many FDMN people are taking this as an opportunity. Moreover, sometime financial incentives also play a role (such as dowry; greediness).
- Child marriage (both male and female)
- High prevalence of extra marital affairs and pre-marital sexual relationships
- Misconception regarding sexual abstinence during pregnancy—the perception that it is not acceptable to have sexual relationship with wife while she has pregnancy
- Misinterpretation of religious values
- Extreme male domination in society
- Discouragement for female education
- Female and child headed household are more vulnerable due to the necessity of support from male

- Camp environment: The poor living condition of the settlement camps, i.e. overcrowding, living in congested premises, lack of proper outdoor lighting premises, inadequate WASH facilities within the camps exposes the community to the risks of physical insecurity and abuses.
- Lack of absolute opportunity to engage in economic activities (i.e. more unproductive leisure time): The FDMN communities lack the opportunity to engage in economic or productive activities. Moreover, they lack the proper entertainment options. All these together play a role in high prevalence of GBV.
- Lack of protection services during nights: not having the presence of law enforcing agencies inside the camp
- Lack of effective law and order conditions (inside the camps)
- Abuse of power by *Mazhis*
- Difficulty in convicting for wrongdoings
- Substance abuse of FDMN communities
- Huge uncertainty regarding future

3.2.4.2 Underlying factors for GBV in host community

It was evident that the host communities are also affected by the FDMN communities. Some practices of FDMN communities are leaving spillover effects on the host communities that resulted in an apparent increase in GBV in the host communities. These are:

- Host communities are influenced by the malpractices of FDMN communities (such as substance abuse)
- No fencing (unprotected camp areas) and therefore it is easy for both communities to mix to each other which leaving some spillover effects
- Increase in polygamy practices in host communities due to FDMN influx. Due to the polygamy the relationship between the husband and the (first) wife is deteriorating which sometimes lead to violence.

3.3 Service provision and gaps

3.3.1 Availability and utilization of GBV services in FDMN camps

As mentioned in the previous section, humanitarian actors are providing different types of services to support GBV survivors. Figure 8 depicts the list of various services available for GBV survivors and gaps in provision. Out of the total FDMN population, 52% are women and girls, 7% are comprised of disabled, separated and unaccompanied children and 16% are single mothers (UNFPA, GBVIMS Quarterly Report, October-December 2018). Many of them have been exposed to widespread and severe forms of sexual violence in Myanmar before and during forcefully displacing and, following displacement, they continue to be at disproportionate risk of GBV. As of November 2018, only 43% of minimum service coverage has been achieved for urgently required GBV case management and psychosocial support for children and adults (Joint response plan for Rohingya Humanitarian Crisis, January-December 2019). Out of 34 camps, four are still not covered by essential minimum GBV services (case management, access to psychosocial services, health, clinical management of rape (CMR), legal counselling

and safe spaces for women and girls); five have only 25-50% of GBV service coverage and another eight camps have 25% service coverage. Moreover, the women and girls fear that moving outside their shelter will further expose them to GBV incidence, which limits their accessibility to the necessary services. To ensure optimum coverage of the lifesaving care for the total population in need including the host communities, at least 115 additional GBV case management service entry points are required, as recommended[19] by the Joint Response Plan, 2019.

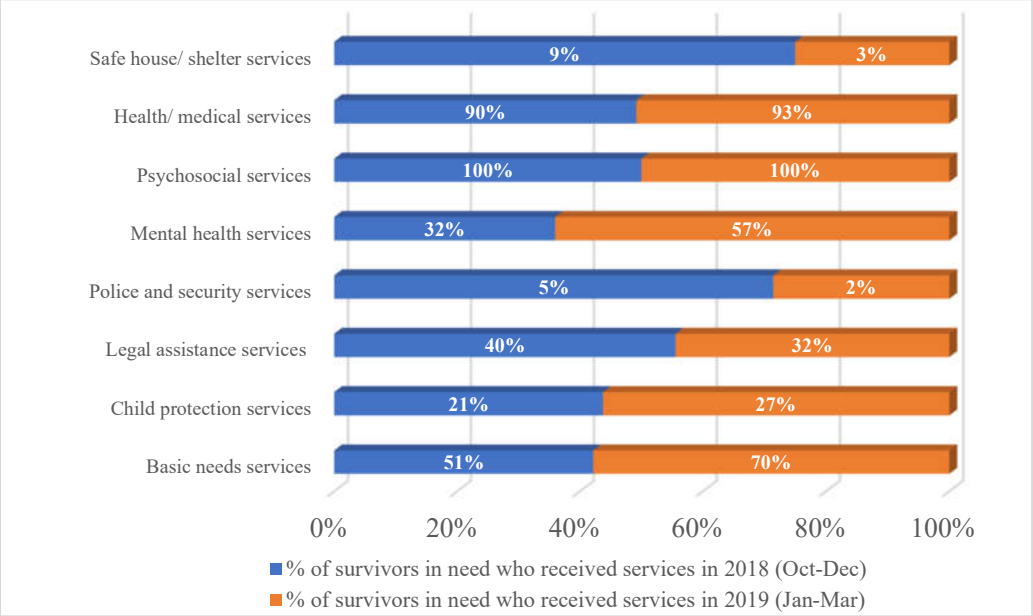

Figure 8: Proportions of survivors receiving GBV related services (Source: GBVIMS by UNFPA Quarterly Factsheet 2019, January-March)

3.3.1.1 Psychosocial[20] and mental health services

Other than MOHFW that has opened the door of their facilities for FDMN communities, major agencies involved with mental health response for the FDMN community in Bangladesh include: Ministry of Women and Children Affairs (MOWCA) of GoB, UN agencies (IOM, UNHCR, UNICEF), INGOs (ACF, Danish Refugee Council, Handicap International, International Rescue Committee, MSF, Relief International, Save the Children, World Concern), National NGOs (BRAC, Gonoshasthaya Kendra, Mukti[21] Cox's Bazar), and Red Cross Societies (Danish Red Cross, International Federation of the Red Cross and Red Crescent Societies). Among them, the GBV services rendered by the MOWCA will be discussed in this report, as most of the agencies neither responded to the study team when they were approached

[19] This figure is based on the ideal that one center can cover approximately 6,000 individuals

[20] Psychosocial services are survivor- centered that build individual and community resilience and support positive coping mechanisms, drawing on family, friends and community members. The survivor is supported to plan for her/his own recovery and access services and support to meet basic needs. It is provided by case workers that received training on GBV case management using the interagency guidelines on GBV case management.

[21] In some places they faced actions by the government due to some irregularities.

nor provided the study team with sufficient data. The Multi-sectoral Programme on Violence Against Women under MOWCA has been contributing immensely to the GBV sub-sector since October 2017.

The programme offers a range of services to the GBV survivors from both FDMN and host communities through One-stop crisis center (at Cox's Bazar Medical College) and One-stop crisis cells (at Kutupalong camp, Ukhiya and Upazila Health Complex, Teknaf) While the OCC at Kutupalong, Ukhiya provides medical treatment, psychosocial counseling, legal support and rehabilitation services to both FDMN and host communities, the one stop crisis cell at Teknaf Upazila Health complex provides the same services only to the host community. In addition, MOWCA operates 8 regional trauma counseling centers (RTCCs) across Cox's Bazar and mental health service centers in 16 FDMN camps which provide psychosocial counselling and referral to legal and health service providers in necessary cases. Each of the mental health service center has a clinical psychologist, psychosocial counselor cum translator and psychosocial volunteers. Realizing the stigma associated with reporting of GBV cases and seeking for services, the psychosocial services providers conduct outreach activities and group sessions in the FDMN community not only to create awareness about the GBV issues but also to identify the GBV survivors in need. The psychosocial volunteers disseminate messages related to reproductive health, mental health, GBV and human trafficking, identify GBV cases in the community. The psychosocial volunteers are selected from host community and FDMN communities alike, can be male or female and might themselves be GBV survivors. They are supervised by the psychosocial counselors cum translators, who are especially trained for managing GBV cases. The psychosocial counselors perform home visits in the camps, conduct group sessions (arranged by the psychosocial volunteers) with the community people and one-to-one psychological counseling sessions (usually 4-6 sessions for each survivor) with the survivors. The clinical psychologists are involved in the provision of counseling services to GBV survivors, facilitating the referral services, training and monitoring the activities of the psychosocial counselors. There are about 10 clinical psychologists, 1 regional coordinator (also a clinical psychologist) for RTCCs, 2 Program Officers and 1 OCC coordinator currently working under MOWCA in FDMN and host communities in Cox's Bazar.

All of the survivors of the reported GBV incidents received psychosocial support at their first service entry point. Psychosocial support is the service that most GBVIMS partners are providing, as of July 2019, about 39% of the children (14,241) benefitted from structured psychosocial support services according to the Situation Report Rohingya Refugee Crisis by ISCG. However, considerable gaps exist for access to Mental health services. For example, according to GBVIMS reports by UNFPA, about 32% and 57% of the survivors received mental health services respectively in October-December 2018 and January-March 2019, and according to Situation Report by ISCG, 49% of the survivors in need received mental health services (July 2019), whilst majority (62%) of survivors in need declined the offer of referral to a mental health service. The KII respondents stated that almost half of the survivor in need did not receive any mental health services, also client drop-out was common, with very few completing the counseling sessions.

About 22% of survivors reported having experienced a GBV incident prior to the one they reported. This may end in causing serious mental health issues to many GBV survivors and needs to be addressed through a well-structured and quality mental health service that is both available and accessible to all FDMNs.

3.3.1.2 Health services

Under the Health Sector[22], 32 program partners (1 UN body, GoB, 16 INGOs and 14 NNGOs) are involved in the provision of health services to the FDMN community free of cost through 134 basic health units (health posts), 29 primary health centers (PHCs) and 8 hospitals. The study team visited several HPs run by different organizations like HEED Bangladesh, IOM, GK, BRAC, Family Welfare Center (PHC) run by IOM, in-patient clinic (providing secondary healthcare) run by MSF-Holland inside different FDMN camps in Teknaf and Ukhiya, one union health and family welfare center (UH&FWC) by MoHFW, GoB adjacent to settlement camp in Teknaf and Upazila Health Complexes (UHCs) in Teknaf and Ukhiya.

The Health Posts (HPs) provide out-patient services only and the operation hours are from 9am-4pm. Though different health posts maintain different human resources structure, the overall requirement of human resources for HPs are one medical officer, one paramedic, one medical assistant and other supporting staff. Some health posts were found to be operating only with two/three health staffs. Male –female balance is strictly maintained among the all Health Post while posting human resources. Health posts mainly provide first aid services and work as referral to facility. If any case arises beyond its capacity, it refers the patient to the primary health care centers (PHCs). Generally, HPs do not provide services for GBV survivors. For GBV cases they refer to facilities like FWC, Sadar hospital, Psychologist, and other tertiary level hospitals. To avoid duplication of services, the health sector partners have delineated responsibility of managing the HPs and PHCs, i.e. an agency that provides HP services in a camp will not provide PHC services, and vice versa. Each facility is assigned a unique identifying number to simplify any facility-based reporting.

Primary health centers (PHCs) provide both outpatient and inpatient services on 24/7 basis. The human resources of Primary Health Centers comprise of one doctor, one paramedic, one medical assistant, one pharmacist, two drug dispensers, four nurses and other supporting staff. The government health centers have unique organogram and essentially consist of one MO, one SACMO, one Senior Staff Nurse (SSN), clinical aids, health center manager, field supervisor and two community health workers. The PHCs provide maternal and child health services including normal delivery, immunization, family planning, nutrition, mental health and eye care and also serve as referral centers. Limited diagnostic services are also available at the PHCs. It is to be noted that the GBV related health services are not available in all PHCs. According to the Health Sector Bulletin#9, about 24 PHCs and the secondary hospitals provide GBV specific treatment, i.e. Clinical Management of Rape (CMR), minimum initial services

[22] Mobile teams and other makeshifts arrangements are also likely to be present there but this report does not include the service provisions by those groups.

package (MISP)[23] that include post-exposure prophylaxis (PEP) against HIV/AIDS, emergency contraception, antibiotics, preventive treatment for sexually transmitted infection (STI) and pregnancy tests, Tetanus toxoid (TT) and Hepatitis B vaccination, safe termination of pregnancy, treatment of injury, mental health and psychosocial support services and referral services, while HIV testing and counseling is available in only 4 facilities, among which only one is situated inside the FDMN camp, which is a secondary (MSF clinic, Kutupalong). The PHC facility visited by the study team was headed by a Medical Officer and operated 8:00am to 5:00pm (only delivery service is available round the clock). All types of required medical treatment and medical test are provided for the GBV survivors in this facility. In case of GBV cases, survivors first report to 'IOM- Safe Space' then they are referred to IOM- FWC for treatment. As per the facility record, during the period of August 2017-April 2019, total 113 GBV cases from the FDMN communities were treated among which 21 (17%) was sexual violence (SGBV) and 92 (83%) was other types of GBV. The GBV specific services available at this facility are CMR (as per the guideline developed by UNHCR, IOM and UNFPA, listed in Annex 7), emergency contraception, pregnancy tests, abortion counselling. MR, etc. After treatment rape survivors are referred to Leda Health Clinic (IOM-LHC) to receive trauma/ psychological counselling. In necessary cases, they refer to other organizations (i.e., police, IOM-GBV center, Sadar hospital, psychologist, etc.). The head of this facility (Medical Officer) and midwife received formal training on the management of sexual violence provided by UNFPA, the duration of the trainings were 7 days and 2 days respectively. The training program covered the following learning things: medical treatment, completing the medico-legal form, laws (covering rape and sexual offences), referrals to other services, giving evidence in court, counselling, things necessary to fill up the needs of female, male and child survivors. While managing the GBV cases, ensuring of privacy and maintaining of confidentiality is mandatory for all service providers. Thus, in case of female survivors, all the physical examinations and other related services handled by female service providers (doctors, midwives). In terms of medico-legal services, a limitation for the NGO-IGNO led health facilities is that they cannot provide medical certificate to survivors; only government facilities are authorized for issuing these certificates. For this purpose, the PHCs coordinate with the CIC office.

Besides the HPs/ PHCs, there are 8 secondary health facilities in the FDMN camps namely IOM Hospital, Malaysian Field Hospital, MSF clinics, Turkish Hospital, Red Crescent Hospital etc. One of the clinics of MSF-Holland was visited and its focal health services provider was interviewed during field survey. The clinic is usually visited by women and girls for general health co-morbidities and reproductive health needs as well as for ANC /PNC/FP. Nonetheless some survivors of GBV also received services from this facility, among which intimate partner violence, sexual violence/ rape and child sexual abuse were the most common

[23] The MISP is a coordinated set of priority sexual and reproductive health activities that should be implemented from the onset of an emergency to save lives and prevent morbidity. The MISP includes measures to prevent and respond to sexual violence, prevent maternal and neonatal mortality and morbidity, reduce HIV transmission and plan for the establishment of comprehensive reproductive health services to ensure a continuum of care.

types. On an average, the clinic receives 30-40 GBV cases per month including both male and female. The clinic operates 24/7 and provides services free of cost. The physical examinations of the patients are conducted in private rooms which are safe and noise proof to ensure privacy and safety. The healthcare staff do treat and provide a comprehensive care (including post exposure prophylaxis) for GBV survivors, therefore many of the survivors do not require to be referred for trauma/psychological counseling to other facilities. The main services offered in their facility related to the GBV cases includes- ensuring structural spaces within facility to enable confidentiality, privacy and sensitivity; sensitizing the community, providing information and raising awareness; providing comprehensive mental health and psychosocial support and offering and providing medical certificate. They do not collect any physical evidence[24] as per the protocol for Health Care Providers prepared by the GNSP Unit of Health Economic Unit under MoHFW, rather they follow the GBVIMS protocol as per standards set in humanitarian settings while keeping records of patients who have been examined after rape. Mainly IOM or CIC receives survivors and facilitates further steps to ensure protection and legal proceedings. In doing so, the survivor's decisions remain central to the care and legal protection. Again, making decision for reporting a case of sexual violence to the police is always based on the willingness and request of the survivors, as mentioned by the respondent. None of the cases from this facility that have gone to court in the past year nor anyone from this facility ever given evidence in court. While discussing about follow ups, the respondents answered that they focus on ensuring that survivors are voluntarily returning to their facility for follow up care through good counselling sessions and they do not follow up the survivors outside our facility due to confidentiality and privacy issues. Since GBV is still highly stigmatizing, every measure is taken to ensure the survivors feel safe and comfortable and not exposed. All staffs providing GBV services are sensitized and well trained. Things covered in the training includes medical treatment; PEP; completing the medico-legal form; laws (covering rape and sexual offences); referrals to other services; counseling; meeting the needs of male survivors; and meeting the needs of child survivors. The coordination between this health care facility and NGOs over GBV cases are maintained by GBV clusters in Cox's Bazar. Along with the Health sector actors, one-third of the GBVIMS organizations provide health services to GBV survivors (GBVIMS quarterly report by UNFPA for October-December 2018). Health/medical services was the second most utilized service by the GBV survivors in need, the utilization rate increased from 90% in October-December 2018 to 93% in January-March 2019, as per the GBVIMS quarterly report (Figure 8). However, access to essential health services for GBV survivors, particularly for the rape/sexual assault survivors is severely limited. While it is known that the response to address health consequences of rape is widely affected by delay in reporting, only 19% and 16.6% rape cases were reported within 72 hours of the incidence during the last quarter of 2018 and the first quarter of 2019 respectively. This means majority of the rape survivors could not access timely healthcare (CMR). The

[24] Swabs of genitalia and smear: perineal swab, vaginal swab (one low-vaginal, mid-vaginal, two high vaginal swab, one or two endocervical swab if more than 48 hours have passes since the alleged incidence); perianal swab; oral swab; swabs from bite marks; hair; fingernail scrapping; clothing or belongings

Multisector Need Assessment (MNSA) conducted in July 2018 and Need and Population Monitoring (NPM) identified several factors that affect the timely access to and provision of quality health care to GBV survivors such as, lack of awareness of available services, insufficient variety of health services, insufficient female doctors, long wait times, distance to facilities, lack of transportation, long wait times, security concerns and lack of requisite medications. In May 2019, an inter-agency GBV service quality assessment was carried by the Health Sector in 16 PHC facilities where CMR services were available and recognized several gaps in health service provision. such as:

- Lack of visible information, education and communication (IEC) materials to inform patients of GBV about the available GBV services, what to do in case of GBV or benefits of reporting
- Lack of the essential infrastructure, equipment and commodities to provide appropriate care, for example, confidential space, lockable cabinets, relevant hepatitis B or tetanus vaccines, emergencies contraceptives, HIV prophylaxis, treatment protocols or GBV registers, in nearly 75% of the facilities
- Lack of appropriate systems for patient identification in case of sexual or intimate partner violence in 80% of facilities; only a few providers had received some training on how to ask about it or identify signs and symptoms
- Inadequate skills of the providers on child friendly communication techniques and lack of understanding of the concept of informed assent for child survivors in some facilities
- Lack of staff trained in clinical contraception, i.e. Intrauterine device insertion/ removal, in 50% of the facilities
- No **r**eferral system to ensure patients are connected to necessary services or follow-up systems, including GBV referral pathway in 70% of the facilities
- While 80% of facilities had staff trained on CMR, most of the outpatient staffs lacked training on CMR resulting in difficulties in patient identification and provision of timely support

The assessment also revealed that, out of the 16 PHCs where CMR was available, only 6 (37%) had attended to survivors of rape. This can be attributed to the limited number of facility-level staff trained on how to identify patients with signs and symptoms of GBV and the lack of systems to inform stakeholders about GBV service availability by the facilities. These constraints combined with the socio-cultural stigma associated to GBV might considerably affect survivors' access to life saving services.

The Union Health and Family Welfare Center (UH&FWC) delivers essential service package to both the FDMN community and host community living in the vicinity. In addition, this facility provides limited GBV related services such as, first point counselling, emergency contraception, prophylaxis for STI, basic psychosocial support and linking, referral and follow-up services to GBV survivors. The UHCs at Teknaf and Ukhiya provide primary healthcare services to both the host and FDMN community. During the acute emergency phase of influx, the UHCs faced high patient flow from the FDMN community which has gradually slowed down. As mentioned earlier, the one-stop crisis cell situated at Teknaf UHC serves GBV cases from the host community only, the GBV survivors from FDMN communities are treated for minor injuries and usually referred to Cox's Bazar District Hospital for further management. As a rule, the FDMNs have to obtain permission from camp authorities and a proper referral

pathway must be ensued to avail the general and GBV related health services from the UH&FWC, UHCs or the Cox's Bazar District Hospital.

3.3.1.3 Legal, security and protection services

Access to justice remained a substantial service gap for GBV survivors. According to GBVIMS quarterly reports, a large proportion of the GBV survivors could not be assisted with the required legal assistance[25] and security services, the situation deteriorated from October-December 2018 to January-March 2019. The KII respondents recognized various factors are to be contributing to the unmet need. First of all, legal assistance and security services are insufficient in many camps. Only MOWCA, UNHCR, CARE, BRAC, BNWLA, and Pulse Bangladesh are known to provide legal services to the GBV survivors. Whilst around one-third of the survivors in need benefitted from legal counselling, more than half of the survivors declined referral to a legal assistance service, and only 1% received assistance from security services (GBVIMS quarterly report by UNFPA). Generally, survivors believe that filing a complaint will result in disclosure of the GBV incident, loss of confidentiality and risk of victim blaming being blamed by security actors. Since battering is accepted in FDMN community, and women and girls who do file a GBV complaint are considered as 'bad women' by their own family and community. Survivors fear retaliation from perpetrators, and/or fear being divorced and separated from their children if they report GBV incidents to legal or security services. One of the legal associates interviewed in this study stated, ***"When a GBV survivor filed a complaint against the perpetrator, the perpetrator threatened the survivor that he will do it again and even threatened to her life. So, as a principle of GBV case management, we can't force the survivor for legal help."***

Moreover, in order to access courts, survivors must report first to police and provide forensic documentation, which is only valid if the forensic examination is conducted at selected government health facilities. The entire process for accessing legal justice is not only lengthy but also can leave survivors re-traumatized at each of the sequential steps. It was reported by the KII respondents that in order to avoid the hassle of legal prosecution, sometimes GBV survivors request Mazhis to mediate GBV incidents. A legal service provider cited, ***"It is hard to believe but true that most of the GBV survivors want financial remedy. So, when they get it through arbitration run by Community leaders like Mazhi and Imam, they didn't want any legal help."***

The service providers face several challenges to conduct legal proceedings. For example, when a GBV survivor filed a complaint, most of the times the perpetrator flew away, making it difficult to carry out the legal procedures in the perpetrator's absence. Sometimes, the survivors relocate in other camps in order to avoid further threats/ incidence, which hampers the continuity of legal actions. These constraints continue to deter survivors to go to legal and

[25] This service consists of providing legal counseling and assistance, taking legal action (filing cases to court, GD, FIR). It also includes forms of mediation and community justice system. It is provided by Legal officer and lawyers some of whom are enrolled lawyer of Bar Council Association who facilitate Refugees access to formal justice (courts/police). Lawyers are trained in GBV core concepts and the survivor centered approach.

security services and may reinforce an environment where impunity will continue to prevail for GBV perpetrators.

There is insufficient presence of security services/police in the camps, especially female police. As a result, Mazhis currently play a leading role for ensuring the security of GBV survivors, especially at night time. The psychosocial volunteers working in the Mental Health Service Centers also carry out patrolling at night. Regarding the safe house/ shelter services, the respondents of this study mentioned that there are 19 women friendly spaces (WFSs) and child friendly spaces (CFSs) operating in the FDMN camps which are the safe entry points for services, places to access information and temporary shelter solutions. The WFSs and CFSs are supported by UNFPA, UNICEF, UNHCR, CARE, DCA, DRC and managed by CARE, BRAC, BNWLA, COAST, CODEC, Mukti Cox's Bazar, World Vision, etc. The CFSs act as a gateway for cross-sectoral interventions such as:

- In-formal education and psychosocial service activities for out of school children and young people
- Identification, documentation and reunification of separated and unaccompanied children and case management for other vulnerable children or children at-risk
- Health and nutrition interventions or messaging
- Support for parents and caregivers
- Community-based protection mechanisms, outreach, community sensitization activities, and adolescent/peer to peer initiatives
- Safe water, sanitation facilities, and hygiene promotion
- Emergency preparedness awareness against cyclones and other national disasters

One the other hand, the WFSs, also called as "Shantikhana" or "Home of peace" by the Rohingya women, offer safe and secure resting place for the women and girls, bathing space and women-only toilets, basic healthcare (dignity kits, voluntary family planning services, prenatal and delivery services by midwives for pregnant women), skill development training and support services including psychosocial support and counselling. The WSFs also provide medical treatment (post-rape care), psychosocial counselling and legal services for GBV survivors, as well as refer them for professional case management services. An important function of the WFSs is to educate the women and girls about gender equity, different forms of GBV and how to prevent and respond to them and to create awareness in the FDMN community by engaging men and boys. Because of the social stigma specially related to intimate partner violence, most survivors in need declined referrals to safe houses/shelter (only 3% of them received this service in January-March 2019, while 87% declined it). Also, women are reluctant to leave their loved ones, they fear being assaulted again by their partner and be perceived as a prostitute or 'not good' woman. An FGD participant discussing about the attitude of the men towards the women friendly spaces cited, ***"The women are becoming aware about their rights and empowered after visiting the women friendly spaces. This is creating conflicts in the families, as the previously timid wives are speaking up for themselves. The husbands now doubt the activities happening inside these facilities are spoiling their wives and do not want to let their wives visit them unless they know their intentions."***

3.3.1.4 Basic needs services

Efforts were made to provide survivors with basic need services[26]. About 70% of GBV survivors received basic need services in January-March 2019, among which 24% of survivors in need received this service at their first entry point and 27% of them were referred to other non GBV actors (Figure 8). However, around one-fourth of survivors in need could not be assisted due to unavailability of basic need services. This might increase GBV risks and especially denial of resources and sexual exploitation and abuse as poverty and deprivation are well recognized to be catalyst for GBV.

3.3.2 Availability and utilization of GBV services in the host community

Among the Bangladeshi host communities, approximately 85% of areas have severely limited access to GBV service provision. This may be attributable to the fact that the priority of the GBV actors is to render GBV services in the FDMN community; only one-third (8) of the GBV sub-sector program partners provide GBV response and prevention services to the host community (listed in Table 10 in Annex 8). Among 32 health sector partners, no more than 5 agencies offer health services to the host community (listed in Table 11 in Annex 9). The Multisectoral program on Violence Against Women under MOWCA plays the major role in providing services to GBV survivors in the host community. The facilities to seek GBV services in the host community are the one-stop crisis cell in Teknaf UHC, one-stop crisis cell at Kutupalong camp, Ukhiya (also serves the FDMN community) and the one-stop crisis center at the district hospital. The OCC centers and cells are run by MOWCA in collaboration with 11 other ministries including the MoHFW (manages health services), MHA (oversees protection services), Law and Justice Division of Ministry of Law (provides legal support) and DSS of MoSW (aids in post-incidence rehabilitation).During the field survey, the study team visited the two UHCs at Ukhiya and Teknaf and the one-stop crisis center at Cox's Bazar District Hospital.

The basic human resources of a One-stop Crisis Cell (OCCs) comprise of a Program Officer, Computer Operator and Resident Medical Officer, who leads the team. The One stop crisis cells provide medical treatment, psychosocial counseling, legal support and rehabilitation services to GBV survivors. The OCCs cell in Teknaf UHC is led by a staff nurse instead of the Resident Medical Officer. Actually, it is of no use as the nurse is trained to refer the GBV cases to the one stop crisis center at Cox's Bazar district hospital. Staff nurse only provides pain killer or some sort of drugs to reduce excess pain and then refer the patient to district hospital. Unless the law enforcement agency sends or the survivor's condition is too serious, almost none visits the OCC cell at upazila health complex.

On the other hand, One-stop Crisis Center (OCC) at the 250 bedded DH is a well-organized structure to provide complete services to GBV services. It is situated at the second floor of the in-patient building of DH. The GBV services available at the OCC center are medical treatment, psychosocial counseling, police assistance, legal support, social welfare services,

[26] Basic needs services include any food or NFI assistance provided to GBV survivors in need to help restore their dignity and to mitigate further risks of GBV and exploitation. This service is composed of one or several of the following: provision of food, spices for daily cooking materials, water and latrines supplies, supplies for shelter, firewood, recycling products, vocational training on tailoring, jewelries, sewing, provision of dignity kits, solar lanterns, thamis/clothing, baby items and emergency cash assistance.

forensic DNA test, rehabilitation, safe custody/ shelter home, and social reintegration. The current number of staff working at OCC is 22 and the manpower consists of one Coordinator, 3 doctors (female), 2 Sub-inspector of Police, one lawyer, one counselor, 8 Senior Staff Nurse, one Computer Operator, 2 Police Constables and 3 messengers. Figure 9 in Annex 10 illustrates the organogram for the OCC. Though it is functional, it lacks appropriate staff mix due to vacancy of sanctioned posts here, especially in case of doctors. The people who are to file cases, or survivors with serious conditions usually seek care from here. The OCC only deals with the GBV cases referred through proper channel or through calling the national helpline number; a survivor cannot report directly at the OCC. The protocol for the OCC services is depicted in Figure 10 in Annex 11. The OCC is a restricted area, entrance with camera is not permitted. This is done so as to maintain the privacy and confidentiality of the survivors. There are 9 beds in OCC for patients. On an average, 10-15 GBV cases take service from OCC per day. The psychosocial counselling services are provided to the GBV survivors by clinical psychologists and psychiatrists. Each survivor requires 4-5 counselling sessions (45-60 minutes long) on an average, with a 5-6 days gap between the sessions.

Figure 11 show the flowchart of supports to the GBV survivors by the OCC:

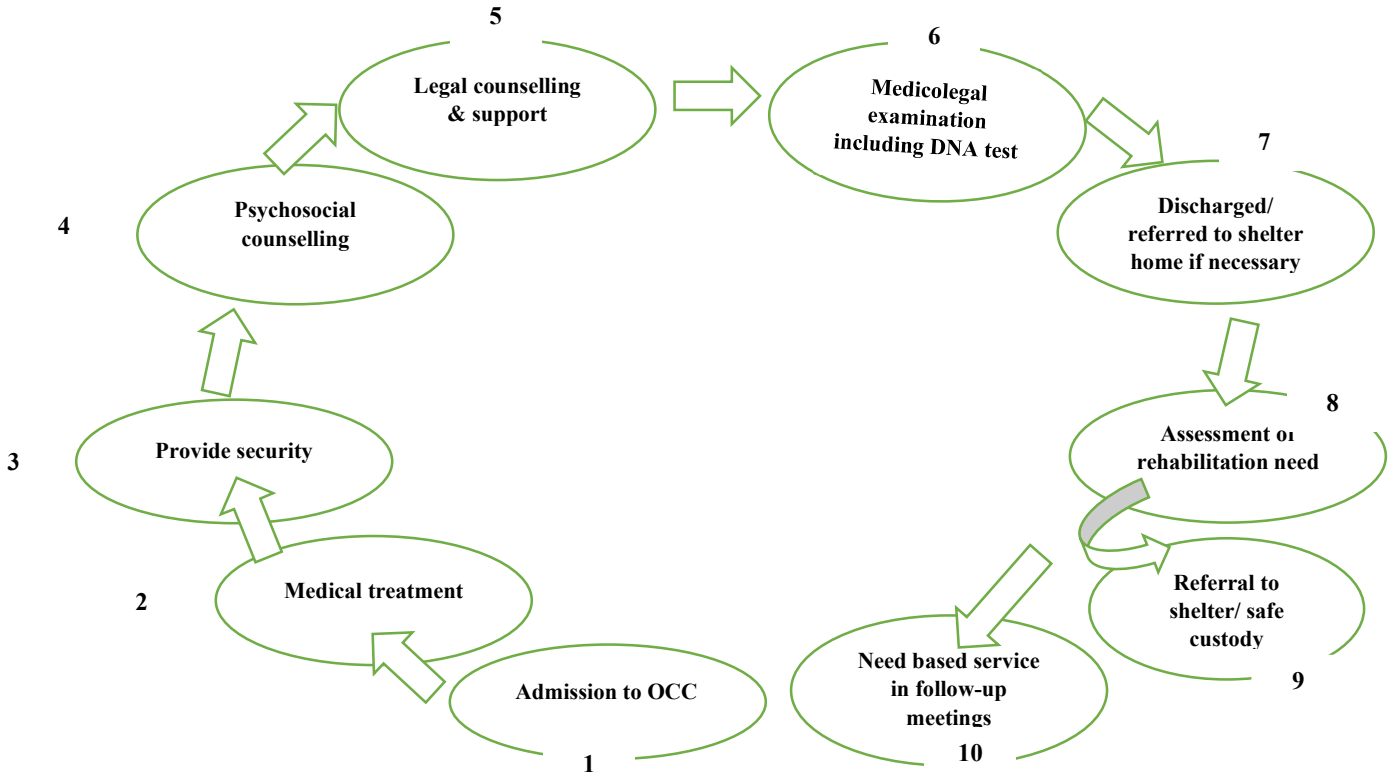

Figure 11: Flowchart of supports to the victims of violence by the One-stop Crisis Center (OCC)
(Source: One-stop Crisis Center at 250 bedded Cox's Bazar District Sadar hospital)

Table 9 presents the utilization of available services by the GBV survivors from the host community. During the period of January 2017-August 2019, total 1336 survivors (women and children) were served. Among them, all of the patients received medical treatment and around 66% received counselling service. In case of legal service, 50% of the survivors filed court

cases, 7% chose mediation and 5% cases were under processing at the time of visit. The remaining 38% of the survivors were not interested to take any legal action. Stigma, the fear of loss of confidentiality, uncertainty about future life etc. are the potential factors behind the underutilization of the legal services, as well as underreporting of GBV cases. There is a critical shortage of safe home/ shelter services for the GBV survivors in the host community. The shelter service is mainly provided by some NGOs (i.e. BNWLA). Albeit limited, some GoB organizations such as the department of Social Services, department of youth development and Jilla Parishad also provide shelter services. This may also be a major reason for under reporting.

3.3.3 Challenges in GBV related service provision

Based on the stakeholder consultations and observations from the field, the study identified few challenges that have some impact on overall service provision as well as planning of service provision. These are:

- Lack of coordination between govt. and external agencies (UN/NGOs/INGOs) working for GBV especially regarding data sharing related to GBV: As discussed in the earlier section, the GBVIMS, led by UNFPA, is a consortium for safe and ethical sharing of GBV related data by the GBV sub-sector partner agencies. The intentions of the GBVIMS are to assist service providers to better understand the GBV situation as well as to enable actors to share data internally and externally (with diverse agencies) to facilitate broader trends analysis and improved GBV coordination. As per the coordination mechanism described in the Joint Response Plan (2019), the GBVIMS partners are supposed to share the data essential for assessing the GBV burden and facilitating the GBV service provision with the GoB, which is a key stakeholder and the coordinator of all humanitarian activities. But it was evident through the interviews and the consultative workshop of this study that the GBVIMS partners do not share the data with the GoB authorities, which arises concerns regarding the transparency and accountability of the humanitarian organizations towards the government of the country they are operating in. Not only most of the international the NGOs declined to share GBV related data to the research, they also did not share the data with government local government bodies, as claimed by the government officials of the study district. Although 29-member GBV committee involves stakeholder from the government, the consultation with government officials indicated that government especially local health administration had been remained in darkness in terms of the GBV data of that district. Even the civil surgeon office had limited access to GBV data from the GOs, and NGOs.
- Initially govt response was mostly focusing emergency issues not GBV. However, government has taken steps with regard to GBV activities when the FDMN settled down. The main activities involved is the organizing training (some of that might be with support from other stakeholders), assigning focal or contact persons in GBV cases, helping or coordinating the development of some uniform IEC materials. However, no strong effort is observed in enhancing the capacity or logistics support to those areas. Most importantly, due to lack of data regarding actual information on the GBV cases, and services rendered by the national and international NGOs, a sound understanding on the current scenario and possible pathway for future takeover of GBV

activity if current partners stop operating is missing. Government has formed a cell to tackle health sector issues, and the cell's activities are in process, yet to see any impact on the field.

- OCC services are available only in Cox's Bazar District Hospital but for access to that facility by FDMN is not easy: a survivor from the FDMN community requires proper referral to the one-stop crisis center which must be authorized by the camp administration. Also, arranging transport (vehicles/ ambulance) and ensuring safety and security en route are difficult for the survivors.
- Ambulance and other similar services that are available for FDMN communities are not equally available for the host-communities: The KII and FGD participants of this study revealed although limited, some organizations (i.e. IOM, UNHCR) provide ambulance services for both FDMN and host communities. While this ambulance service is provided free of cost to the FDMN community, the host community need to pay for it. Furthermore, due to the fact that the FDMNs are an extremely vulnerable population in dire need of life-saving services even in the stabilized[27] phase, the most of the humanitarian organizations serve only the FDMN community. Very few agencies offer their services to both the FDMN and host community, then again, the former is served on priority basis and the services are provided free of cost to them. As a result, the host community faces difficulties to avail basic healthcare and other services and is often left with unmet need.
- GBV services provided for the host-community not increased even with increase in GBV due to the influx of FDMN: The massive influx of FDMN community is found to have a multifaceted impact on the host community (Shatil and Ahmed, 2017). The KII and FGD respondents discussed that the malpractices of the FDMN community such as battering, polygamy, child marriage, sex trading, substance abuse is being inflicted upon the host community, causing a rise of GBV incidence in the latter. However, unlike the FDMN community, the scope of GBV service provision is still limited for the host community, with MOWCA being the sole organization offering a comprehensive GBV related services. The needs of the host community were not previously considered by the humanitarian actors. As the stage of acute emergency receded, the sector actors must understand the existing inequity in the service provision and utilization of GBV services between the FDMN and the host community and address them accordingly.
- GNSP unit of the Health Economics Unit has developed a comprehensive protocol titled "Health Sector Response to GBV: Protocol for Health Care Providers". However, upon consultation it has become clear that many NGO officials who are involved with providing GBV services are not aware of it. As per the government circular all

[27] The Inter-Sectoral Coordination Group (ISCG) described three general phases of humanitarian emergencies for the strategic distribution of key interventions for preventing and responding to gender-based violence:

1) Emergency Preparedness/ phase of acute emergency: August 2017-August 2018 (in case of FDMN crisis)
2) Early Phase (Minimum Prevention and Response)/ intermediate phase: September 2018-December 2018 (in case of FDMN crisis)
3) Stabilized phase (Comprehensive Prevention and Response)/ post-emergency phase: January 2019-present (in case of FDMN crisis)

stakeholders who are providing GBV related services are required to comply with the protocol. Not knowing the existence of this protocol and circular, however, clearly demonstrates a lack of coordination between government and NGOs.

Chapter 4: Conclusion & Recommendations

This study provides an insight into the current situation of heath care and protection service provision and utilization by GBV survivors in FDMN (Rohingya) community, as well as by host community. The findings reveal that GBV cases are highly under-reported, in both communities. While majority of the GBV survivors received clinical care, psychosocial and basic needs services, a large proportion of survivors have had unmet need of mental health, child protection, legal assistance and security services. The study also finds that there is a paucity of information about the details regarding the services rendered by the INGO/NGO and multilateral agencies as a whole. In addition, information regarding available services to children and male survivors and GBV prevention strategies are also insufficient. There is a lack of structured intervention on Intimate Partner Violence (IPV) as well as Conflict Related Sexual Violence (CRSV). Inadequate presence of security actors at night time and scarcity of female police in the camps were also evident. There is a lack of coordination of services across parners and service providers of various stages Based on the information gathered from the field, and verification of those findings from one day consultation meeting, the study recommends adopting the following steps to improve GBV service provision as well as to reduce the GBV both in FDMN and host communities:

1. Fencing around the camps and restricting inter-camp movements so there is a regulated movement between host and FDMN communities. Since a cultural difference exists between FDMN and host communities, fencing can reduce the mingling which can reduce the problems associated with cultural differences.
2. Introducing camp-centric judicial services (similar to village courts) for the FDMN communities for some misdemeanors. Unless the perpetrators punished in time due to long and lengthy judicial process, controlling GBV will be difficult. Camp-centric judicial services can be an interim solution to the delay in judgement of the misdemeanors.
3. Ensuring OCC services within or close to the camps at least as the capacity of One stop Crisis Cells (OCCs) and if possible, of OCC (One-stop Crisis Center) so that prompt services can be ensured without fearing complicated referral process.
4. Ensuring effective protection services during night time
5. Improving WASH facility and lighting facility around the camp areas so the stalkers and perpetrators cannot take advantage of darkness
6. Increasing the number of WFS with having minimum one in each camp, and encouraging the use of WFS and inclusion of more services within WFS so that social taboo of using WFS services can be reduced resulting higher utilization
7. Digitalization of marriage registration and making sure the data sharing to combat burgeoning polygamy culture in FDMN communities
8. Involving religious leaders in awareness building among communities especially targeting males regarding the gender norms and GBV

9. Increasing the number of female Mazhis and changing Mazhis within specific time period (yearly or biennially) so that the victims who are disproportionately female can have better access to the GBV services as Mazhis in most case serve as gatekeepers.
10. Strengthening the GO-NGO collaboration and coordination especially in better coordinating the tasks with data sharing among the stakeholders with maximum privacy protection
11. Ensuring stewardship of the government in all activities especially under the leadership of district heads
12. Strict enforcement of law in the camps and in the surrounding areas
13. Improving school-based facility (e.g., extending schooling for adolescents) so that adolescents can be involved with more capacity and awareness building
14. Increasing recreation facilities for the FDMN communities so that frustration emanated from the uncertainty concerning the future cannot creep them in wrong-doing

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Annex

Annex 1: Table 1: Summary of research activities

Activities	Sample (n)	Participants	Objectives covered
Key Informant Interviews (KII)	25	- RRRC officials: Health coordinator - MoHFW Coordination center officials: Chief Coordinator and Field Coordinator - Health managers and GBV service providers: Civil Surgeon, UHFPOs of Teknaf and Ukhiya Upazila Health Complex, OCC Coordinator - FDMN camp administrative officials: Camp-in-charge - Programme/project focal points of UN/NGOs/INGOs working on the GBV sector: BRAC, GK, IOM, HEED Bangladesh, MSF, IRC, UNFPA, UNHCR - Local public representatives, i.e. Upazila Chairmans, Chairman and female member of Union Council - Local administration officials such as,Upazila Nirbahi Officers (UNOs) and Officers-in-Charge (OCs) at local police stations, Upazila women affairs officers - Legal service providers: Legal officers serving at GO-NGO agencies	1) To assess the magnitude of burden of GBV survivors and their health consequences (Number of new cases, repeat/follow up cases, number of cases received CMR, number of cases provided PFA) 2) To ascertain changes in service modalities towards adopting gender sensitive approaches in both GO-NGO providers in the area (Installation of Women Friendly Spaces, care providers trained on CMR, designated service provision for female clients i.e. separate que, proportionate gender equity among care providers to encourage utilization of services by GBV survivors) 3) To determine the level of access and utilization of services by both host and FDMN communities 4) To identify coordination among mainstream actors in GBV (service mapping, inter sector coordination, referral pathways)

Focus Group Discussion (FGD)	5	- Agency focal persons of protection sector from UN bodies and INGO/ NGO/ multilateral organizations - Medical officers from Cox's bazar district hospital and Teknaf and Ukhiya upazila health complexes - Psychosocial counsellors from MOWCA - Camp leaders selected from the FDMN community such as, Mazhis - Host community representatives	1) To ascertain changes in service modalities towards adopting gender sensitive approaches in both GO-NGO providers in the area 2) To identify coordination among mainstream actors in GBV (service mapping, inter sector coordination, referral pathways) To determine the level of access and utilization of services by both host and FDMN communities
In-Depth Interview (IDI)	20	- Healthcare providers: Public and private healthcare providers serving the GBV survivors within the FDMN camps, public and private healthcare providers serving the GBV survivors in the host community (Medical officers at UHC, Union health and family welfare center, Programme officers at OCC) - GBV survivors from FDMN (Rohingya) community	1) To assess the magnitude of burden of GBV survivors and their health consequences (Number of new cases, repeat/follow up cases, number of cases received CMR, number of cases provided PFA) 2) To determine the level of access and utilization of services by both host and FDMN communities 3) To ascertain changes in service modalities towards adopting gender sensitive approaches in both GO-NGO providers in the area
One-day Consultative Workshop	1	Focal points of providers and local elected representatives	To identify coordination among mainstream actors in GBV (service mapping, inter sector coordination, referral pathways) - To review the key study findings

Annex 2: Data Collection Instruments (DCI)

Data collection instruments: guidelines and checklists

District Authorities Structured Interview Guide (KII)

(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name, position and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.)

Date of interview:_____

Name of the institution/agency:_____

Name of person interviewed and contact details (optional):_____

Position in the institution/agency:_____

1. What does gender-based violence mean to you?

(If the respondent does not seem to know ask: What kinds of incidents of sexual violence, or domestic violence between intimate partners do you hear about?)

2. What types of GBV do you think are most prevalent in this community?

- What types of cases of gender-based violence are you involved in as a DA? *(If they list something other than sexual violence, ask them what is the most frequent type of violence against women and girls that they handle.)*
- How often (if ever) do you see sexual violence cases or other forms of gender-based violence? How many per week or month?
- How often (if ever) do you see domestic violence cases? How many per week or month?

3. What are the commonly used channels for reporting gender-based violence? From what individuals or organizations do you typically receive reports of sexual violence? *(PROBE: survivors, family members, health professionals, police, NGOs, local elites, local elected representatives etc.)*

4. Have you been trained on sexual violence or other forms of gender-based violence? How long did the training last and who provided it?

5. How do you respond to cases of sexual violence or other forms of sexual violence? For what services do you refer (psychosocial, medical, legal)?

6. Are there places for survivors of gender-based violence (or specifically sexual or domestic violence) to go to when their life is in danger? Where can you refer such clients (shelters, etc.)?
7. Does your police station has provision of transport or accompany survivors for further services? If no, how do survivors access the services? (PROBE: sexual violence survivors)
8. What kind of documentation is required to initiate legal proceedings and investigations?
9. How would you describe the relationship between this police station and NGOs over rape cases?
10. What policies or laws (national, county-level) are in place for cases of sexual violence or other forms of gender-based violence? How do you use these policies? Are cases of sexual violence ever handled by village leaders? How do they intervene in these cases?
11. What other committees and forums (or other coordination system) are your institution involved in addressing the needs of survivors of sexual violence or other types of gender- based violence?
12. What other challenges are there related to ensuring that survivors of gender-based violence have access to services and in preventing gender-based violence? How do you think some of these challenges could be addressed?

Health Services Structured Interview Guide (KII)
(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name, position and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.) Date of interview: Name of the health care facility: Name of person interviewed and contact details (optional): Position in the health facility:

1. What do the words gender-based violence mean to you?
2. What are the most frequent reasons given by women and girls for coming to this health facility?
3. Does your facility treat survivors of gender-based violence (e.g., survivors of sexual violence)? Probe: What are the most common types of violence that women and girls receive services for? Probe: What kinds of services are provided?
4.What pregnancy-related services do you routinely offer the patient after rape?
5. How often do you refer rape survivors for trauma/psychological counseling? Is it possible for survivors to receive counseling in this facility? Do you refer to other service providers, police and courts? What are the organization referred to (NGOs, support groups)? (Try to get the names of the institutions.) How do you follow-up on survivors once they have left the health facility?
6. Do you collect physical evidence from survivors (e.g., clothing, footwear, hair, fibers etc.)? If so, where do you store it?
6. Do you keep records of patients who have been examined after rape? If yes, ask: Where do you keep the files related to cases of sexual violence? Who keeps the key to these areas? Are there specific forms that you use? (Request a copy of all of the forms that they use, including referral forms.)
8. Does this facility have protocols/guidelines for the management of rape survivors? If yes, ask: Where do you keep them? And ask to see them.
9. Who makes the decision when reporting a case of sexual violence to the police (health care providers, the survivors of the violence, parent/guardian)?
10. What do you do if you have a suspicion that a parent or guardian is involved in the sexual abuse of a child? How do you proceed with managing the safety needs of that child?
11. How many adult survivors (18 years and older) were examined/treated after sexual violence during the last

five months? # of males: # of females: Or, on average, how many adult survivors do you see each month?
12. How many child survivors (17 years and younger) were examined/treated after child sexual abuse in the last five months? What were the ages of the child survivors? # <5 # 5-9 # 10-14# 15 and > Or, on average, how many child survivors do you see each month?
13. Have you or anyone else at this facility received formal training on the management of sexual violence/ rape? If yes, ask: how many different trainings have you attended, and who provided the trainings? How many days did the training last?
14.What kinds of things were covered in the trainings that you attended? Check anything that applies and/ or use list to help you probe.
15. Do you think rape always leaves obvious signs of injuries?
16. How would you describe the coordination between this health facility and the closest police station over rape cases?
17. How would you describe the coordination between this health care facility and NGOs over rape cases?
18. What other committees and forums (or other coordination system) are your institution involved in to address the needs of survivors of sexual violence or other types of gender-based violence?

19. Are you aware of any of any cases from this facility that have gone to court in the past year?
20. Have you ever given evidence in court?
21. Where do the examinations take place? Is there a private room? How does the staff ensure confidentiality?
22. What are the hours of operation of the facility?
23. How much does the services for sexual violence cost?

Legal Services Structured Interview Guide (KII)
(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.) Date of interview:_____ Name of the institution/agency:_____ Name of person interviewed and contact details (optional):_____ Position in the institution/agency:_____
1. What do the words gender-based violence mean to you? *(If the respondent does not seem to know what GBV is, ask What about sexual violence or domestic violence? to see if they encounter these things.)*
2. What types of cases of gender-based violence do you handle? *(If the respondent lists something other than sexual violence, ask him/her what is the most frequent type of violence against women and girls that he/she handles?)*
3. How often do you handle sexual violence cases? How many per week or month?
4. How often do you handle domestic violence cases? How many per week or month?

5. From what individuals or organizations do you typically receive reports of sexual violence? *(PROBE: survivors, family members, health professionals, police, NGOs, local elites, local elected representatives etc.)* Who are the survivors of sexual violence? *(PROBE: who are the main perpetrators, survivors(FDMN/Host communities), what are their ages, sex…?)*
6. What legal facilities or personnel exist for survivors of sexual violence or other forms of gender-based violence and punish perpetrators? (e.g., court, local/traditional, or civil authorities)
7. Has anyone in your institution received training on sexual violence or other forms of gender- based violence? If so, what was the training about, who received it, who provided it, and duration of training? Are the individuals who were trained still in their post?
8. What services do you provide to survivors of sexual violence or other forms of gender- based violence? *(Try to get the respondent to be as specific as possible, e.g., provision of information on court process, roles and responsibilities of different actors, time frames, etc.)*
9. What kind of documentation is required to facilitate legal proceedings and investigations? What are the major challenges experienced? What is the time period that it takes to finalize a case, and why?
10. Does anyone from this institution accompany, advocate for and support the survivor during any meetings with the police or court officials? *(If yes, ask the respondent to describe how this process works and who is responsible for doing this.)*
11. Who is responsible for providing support to the survivor during the legal proceedings? *(PROBE: Liaison with the police? Legal or trial proceedings? Psychosocial support? Logistical support/accommodation and food?)*
12. Which laws are used in addressing gender-based violence and how are they enforced, and by whom?
13. How do you ensure the survivor's confidentiality and protection (during pre-trial, trial and post-trial)?

14. Do you ever refer survivors to other services such as counseling or healthcare? If yes, where are these services located? How do they provide the referral? How do you ensure that the service is provided?
15. How do you coordinate with other service providers (NGOs, government departments, health facilities, legal, law enforcement, and psychosocial (social welfare)) on the issue of gender-based violence?
16. What other committees and forums (or other coordination system) are your institution involved in addressing the needs of survivors of sexual violence or other types of gender- based violence?
17. What are some of the challenges that you face in responding to sexual violence or other form of gender-based violence? How do you think these challenges could be addressed?

Protection Services Structured Interview Guide (KII)
(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name, position and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.) Date of interview:_____ Name of the institution/agency:_____ Name of person interviewed and contact details (optional):_____ Position in the institution/agency:_____
1. What does gender-based violence mean to you? (If they do not seem to know, ask What kinds of incidents of sexual violence or domestic violence between intimate partners do you hear about?)
2. What types of GBV do you think are most prevalent in this community? What types of cases of gender-based violence do you handle? (If they list something other than sexual violence, ask them what is the most frequent type of violence against women and girls that they handle.)

3. How often (if ever) do you handle sexual violence cases or other forms of gender-based violence? How many per week or month?
4. What are the commonly used channels for reporting gender-based violence? From what individuals or organizations do you typically receive reports of sexual violence? (PROBE: survivors, family members, health professionals, host communities, local representatives, etc.)
5. Is there someone at the police station specifically trained to provide victim -friendly services? Have they been trained to handle sexual violence or other forms of gender-based violence? How long did the training last and who provided it?
6. Are survivors attended to by same-sex officers? If not, why?
7. How do you respond to cases of sexual violence or other forms of sexual violence? For what services do you refer (psychosocial, medical, legal)?
8. Are you able to help survivors of gender-based violence (or specifically sexual or domestic violence) relocate when their life is in danger? Where can you refer such clients (shelters, etc.)?
9. Does your police station have the provision to transport or accompany victims/survivors for further services? If no, how do victims/survivors access the services? (PROBE: sexual violence survivors)
10. How do you document the victim's statement? Are there specific forms that you use? (Request a copy of all of the forms that they use, including referral forms). How much do the forms cost?
11. What kind of documentation is required to initiate legal proceedings and investigations?
12. Do you or others in your station ever testify in court about investigation findings, if the survivor chooses legal action?
13. Are there any cases where investigating or following-up on cases seems impossible? What are the challenges? How would you describe the relationship between this police station and the closest health facility over sexual violence as well as gender-based violence? How do you work together?

14. How would you describe the relationship between this police station and NGOs over rape cases?
15. What policies or laws (national, county-level or traditional) are in place for cases of sexual violence or other forms of gender-based violence? How do you use these policies?
16. What other structures, activities and forums (or other coordination system) is your institution involved in to address the needs of victims/survivors of sexual violence or other types of gender-based violence?
17. How do you think some of these challenges you face could be addressed?

Psychosocial Services Structured Interview Guide (KII)
(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name, position and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.) Date of interview: Name of the institution/agency: Name of person interviewed and contact details (optional): Position in the institution/agency:
1. What do the words gender-based violence mean to you? (If the respondent does not seem to know what GBV is, ask What about sexual violence or domestic violence? to see if they encounter these things.)
2. What types of cases of gender-based violence do you handle? (If they list something other than sexual violence, ask what is the most frequent type of violence against women and girls that they handle.)
3. How often (if ever) do you handle sexual violence cases? How many per week or month?
4. From what individuals or organizations do you typically receive reports of sexual violence? (PROBE: victims/survivors, family members, health professionals, etc.)

5. Is there someone in this organization who is specifically trained to work with sexual violence or other forms of gender-based violence? What kind of training did they receive, who provided it, and what did it focus on? How many days did it last?
6. How does your organization ensure the survivor's confidentiality?
7. Can you tell me how you document the survivor's statement? Are there specific forms that you use? (Request a copy of all of the forms that they use, including referral forms.)
8. Where do you keep the case files for incidents of gender-based violence?
9. What if any, follow-up and/or referral do you provide? Where do you make referrals?
10. What policies or laws (national, provincial, district or traditional) are in place for cases of sexual violence or other forms of gender-based violence?
11. What measures does your organization have in place to protect survivors and their families?
12. How would you describe the relationship between this organization and other service providers (police, courts, health facilities)? What about the relationship between the police and the health care facility?
13. How would you describe the relationship between the closest police station and NGOs over rape cases?
14. What other structures, activities and forums (or other coordination system) is your institution involved in to address the needs of victims/survivors of sexual violence or other types of gender-based violence?

15. What are some of the challenges you face in responding to sexual violence or other forms of gender-based violence?

How do you think these challenges could be addressed?

Checklist for IDI

Investigator's name:
Place of study: .....
Risk and benefit: There is no risk associated with this study. This study will help to strengthen the understand the health system barriers and explore strategies to improve them.
Privacy and confidentiality: The information collected through this study will be kept confidential. The collected information will be used only for research purpose.
Right to withdraw: You have the right to refuse to participate in this study and refusing to participate will not affect your treatment in any way. You can stop participating in the study at any point of time.
If you agree to my proposal of enrolling you in this study, please indicate that by signing or putting your thumb impression at the specific space below.

Thanks for your valuable time and cooperation.

Signature of the patient or attendant
(verbal consent is acceptable)
Date:

Signature of the investigator
(verbal consent is acceptable)

Date:

Thank you for your willingness to participate. There are no right or wrong answers to these questions. Your name will not be linked to any information that you individually provide. This is not a test of your knowledge, if you do not know an answer to a specific question that is okay. You can skip any questions you want, and you can end our conversation at any time. I will take notes, and if it's okay with you, I would like to audio record, so I can focus more on our discussion and fill in my notes later. If you don't want me to record or want to stop the recording at any time, that is completely okay, just let me know. Do you have any questions before we get started?

Do I have your permission to begin this interview? O Yes O No
(THANK RESPONDENT & STOP HERE)
Do I have your permission to audio record? O Yes O No
(TURN OFF AUDIO RECORDER)

Questions

1.	Name (pseudonym)/Respondent's ID :
2.	Age:

3.	Gender:
4.	Education:
5.	Occupation:
6.	Have you visited any health facility after incidence of violence?
7.	Did you receive the expected care? If not, why?
8.	Did you receive any mental health services?
9.	Did you receive any protection services after entering into Bangladesh?

Annex 3: Table 3: Partners engaged with the Inter Sector Coordination Group (ISCG) (Source: Joint Response Plan at a glance for Rohingya Humanitarian Crisis, January-December 2019)

Name of organization	Type of organization	Name of organization	Type of organization
Action Aid Bangladesh (AAB)	INGO	International Rescue Committee (IRC)	INGO; Appealing agencies
AAN		International Union for Conservation of Nature (IUCN)	International
AB		Jagorani Chakra Foundation (JCF)	NNGO
Action contre la Faim (ACF)	INGO; Appealing agencies	Johns Hopkins University Center for Communication Programs (JHUCCP)	INGO

Agency for Technical Cooperation and Development (ACTED)	INGO; Appealing agencies	LHB	
Adventis Development and Relief Agency (ADRA)	INGO	Mercy Corps (MC)	INGO
AF		MDMF	
AfA		Medair	INGO
Agrajattra	NNGO; Appealing agencies	Mercy Malaysia (MM)	INGO; Appealing agencies
Anando	NNGO	Ministry of Disaster Management and Relief (MoDMR)	GoB
BBC Media Action (BBC MA)	INGO: Appealing agencies	Ministry of Foreign Affairs (MoFA)	GoB
BC		Ministry of Home Affairs (MoH)	GoB
Bangladesh Red Crescent Society (BDRCS)	NNGO	Ministry of Health and Family Welfare (MoHFW)	GoB
Bangladesh Forest Department (BFD)	GoB	Ministry of Social Welfare (MoSW)	GoB
Bangla-German Sompreeti (BGS)	NNGO	Medical Teams International (MTI)	INGO
Bangladesh Institute of Theatre Arts (BITA)	NNGO	Mukti	NNGO; Appealing agencies
Bangladesh National Women Lawyers' Association (BNWLA)	National Civil Society organization	Norwegian Church Aid (NCA)	INGO

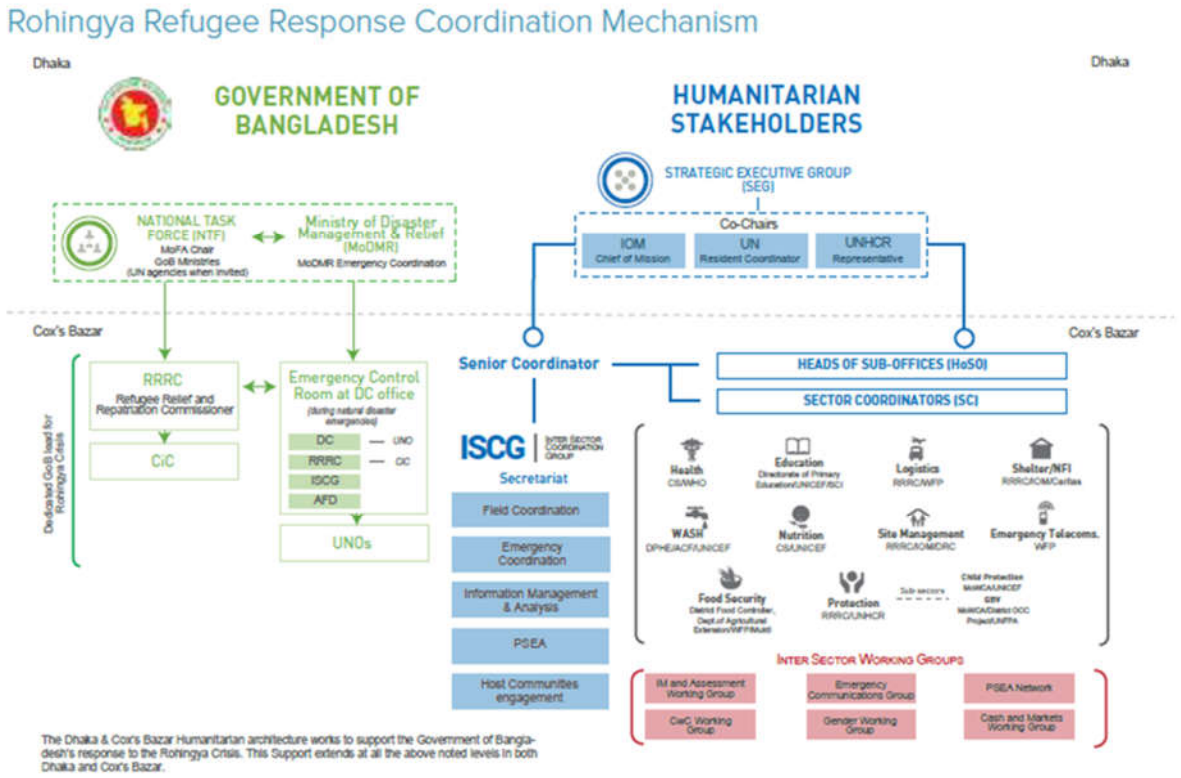
BRAC	NNGO; Appealing agencies	NGO Forum for Public Health (NGOF)	NNGO
Christian Aid (CA)	INGO; Appealing agencies	Norwegian Refugee Council (NRC)	INGO; Appealing agencies
Cooperative for Assistance and Relief Everywhere (CARE)	Appealing agencies	OBAT	NNGO; Appealing agencies
Caritas	NNGO; Appealing agencies	Oxfam	INGO; Appealing agencies
CBM International	INGO; Appealing agencies	PA	
Cox's Bazar CSO and NGO Forum (CCNF)	National Civil Society Organization and NGO	Programme for Helpless and Lagged Society (PHALS)	NNGO
Center for Disability in Development (CDD)	INGO	Partners in Health Development (PHD)	NNGO
CIS		People in Need (PIN)-Czech Republic	INGO
Center for Natural Resource Studies (CNRS)	NNGO	Plan	INGO; Appealing agencies
Coastal Association for Social Transformation Trust (COAST)	NNGO; Appealing agencies	Prantic	NNGO
Community Development Center (CODEC)	NNGO	Prottyashi	NNGO
Community Partners International (CPI)	INGO; Appealing agencies	Premiere Urgence Internationale (PUI)	INGO; Appealing agencies
CSI		Pulse	NNGO; Appealing agencies

Concern Worldwide (CWW)	INGO; Appealing agencies	Peace Winds Japan (PWJ)	INGO; Appealing agencies
Dalit	NNGO; Appealing agencies	QC (Qatar Charity)	Appealing agencies
Department of Agricultural Marketing (DAM)	GoB	REACH	
Dan Church Aid (DCA)	INGO; Appealing agencies	Rokeya Foundation (RF)- Rohingya Women Welfare Society	NNGO; Appealing agencies
Dhaka Community Hospital Trust (DCHT)	NNGO	Refugee Health Unit (RHU)	GoB
DoAE		Relief International (RI)	INGO; Appealing agencies
Department of Environment (DoE)	GoB	RIC	NNGO
(DoF)	GoB	RISDA	NNGO
Department of Public Health Engineering (DPHE)	GoB	Research, Training and Management, International (RTMI)	NNGO
Danish Refugee Council (DRC)	INGO; Appealing agencies	RtR	
Dustha Shasthya Kendra (DSK)	NNGO	Rupantar	NNGO
Doctors Worldwide (DWW)	INGO	Social Assistance and Rehabilitation for the Physcially Vulnerable (SARPV)	NNGO
Food and Agriculture	UN; Appealing agencies	Save the Children International (SCI)	INGO; Appealing agencies

Organization (FAO)			
Finn Church Aid (FCA)	INGO	Society for Health Extension and Development (SHED)	NNGO
FDSR	NNGO	Shushilan	NNGO
Food for the Hungry (FH)	NNGO	Solidarites International (SI)	INGO; Appealing agencies
Friends in Village Development Bangladesh (FIVDB)	NNGO; Appealing agencies	SWB	
Friendship	NNGO; Appealing agencies	Technical Assistance Inc. (TAI)	INGO
GAA	Appealing agencies	Terre des Hommes (TdH)	INGO; Appealing agencies
Gonoshasthaya Kendra (GK)	NNGO	Translators Without Borders (TWB)	INGO
GlobalOne	INGO	United Nations Development Programme (UNDP)	UN
Gana Unnayan Kendra (GUK)	NNGO	United Nations Population Fund (UNFPA)	UN; Appealing agencies
Health and Education for All (HAEFA)	NNGO; Appealing agencies	United Nations High Commissioner for Refugees (UNHCR)	Appealing agencies
Hilfswerk der Evangelischen Kirchen Schweiz (HEKS)	INGO; Appealing agencies	United Nations International Children's Emergency Fund (UNICEF)	Appealing agencies
HelpAge	INGO; Appealing agencies	UN Women	Appealing agencies
HOPE Foundation (HF)	INGO; Appealing agencies	United Purpose (UP)	INGO

Handicap International: Humanity & Inclusion (HI)	INGO	Village Education Resource Center (VERC)	NNGO
Helvetas Swiss Intercooperation (HIS)	INGO; Appealing agencies	WaterAid	INGO
ICCO Cooperation	INGO; Appealing agencies	World Concern Development Organization (WCDO)	Appealing agencies
International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b)	International health research institute	World Food Programme (WFP)	Appealing agencies
International Red Cross (Int. R C)	INGO	WHH	INGO
Internews	International non-profit	World Health Organization (WHO)	Appealing agencies
International Organization for Migration (IOM)	Appealing agencies	World Vision International (WVI)	Appealing agencies
Ipas	INGO	Young Power in Social Action (YPSA)	NNGO

Annex 4: Figure 3: FDMN response coordination mechanism (Source: Joint Response Plan for Rohingya Humanitarian Crisis, January-December 2019)



Annex 5: Table 4: List of program partners and implementing partners working in GBV sub-sector in response to humanitarian crisis in Cox's Bazar (Source: Rohingya Refugee Crisis Response: ISCG 4W Dashboard by Camp, August 2019)

Type of program partner	Program partners (n = 24)	Implementing partners (n = 27)	Activity
UN (5)	International Organization for Migration (IOM)	International Organization for Migration (IOM)	GBV prevention
			GBV response
		Pulse Bangladesh	GBV prevention

			GBV response
	United Nations Population Fund (UNFPA)	Mukti Cox's Bazar	GBV prevention
			GBV response
	United Nations High Commissioner for Refugees (UNHCR)	Bangladesh National Women Lawyers' Association (BNWLA)	GBV prevention
			GBV response
		BRAC	GBV prevention
			GBV response
		Relief International (RI)	GBV prevention
			GBV response
		Research, Training and Management, International (RTMI)	GBV prevention
			GBV response
		Technical Assistance Inc. (TAI)	GBV prevention
			GBV response
		United Nations High Commissioner for Refugees (UNHCR)	GBV prevention
			GBV response
	United Nations International Children's Emergency Fund (UNICEF)	Action Aid Bangladesh (AAB)	GBV prevention
			GBV response
		BRAC	GBV prevention
			GBV response
		Cooperative for Assistance and Relief Everywhere (CARE)	GBV prevention
			GBV response
		Dan Church Aid (DCA)	GBV prevention
			GBV response
	UN Women	AAB	GBV prevention
			GBV response
INGO (12)			GBV prevention

	Action Aid Bangladesh (AAB)	Young Power in Social Action (YPSA)	GBV response
	Action contre la Faim (ACF)	Action contre la Faim (ACF)	GBV prevention
	Cooperative for Assistance and Relief Everywhere (CARE)	Bangladesh National Women Lawyers' Association (BNWLA)	GBV prevention
			GBV response
		CARE	GBV prevention
			GBV response
		Coastal Association for Social Transformation Trust (COAST)	GBV prevention
			GBV response
		Young Power in Social Action (YPSA)	GBV prevention
			GBV response
	Community Partners International (CPI)	Community Partners International (CPI)	GBV prevention
			GBV response
	Dan Church Aid (DCA)	Dan Church Aid (DCA)	GBV prevention
			GBV response
	Danish Refugee Council (DRC)	DRC	GBV prevention
			GBV response
	International Rescue Committee (IRC)	International Rescue Committee (IRC)	GBV prevention
			GBV response
		Mukti Cox's Bazar	GBV prevention
		Research, Training and Management, International (RTMI)	GBV prevention
	Muslim Hands International (MHI)	Muslim Hands International (MHI)	GBV prevention
			GBV response

	Norwegian Church Aid (NCA)	Norwegian Church Aid (NCA)	GBV prevention
	Oxfam	Oxfam	GBV prevention
	People in Need (PIN)- Czech Republic	People in Need (PIN)	GBV prevention
		Pulse Bangladesh	GBV prevention
	Relief International (RI)	Relief International (RI)	GBV prevention
			GBV response
NNGO (7)	Alternative Development Initiative (ADI)	Alternative Development Initiative (ADI)	GBV prevention
		Nowzuwan	GBV response
	BRAC	BRAC	GBV prevention
	Good Neighbors Bangladesh (GNB)	Good Neighbors Bangladesh (GNB)	GBV prevention
			GBV response
	NGO Forum for Public Health (NGOF)	NGO Forum for Public Health (NGOF)	GBV prevention
			GBV response
	Nowzuwan	Nowzuwan	GBV response
	Pulse Bangladesh	International Organization for Migration (IOM)	GBV prevention
	World Vision International (WVI)	World Vision International (WVI)	GBV prevention
			GBV response

Annex 6: Table 6: List of program partners and implementing partners working in Health sector in response to humanitarian crisis in Cox's Bazar (Source: Rohingya Refugee Crisis Response: ISCG 4W Dashboard by Camp, August 2019)

Type of program partner	Program partners (n = 32)	Implementing partners (n = 32)
UN (1)	International Organization for Migration (IOM)	International Organization for Migration (IOM)
GoB (1)	Refugee Health Unit (RHU) by RRRC	Refugee Health Unit (RHU) by RRRC

INGO (16)	Cooperative for Assistance and Relief Everywhere (CARE)	Cooperative for Assistance and Relief Everywhere (CARE)
	Center for Disability in Development (CDD)	Center for Disability in Development (CDD)
	Community Partners International (CPI)	Community Partners International (CPI)
	Handicap International: Humanity & Inclusion (HI)	Handicap International: Humanity & Inclusion (HI)
	HelpAge International UK	HelpAge International UK
	International Rescue Committee (IRC)	International Rescue Committee (IRC)
	Medecins Sans Frontieres (MSF) International	Medecins Sans Frontieres (MSF) International
	MEDAIR	MEDAIR
	Orbis	Orbis
	Peace Winds Japan (PWJ)	Peace Winds Japan (PWJ)
	QCH (Qatar Charity)	QCH (Qatar Charity)
	Relief International (RI)	Relief International (RI)
	Save the Children International (SCI)	Save the Children International (SCI)
	Turkish Red Crescent Society (TRCS)	Turkish Red Crescent Society (TRCS)
	Terre des Hommes (TdH)	Terre des Hommes (TdH)
	United Purpose (UP)	United Purpose (UP)
NNGO (14)	Bangladesh Red Crescent Society (BDRCS)	Bangladesh Red Crescent Society (BDRCS)
	BRAC	BRAC
	Dustha Shasthya Kendra (DSK)	Dustha Shasthya Kendra (DSK)
	Food for the Hungry (FH)	Food for the Hungry (FH)
	Friendship	Friendship
	Gonoshasthaya Kendra (GK)	Gonoshasthaya Kendra (GK)
	Health and Education for All (HAEFA)	Health and Education for All (HAEFA)

	Health Management BD Foundation (HMBDF)	Health Management BD Foundation (HMBDF)
	HOPE Foundation for Woman and Children of Bangladesh	HOPE Foundation for Woman and Children of Bangladesh
	Partners in Health Development (PHD)	Partners in Health Development (PHD)
	Reaching People in Need (RPN)	Reaching People in Need (RPN)
	Research, Training and Management, International (RTMI)	Research, Training and Management, International (RTMI)
	Salt Financial Literacy International, Inc. (SALT)	Salt Financial Literacy International, Inc. (SALT)
	Sajida Foundation	Sajida Foundation

Annex 7: Standard guidelines for Clinical Management of Rape developed by UNHCR, IOM and UNFPA

Guidelines for Clinical Management of Rape

General Guidelines:	Within 72 Hours	After72 Hours
• Reassure the survivor • Take history including preexisting pregnancy • Check vital sign • Obtain consent for examination • Prepare the survivor for examination • Collect and documents the evidence Follow specific guidelines for treatment	• Medical examination should be guided by the survivor's history of assault • Assess survivors mental and emotional status • Inspect the genitalia and provide wound care if needed • Follow instructions and offer prophylaxis as per box: 1, 2, 4, 5, 6, 7/8 • Provide psychosocial support and ask for follow up • Discuss about HTC	• Medical examination should be guided by the survivor's history of assault • Assess survivor's mental and emotional status • Inspect the genitalia and provide wound care if needed • Follow instructions and offer prophylaxis as per box: 1, 2, 4, 6, 8 and 5 if <120 hours • Provide psychosocial support and ask for follow up • Discuss about HTC

1. Check for preexisting pregnancy			2. STI Prophylaxis	3. STI Treatment
Pregnancy test	Within 72 hrs	After 72 hrs	• Adult >45 kg: Cefixime 400 mg+ Azithromycin* 1 gm+ Metronidazole**2 gm orally single dose	• Use STI treatment guidelines for
Positive	Assume the survivor that it is	Try to ascertain if it could be due to rape		

	not due to rape	and counsel accordingly	• Children <12 yrs and <45 kg: Cefixime 8mg/kg+ body weight Azithromycin 20mg/kg body weight+ Metronidazole 5mg/kg body weight orally TDS for 7 days * Use Erythromycin 500 md QDS for 7 days for pregnant women ** DO not use Metronidazole in first trimester of pregnancy N.B.: STI prophylaxis is applicable up to 2 weeks from the time to incident	specific condition
Negative	Offer ECP and provide follow up	<120 hrs offer ECP and provide follow up		

4. Tetanus Toxoid			5. Emergency Contraception (ECP)	6. Hepatitis B
Provide TT prophylaxis if there is any breaks in the skin or mucosa			If pregnancy test is negative- 1.5 mg of levonorgestrel single dose	• 1 ml for adult and 0.5 ml for children IM • 3 doses- 0,1,6 months First dose ideally within 14 days of incidence but can be given within 6 months
H/O TT Immunization	Clean wounds and <6 hrs	All other wounds		
Uncertain or <3 doses	TT-Yes TIG-No	TT-Yes TIG-Yes		
3 doses or more	TT-No, unless last dose 10 yrs age TIG-No	TT-No, unless last dose 5 yrs age TIG-No		
Previously unimmunized survivor need to get a second dose at 4 weeks and third dose at 6 months to 1 year			7. Post Exposure Prophylaxis (Adult & Adolescent > 10 yrs)	**8.** Post Exposure Prophylaxis (Children <= 10 yrs)
			• TDF+ 3TC (of FTC)- preferred regimen, 1 Tab per day for 28 days • ATV/ r is recommended as the preferred third drug	• AZT+ 3TC (of FTC)- preferred regimen, 1 Tab per day for 28 days • LPV/ r is recommended as

		(TDF- Tenofovir, 3TC-Lamivudine, FTC-Emticitabine, ATV/r-Atazanavir/ritonavir) Provide full course (28 days) of drugs on the first day	the preferred third drug (AZT- Zidovudine, 3TC-Lamivudine, FTC-Emticitabine, LPV/r-Lopinavir/ritonavir) Provide full course (28 days) of drugs on the first dayV/ r is recommended as the preferred third drug (TDF- Tenofovir, 3TC-Lamivudine, FTC-Emticitabine, ATV/r-Atazanavir/ritonavir) Provide full course (28 days) of drugs on the first day

9. Follow Up:	
Week 1	Week 6 & 12
Evaluate for pregnancy	Evaluate for pregnancy
Check for side effects and compliance	Check for side effects and compliance
Monitor emotional status	Monitor emotional status
Consider STI treatment	Discuss about HTC
Discuss about HTC	

10.HIV Testing and Counselling
• Ashar Alo, District Sadar Hospital, Cox's Bazar: 01814074669, 01812678785 • Upazila Health Complex, Ukhiya: 01730324471 • Upazila Health Complex, Teknaf: 01730324470 • MSF Clinic, Kutupalong: 01814050199

Annex 8: Table 10: List of program partners and implementing partners working under GBV sub-sector for providing GBV services to host community in Cox's Bazar (Source: Rohingya Refugee Crisis Response: ISCG 4W Dashboard by Camp, August 2019)

Type of program partner	Program partners (n = 8)	Implementing partners (n = 9)	Activity

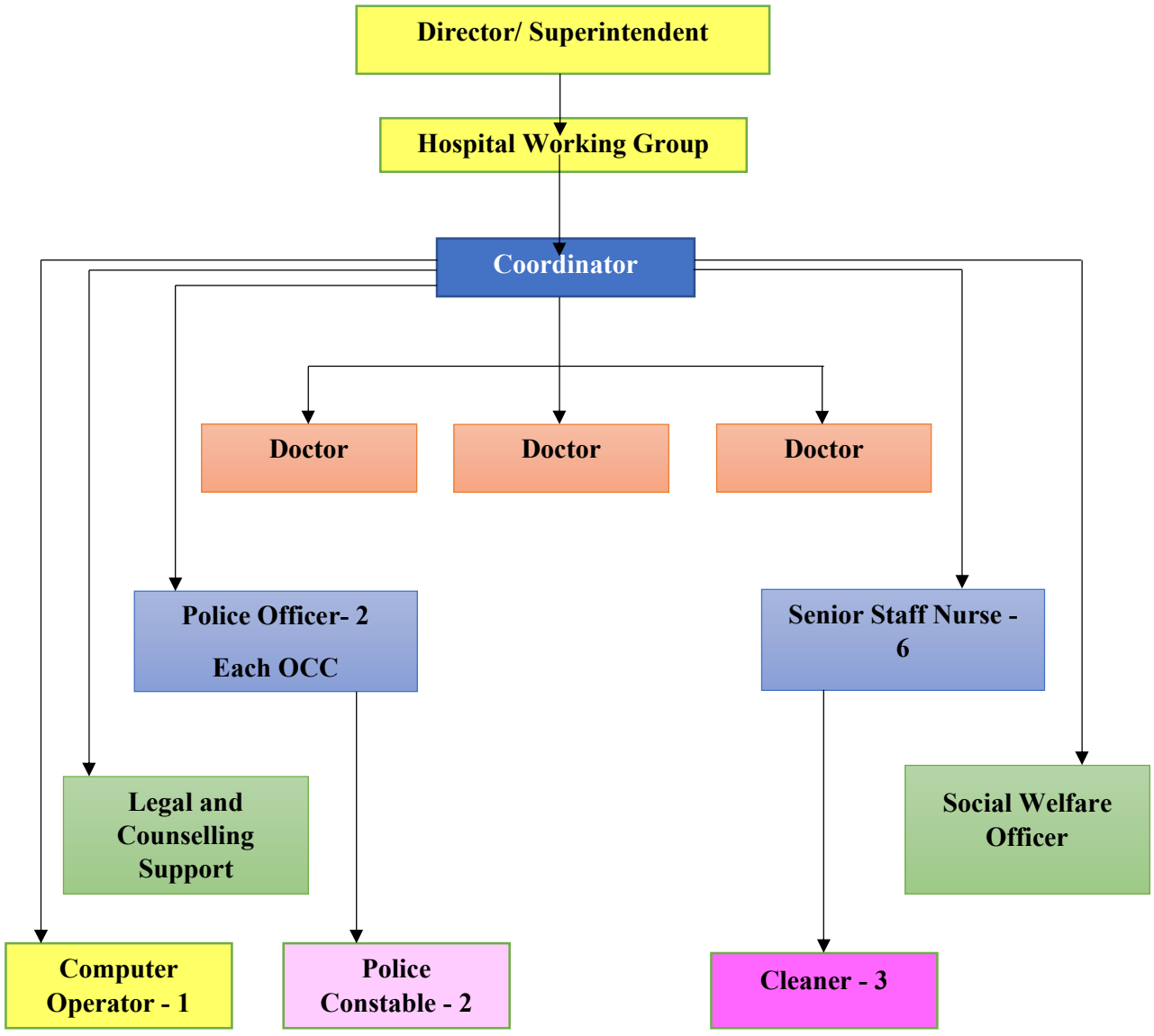
UN (2)	United Nations Population Fund (UNFPA)	Mukti Cox's Bazar	GBV prevention
			GBV response
	United Nations International Children's Emergency Fund (UNICEF)	BRAC	GBV prevention
			GBV response
		Cooperative for Assistance and Relief Everywhere (CARE)	GBV prevention
INGO (4)	Cooperative for Assistance and Relief Everywhere (CARE)	Bangladesh National Women Lawyers' Association (BNWLA)	GBV response
		Young Power in Social Action (YPSA)	GBV prevention
			GBV response
	Danish Refugee Council (DRC)	DRC	GBV prevention
			GBV response
	International Rescue Committee (IRC)	IRC	GBV prevention
			GBV response
	Relief International (RI)	RI	GBV prevention
			GBV response
NNGO (2)	BRAC	BRAC	GBV prevention
	Pulse Bangladesh	International Organization for Migration (IOM)	GBV prevention

Annex 9: Table 11: List of program partners and implementing partners working under Health sector for providing health services to host community in Cox's Bazar (Source: Rohingya Refugee Crisis Response: ISCG 4W Dashboard by Camp, August 2019)

Type of program partner	Program partners (n = 2)	Implementing partners (n = 3)
INGO (2)	Center for Disability in Development (CDD)	Center for Disability in Development (CDD)

	Peace Winds Japan (PWJ)	Dhaka Community Hospital Trust (DCHT) Peace Winds Japan (PWJ)

Annex 10: Figure 9: Organogram for One-stop Crisis Center (Source: One-stop Crisis Center at 250 bedded Cox's Bazar District Sadar hospital)



Annex 11: Figure 10: Protocol for the OCC service (Source: One-stop Crisis Center at 250 bedded Cox's Bazar District Sadar hospital)