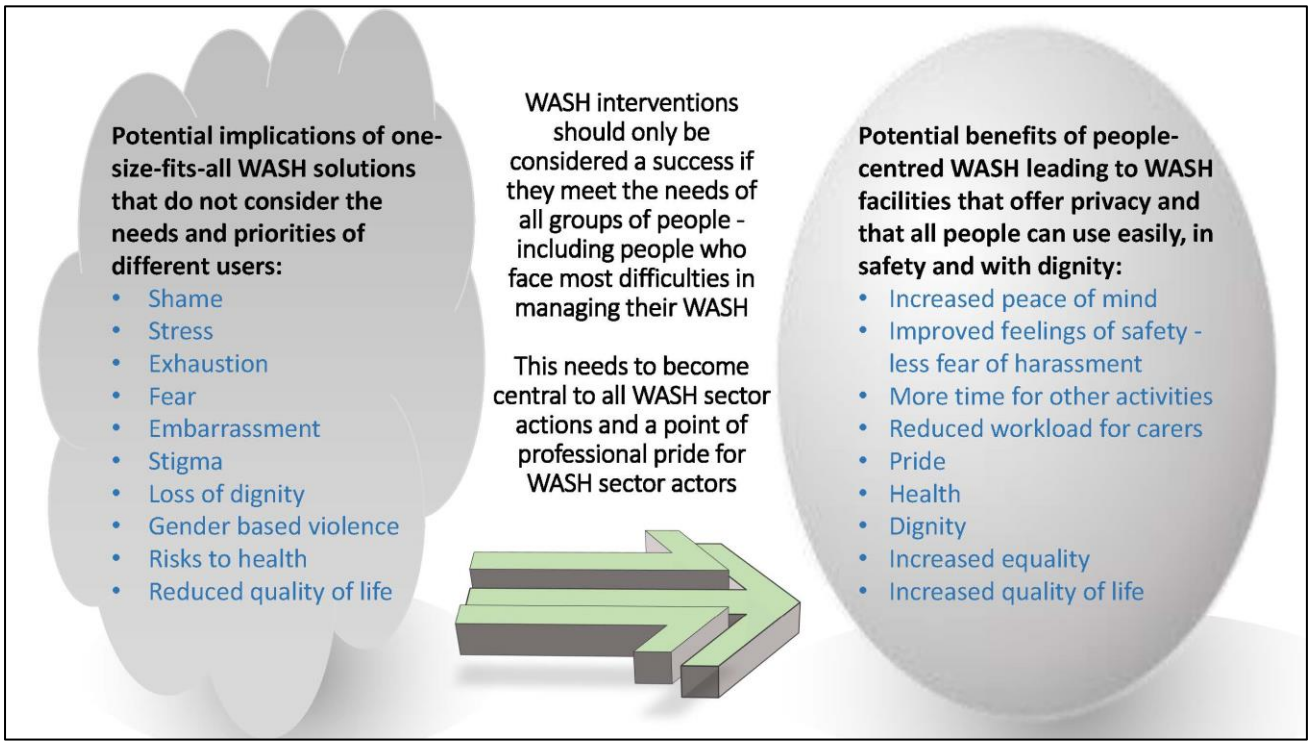
Strengthening the humanity in humanitarian action in the work of the WASH sector in the Rohingya response

Gender, GBV and inclusion audit of the work of the WASH sector and capacity development assessment



Dr Sarah House – WASH, Gender, GBV and Inclusion Consultant

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All photos were taken by S. House / UNICEF unless otherwise credited.

Acknowledgements

Sincere thanks to:

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Table 1 - Organisations with at least one member of staff who participated in the process

Action Against Hunger (AAH) / ACF	HelpAge	Save the Children
Bangladesh Institute of Theatre Arts (BITA)	Hope Foundation	Swiss Development Cooperation (SDC)
British Red Cross (BRC)	International Federation of Red Cross and Red Crescent Societies (IFRC)	Solidarités
Building Resources Across Countries (BRAC)	Inner Power	Terres des Hommes (TdH)
CARE International	International Office for Migration (IOM)	United Nations Children's Fund (UNICEF)
CBM	Inter Sector Coordination Group (ISCG)	United Nations High Commissioner for Refugees (UNHCR)
Centre for Disability in Development (CDD)	NGO Forum	United Nations Women (UN Women)
Department of Public Health Engineering (DPHE)	Norwegian Church Aid (NCA)	Village Education Resource Centre (VERC)
Dushtha Shasthya Kendra (DSK)	Practical Action Bangladesh (PAB)	WaterAid Bangladesh (WAB)
Environment Infrastructure Management Solutions (EIMS)	Refugees, Relief & Repatriation Commission, RRRC (Camp in Charge from Ministry of Public Administration)	World Food Programme (WFP)
Handicap International / Humanity & Inclusion (HI)	Resource Integration Centre (RIC)	World Vision Bangladesh (WVB)
		Young Power in Social Action (YPSA)

Contents

For the Annexes – see the separate document – these include:

Acronyms

Acronym	Expansion
AAP	Accountability to affected populations
AFA	Area Focal Agency
AFS	Age-friendly space
BCC	Behaviour change communication
CFS	Child-friendly space
CFT	Core Facilitation Team
CiC	Camp in Charge
CLTS	Community Led Total Sanitation
CwC WG	Communication with communities working group
CXB	Cox's Bazar
DPHE	Department of Public Health Engineering
FGDs	Focus group discussions
GBV	Gender based violence
GBViE	Gender based violence in emergencies
GiHA WG	Inter-sector Gender in Humanitarian Action Working Group
HP	Hygiene promotion
IASC	Inter-Agency Standing Committee
IEC	Information, education and communication
IOM	International Office for Migration
ISCG	Inter Sector Coordination Group
JRP	Joint Response Plan
KIIs	Key informant interviews
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MEAL	Monitoring, evaluation, accountability and learning
MHM	Menstrual hygiene management
NFI	Non-food item
PSEA	Prevention of sexual exploitation and abuse
RRRC	Refugees, Relief & Repatriation Commissioner ('Triple R C')
SADD	Sex and age disaggregated data (or sex, age and disability disaggregated data)
SAG	Sector Advisory Group
SEG	Strategic Executive Group
SGM	Sexual and gender minorities
SOP	Standard operating procedure
TBA	Traditional Birth Attendants
ToR	Terms of reference
TWG	Technical working group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene

See also a list of institutions / organisations with their associated acronyms included in the Acknowledgements section.

Terminologies

- *Majhis* – Community leaders placed by government officials[1]
    - *Head Majhi* – covers 1,600 households
    - *Sub-Majhi* – covers 100 households
- *Hafes & female Hafes* – A person who has completely memorised the Qur'an

Settlement characteristics[2]

- **Collective sites** – Camp like settings with exclusively Rohingya population – Includes:
    - Registered refugee camps
    - Makeshift settlements
    - Spontaneous settlements where no Bangladeshi communities live
- **Collective sites with host community** (also referred to as "paras") – Collective camp-like settlements that developed around existing Bangladeshi communities, presenting a mixed population
- **Dispersed sites** – Villages and dispersed locations where Rohingya refugees reside among Bangladeshi host communities

Government divisions

- Divisions (regions, 8 in total) - Districts - Upazila - Union Council - Villages

Camp structure[3]

- **Block Committees** – elected 7 members of which 2 were female
- **Camp Committees** – consisting of 3 representatives from each block

[1] ACAPS, NPM & Analysis Hub (2018)
[2] ACAPS, NPM & Analysis Hub (2018)
[3] ACAPS, NPM & Analysis Hub (2018)

Terminology - Gender, GBV and Inclusion

In reality the following terms have overlapping meanings, but have been separated so that key issues are not forgotten or overlooked. They have also been left as separate concepts, as different actors in the Rohingya response are focussing on them as separate issues, such as: members of the Gender in in Humanitarian Action group; GBV sub-sector working group; disability and older persons working group.

	Main issues that should be considered by the WASH sector
Gender	• The opinion, needs and priorities of women and adolescent girls are specifically sought out as well as the needs of men and adolescent boys. • Gender equality and inequality – including the different gender roles, responsibilities, decision-making power and restrictions of females, males and people of different ages, which are socially ascribed are identified and understood. This includes how this then impacts on different people's abilities to access services, opportunity to take up roles and gain an income. • Note that the situation, opinion, needs and priorities of people who are sexual and gender minorities (SGM) also comes under gender. But in the Rohingya response, it is recommended that all identification and engagement of people who are SGM should only be done directly by the Protection Sector specialists. They can then inform the WASH sector of any actions it needs to take if appropriate, communication should not be done by the WASH sector directly. This is because inappropriate communications could potentially put people who are SGM in more danger.
Gender Based Violence (GBV)	Understanding the ways that women and girls, boys and men can face different forms of violence in relation to WASH in the Rohingya response. Whilst some of these ways are not specifically related to gender (and hence may not officially come under the title of GBV), many do and all relate to violence of one kind or level[4]: Examples of violence related to WASH include: • Verbal harassment, staring, touching of bodies of women and girls while they are standing in queues, or peeping through gaps in walls or doors, as they use WASH facilities.

[4] For more information see: House, S. Ferron, S, Sommer, M, and Cavill, S. (2014) *Violence, Gender & WASH: A Practitioner's Toolkit - Making water, sanitation and hygiene safer through improved programming and services*. London, UK: WaterAid/SHARE (co-published by 27 organisations) http://violence-WASH.lboro.ac.uk; and Inter-Agency Standing Committee (IASC) (2015) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*. https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

	• Physical violence between adults and children, or between adults and children, males and females, males and males, or females and females, particularly when in queuing situations, such as collecting water or waiting for a toilet. • Verbal abuse between different individuals if they are using WASH facilities that are not considered to be allocated to them, or because of social ostracism (such as a person is from a minority or excluded group). • Making derogatory comments and putting women down, making them feel uncomfortable, or threatening them, when they take on roles that some people do not consider are suitable for a person of their gender. • Physical assault or rape, which can happen against women, adolescent girls, adolescent boys, children and sometimes also men.
Inclusion	*"The aim of inclusion is to embrace all people irrespective of race, gender, disability, medical or other need. It is about giving equal access and opportunities and getting rid of discrimination and intolerance (removal of barriers). It affects all aspects of public life".* *"Inclusive design is about making places that everyone can use. The way places are designed affects our ability to move, see, hear and communicate effectively. Inclusive design aims to remove the barriers that create undue effort and separation. It enables everyone to participate equally, confidently and independently in everyday activities"[5].* In relation to the Rohingya response, in addition to considering gender and GBV, particular attention also needs to be made to make sure that the following groups of people are considered, consulted and involved. They are facing additional barriers and challenges to benefit from the WASH services and to manage their WASH easily, safely and with dignity: • People with disabilities and older people. • Female headed households including widow headed households. • Child and older person headed households. • People who are chronically ill.

[5] https://www.inclusion.me.uk/news/what_does_inclusion_mean

1. Executive summary

Background - Following violence in south-west Myanmar in August 2017, a large influx of Rohingya men, women and children fled into Bangladesh. An estimated 680,000 new arrivals joined over 310,000 existing Rohingya people who had fled previous conflicts. Together with people in the host communities, this has led to more than 1.2 million people in need of support. Most people from the Rohingya community are living in refugee camps, makeshift camps and spontaneous settlements in Ukhia and Teknaf Upzila's in Cox's Bazar. Various studies and consultations have highlighted that whilst a huge effort has been made to respond to the WASH needs of the affected communities (for example over 47,000 latrines have been constructed and thousands of water points), that the resulting solutions are not felt to be fully suitable by many people within the affected communities. Particular concerns have been expressed by women and girls, older people and people with disabilities, with gaps related to the consideration of gender, protection and accessibility.

Purpose of this consultancy - To advise UNICEF & WASH Sector responding to the Rohingya influx on strategies & approaches for gender, GBV and inclusion integration & to develop capacities of UNICEF and sector partners to strengthen the implementation.

Scope of work and timeline - The scope of work includes: a) To undertake a gender, GBV and inclusion audit of the WASH Sector response; b) Undertake a capacity assessment of WASH Sector partners; c) Develop a roadmap (action plan) to improve capacity for the WASH Sector & UNICEF programmes; d) Advise on strategies and approaches; e) Develop and provide training to UNICEF staff and WASH sector partners; f) Review WASH strategies, tools, programmatic documents and make recommendations. The work is being undertaken between Sept 2018 and February 2019.

Approaches and people who engaged in the process - Approaches used included a desk review, key informant interviews, focus group discussions, participatory workshops, meetings, household visits, individual interviews and observations. Over 115 community members engaged in the process from Rohingya or the host communities (62 female; 52 male; with a mix of ages and including people with disabilities and their carers); and over 130 humanitarian actors, working across sectors and technical areas (WASH, protection, gender, GBV, disability, older person, site management, energy, livelihoods, cash working group, communication, education, health, M&E and construction). The team visited 7 camps and one host community and undertook household visits and visits to institutions, such as child and age friendly spaces, a Sanimart, a maternity hospital, information centres, distribution centres and a madrassa.

Limitations – The audit and capacity development process in Cox's Bazar was undertaken during a 3-week period in Nov 2018, with some follow-up meetings and discussion in another 3 week period in Jan/Feb 2019. This limited the number of people and communities it was possible to meet, and some findings were based on limited interactions. However, with triangulation of information between a range of in-depth studies, meetings, visits, observations and facilitated discussions, a reasonably clear picture has been developed, from which the roadmap has been proposed.

Audit - positive efforts made to respond to gender, GBV and inclusion – The response itself has been impressive from the perspective of the huge scale of provision of facilities and services in a complex topographical and political context. This has saved many lives. There is also evidence that the WASH facilities and services have been improving over time. A range of positive efforts have also been made in improving the situation, from the perspective of different groups of people within the communities. Many toilets have locks and lighting in the camps is increasing. People have also been finding their own solutions, such as constructing bathing facilities in their own shelters. Data collection and monitoring related to safety and disaggregation of assessments by gender, has been improving and there have been a number of specific studies that have identified WASH and gender and gender-based violence (GBV) related information. Hygiene promotion and community engagement is being strengthened and an effort has been made to integrate issues related to the safety and dignity of the affected populations into strategic documents and guidelines. Efforts have started to coordinate across sectors in the area of menstrual hygiene management and incontinence and some specific studies have been undertaken to investigate the priorities of women and girls. There have also been some positive examples of collaboration across a number of sectors, with particular support provided by the GBV, protection and gender actors.

Audit - challenges and gaps – Most of the communal toilets and bathing facilities are not gender-segregated (i.e. there is no separation by distance or by wall/screen). This has resulted in males and females having to queue together, something that is particularly not felt to be appropriate culturally, including because of the practice of *Purdah*. A large number of women and girls are not using the communal WASH facilities, except at night and some have expressed fear and shame to use communal water points, toilets and bathing facilities while men are present. Men and boys have been washing by the water points and sometimes also use the facilities allocated for women and girls. Inclusion of older people and people with disabilities in the response has been minimal and WASH facilities in general have not been made accessible, although there are a few examples of good practice. Gender, GBV and inclusion seem to have been mainly be seen as the responsibility of the hygiene promotion teams and if mentioned tend to be 'tack on' to activities added at the end, rather than central to all work of the sector. The quality of 'community consultation' has been questionable with specific groups of people such as older people and people with disabilities being obvious by their absence. Some opportunities for cross-sectoral collaboration have not been made the most of, such as engagement with the health sector and the disability and age- related specialists, although some efforts have previously been made from the WASH sector's side to link with the Health Sector. There has been limited success with the disposal of child faeces and the responsibilities for the management of the drainage system are not clear, leading to stagnant water and sullage.

Impacts of gaps – The potential negative impacts of the gaps in the response of the WASH sector to understand and respond to gender, GBV and inclusion, include: feelings of shame, stress, exhaustion (such as for carers), fear, embarrassment, increased stigma, loss of dignity, increased risks of GBV, risks to health and reduced quality of life.

Capacity assessment – There is a need for building capacity, leadership, commitment, confidence and pride in the work of the WASH sector that meets the needs of different groups of people, including those who face the most difficulties meeting their WASH needs. Various reasons (or excuses depending on your perspective) as to why these issues have not been considered have been shared, but whilst some have a degree of validity, the biggest issue appears to be a gap in mindset and recognition of the importance of these issues and the resulting negative implications on the affected populations if they are not considered as central to the WASH sector's work. Capacity, confidence and commitment building, are needed from senior to field levels, across agencies and in a number of areas. This includes raising awareness of why considering these issues are essential (the 'lightbulb' or 'ah ha!' moments), in technical areas, such as how to practically improve accessibility, and in particular how to undertake effective community consultations, including involving people who may face more barriers than most in responding to their WASH needs.

Some training on codes of conduct, referral systems, GBV and the prevention of sexual exploitation and abuse (PSEA) has been reported to have occurred, but it is not clear whether this has reached all frontline workers, including those working on hygiene promotion, community mobilisation and construction. Turnover is also a challenge for capacity building at all levels. There is a particular need to build commitment and leadership at the senior levels in the response, to ensure that these issues are kept on the agenda and also that partners are required to respond to these issues as part of their contracts. It needs to be mandatory with integrated budgets, capacity building and guidance. Further attention is needed as to how to recruit and retain more female staff and volunteers at all levels and to also recruit people with disabilities as part of the response teams. A range of approaches will be needed for capacity building. Guidance is needed that is in a simple language and is tangible and practical.

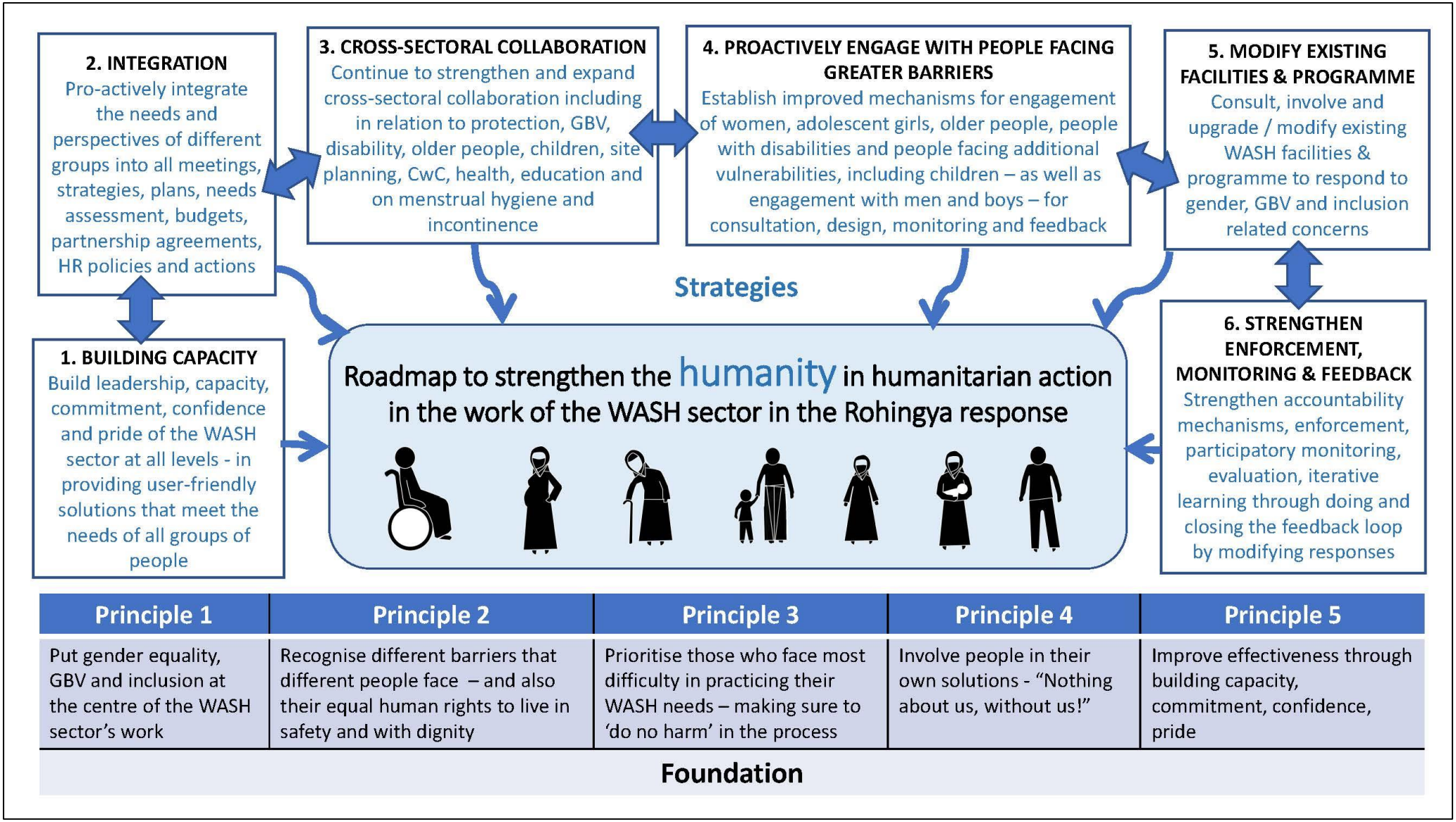
Challenges and barriers for going forward – The biggest challenges and barriers going forward include the understanding of the sector leaders / managers as to why these are critically important issues and the commitment to keep them on the agenda as well as committing to respond at scale rather than only on a small scale and ad hoc basis. It includes the complexity of needs and priorities, combined with the scale of the response and the difficult topography and space constraints. The huge numbers of humanitarian staff and turnover, also pose challenges for both coordination and capacity building, as do the language barriers between Chittagong and Rohingya and Bangla and English. Another challenge is the lack of confidence in the sector in supporting accessible WASH and the skills required to facilitate discussions and agreements on how to improve the current WASH facility arrangements and small sizes of the disability and older person specialist organisations. The unified designs also need updating to respond more systematically to gender, GBV and inclusion, as in some cases they are being used as an excuse for non-action; but at the same time to review and improve the existing construction, improving the existing designs.

Recommendations - The recommendations from this audit and capacity building process have been integrated into a draft roadmap for going forward. The roadmap is structured around 5 principles

and 6 core strategies. Quick wins, interim solutions and longer-term goals have been identified. Refer to the image on the following page for an overview, and to the roadmap itself for details.

Concluding remarks – There is a need to encourage that all WASH actors adopt a mindset that leads them to see the different needs and barriers that different people face. The sector needs to understand and care that if as professionals we do not consider and respond to these issues, that whilst people who face more barriers tend to be very strong and resilient because they have to be, some people are more likely to struggle to meet their WASH needs which can result in a range of possible negative impacts to health, dignity, safety and quality of life. There is a need to start acting at scale, to consult and involve different groups of people (women, adolescent girls, older people, people with disabilities as well as men and boys), including those who face greater barriers and to learn by doing; and with this to bring a greater focus on **humanity** into the work of the WASH sector in the Rohingya response.

Fig 1 - Roadmap to build the capacity and commitment of the WASH sector in the Rohingya response to support people-centred solutions



2. Background, purpose, scope, schedule

2.1 Background

Following violence in south-west Myanmar in August 2017, a large influx of Rohingya men, women and children fled into Bangladesh. An estimated 680,000 new arrivals joined over 310,000 existing Rohingya people who had fled previous conflicts. Together with people in the host communities who have also been affected by the influx, this has led to more than 1.2 million people in need of support. Most Rohingya people are living in refugee camps, makeshift camps and spontaneous settlements in Ukhia and Teknaf Upzila's in Cox's Bazar. Of the total affected population, it is estimated that over 720,000 are children, making this very much a children's crisis[6]. They, along with the women and men who also fled, have experienced extremely high levels of violence and trauma and children have had their rights to education taken away. It is estimated that approximately 9 percent of the population are also over 50 years old[7]. From a HelpAge study of camps 8E, 13 and 15, it was established that of the people over 50 years old, 53% are between 50-59 years old; 32% are 60-69 years old; 11% are between 70-79 years old and 4% are 80 years or above.

Somewhere between 3 to 14 percent of the population[8] may be considered to have a disability and some form of impairment. There are also many widows, female headed households, orphans and older people living alone in this emergency, which adds additional challenges for them and their families.

Various studies and consultations have highlighted that whilst a huge effort has been made to respond to the WASH needs of the affected communities (for example over 47,000 latrines have been constructed), that the resulting solutions are not felt fully suitable by many people within the affected communities. Particular concerns have been expressed by women and girls, older people and people with disabilities, with gaps related to the consideration of gender, protection and accessibility.

This audit and capacity development assessment has been supported to understand the current situation and to consider the ways forward and what capacity building will be needed to make this happen.

2.2 Purpose of the consultancy

To advise UNICEF & WASH Sector responding to the Rohingya influx on strategies & approaches for gender, GBV and inclusion integration & to develop capacities of UNICEF and sector partners to strengthen the implementation.

[6] UNICEF Terms of Reference
[7] Data estimation from HelpAge
[8] Estimates vary on the number of people with disabilities in the affected populations. This range has been included to recognise that the numbers of people with impairments at even 3 percent already is huge numbers of people, but could potentially be much higher as per the estimates of disability specialist organisations working in the response.

2.3 Scope, outputs and target dates

Scope of work

1. Undertake a gender, GBV and inclusion audit of the WASH Sector response
2. Undertake a capacity assessment of WASH Sector partners
3. Develop a roadmap (action plan) to improve capacity for the WASH Sector & UNICEF programmes
4. Advise on strategies and approaches
5. Develop and provide training to UNICEF staff and WASH sector partners
6. Review WASH strategies, tools, programmatic documents and make recommendations

Outputs

Table 2 - Outputs and target dates

	Output	Target date
1	Inception report on the gender and inclusion audit of the WASH sector in CXB	First draft - 30 Dec 2018
2	Capacity assessment and development plan for sector personnel, including mentoring of UNICEF staff and consultants	First draft - 30 Dec 2018
3	Clearly defined strategies and approaches with a roadmap of activities for gender, GBV and inclusion in WASH in CXB	First draft - 30 Dec 2018
4	Training workshop undertaken	30 Jan 2019
5	Final versions of reports, roadmap and recommendations	Final - 21 Feb 2019

This report and the associated separate Annexes, contains outputs 1 and 2. Rather than writing them twice, the recommendations from this audit and capacity development assessment have been integrated into the document on the recommendations of the consultant for the roadmap, which has also been presented as a separate document.

Schedule

- **Sept / Oct 2018** – Desk work – Planning and document review
- **Nov 2018** – Visit 1 to Cox's Bazar – Audit & capacity assessment
- **Dec 2018** – Analysis & write up
- **Jan 2019** – Preparation of capacity building materials + visit 2 to CXB for capacity building
- **Feb 2019** – Final reports and outputs

2.4 People who engaged in the process – during trip 1

Over 115 community members from Rohingya or host communities (estimate):

- 62 female; 52 male
- 3 women's groups (1 with women and adolescent girls; 1 older women's group; 1 host community); 3 men's group (1 older man; 1 host community leaders)
- 20 older people; 4 people with disabilities or their carers[9]; a few children
- 15 Hygiene Promotion (HP) or information centre-based community volunteers / 'Model Mothers', or Traditional Birth Attendants (female)
- 10 Rohingya and host community HP volunteers (male) + 1 community technician (male)
- 5 Majhis / sub-Majhis (male)
- 1 CFS staff member; 2 information centre staff (male and female); 3 Madrassa staff (male)

Note that the team met more people than are indicated here. The number above summarises an estimation of the number of people who engaged/spoke with the team, rather than all people present in meetings.

130+ humanitarian actors:

- WASH – 86
- Protection, gender, GBV – 12
- Disability or older person specialists – 15
- DPHE / CiC - 2
- Site management, energy, WFP, cash working group etc – 5
- UNICEF C4D, education, health, M&E – 8
- Contractor / EIMS Consultancy (who monitored / support the army supervisors) - 3

Table 3 - Visits made during the first CXB visit

• Camps - 2, 6, 7, 11, 14, 15, 18 • Host community in Balongkhali Union – 1 • Household visits – 5 (plus met outside other households + at WASH facilities)	• Child Friendly Space x 1 (plus saw others from outside) • Age Friendly Space x 2 • Sanimart x 1	• Maternity hospital x 1 • Information centres x 2 • Distribution centres x 2 (saw from outside) • Madrassa - 1

A number of other professionals also contributed during the second visit, filling in gaps from the main audit and capacity assessment process undertaken during the first visit. They have not been counted above.

[9] There may have been more, but the team did not specifically ask all people met

2.5 Limitations

The limitations of the consultancy are highlighted in the following table.

Table 4 - Limitations of the consultancy

	Limitation	Efforts to respond to limitation
1	Short time in CXB to undertake audit and assessment of large-scale response	Utilised learning from existing documentation and triangulated through in-country meetings, key informant interviews (KIIs), focus group discussions (FGDs), in-depth interviews (IDIs) and observations. Added extra few days on first trip for admin and security clearances, to allow more time to focus on audit and assessment.
2	Consultant does not speak Rohingya	Working with the UNICEF CXB team with support for translation by team members, partners and independent consultants.
3	Gaps in who it was possible to meet during the first visit to Cox's Bazar	Even though an additional week was added on by the consultant to the first visit to enable a more comprehensive audit and capacity development process; due to limitations in time and competing demands for sector respondents time, it was not possible for the team to meet a number of key people or visit some institutions. Some it was possible to meet on the second trip. Those the consultant did not meet during either trips included: • Representatives of the IOM site planning and energy teams • The outgoing lead of UNHCR WASH (during the first trip) and the new UNHCR WASH lead (during the second trip) • Not many adolescent girls or boys (one FGD was requested with adolescent girls but did not happen) • Only a few children were spoken to directly • Teknaf camp (this was planned but at a later stage and did not happen) and only visited one host community • No learning centres (this was planned but did not happen), women friendly spaces or schools were visited • Attendance at the Communicating with Communities or Water TWG meetings (although a workshop was held with the Water TWG on the second trip)
4	Large numbers of WASH sector actors and limited time for capacity building on second trip	Prioritised CXB senior level trainees for initial capacity building with the aim to strengthen commitment to establish other capacity building opportunities for other actors. Mentored new WASH, Gender, GBV and Inclusion Consultant and involved some co-trainer(s) who can subsequently develop / support other trainings. Development of a few key tools.

3. Methodologies, information gathering framework and ethics

3.1 Methodology, approaches and tools

The methodology for the consultancy was mainly qualitative, but considering quantitative data where it exists. The aim was to hear from a range of different people affected by and supporting the response. Particular attention was to speak to some of the people who may be facing more vulnerabilities and struggling most with practicing their WASH and to triangulate the information. The approaches used for information gathering included:

- **Desk review of the humanitarian response, sector and programme documentation** – CXB WASH, gender, GBV and protection related studies and other cross-sectoral materials, UNICEF programme documentation and global good practice.
- **Key informant interviews (KIIs)** – Range of professionals across sectors (see table of contributors in **Acknowledgements**)
- **Practitioner meetings, focus group discussions (FGDs), half day workshops and participation in sector coordination meetings** – To understand current engagement in these issues and promote debate on specific issues, challenges, gaps and ways forward.
- **Meetings / FGDs at community level** – To meet with practitioner's and representatives of specific groups within the community to discuss issues, challenges and suggestions for moving forward.
- **Household visits with individual interviews and observations of WASH facilities** – To see WASH facilities and to understand the difficulties people face to access facilities and practice their WASH.
- **Participatory exercises and tools** – A few participatory exercises were undertaken during different FGDs, meetings and workshops, including a picture-based gender and inclusion analysis; a three-pile sorting; a couple of ranking exercises; drawing solutions; & discussions on visual aids.

3.2 Information gathering framework

The core information gathering questions focussed on the following areas:

Audit:

1. Orientation of the context and humanitarian response
2. WASH sector and UNICEF strategies, processes and tools
3. Current strengths and gaps of the WASH sector response and barriers
4. Engagement with and concerns expressed by the Rohingya refugees and host communities
5. Linkages between protection sector and gender, GBV and inclusion specialists
6. What is being done to respond to the gaps and what needs to be done

Capacity development assessment:

1. Whose capacity needs developing
2. Human resource knowledge / skill strengths and gaps
3. Enabling environment capacity strengths and gaps

Refer to **Annex III** for the overview information gathering framework. The more detailed information gathering framework with questions for specific technical areas and cross-sectoral considerations, can be provided on request.

3.3 Ethical considerations

During the process, a number of ethical principles were followed. Information was given on the purpose of the discussions and visits and verbal consent was requested to ask questions and to take and use photographs. For community members, names were not recorded to encourage people to speak freely and share their opinions. Most photographs taken were only of WASH facilities and not of people, to reduce intrusiveness and to encourage openness in responses. The team were careful to try to put people at ease and to not cause any increased stigmatisation of people who are facing particular challenges. Participants from community level were informed that they could choose not to answer the questions asked and could stop at any time. To understand the balance of people met, general numbers of characteristics of people met were estimated – if the person was male, female, an older person, or they have a disability. People with disabilities were not asked specific questions about their impairment, but asked about difficulties they face undertaking WASH tasks.

3.4 Documentation review

A wide range of documents were reviewed and information collated against the headings: general; coordination; gender; livelihoods and control over resources; GBV and protection including coordination and referral channels; PSEA; vulnerability; lighting; disability / accessibility; consultation with users; minimum standards; water; latrines; bathing and soap access; MHM; incontinence; children's faeces; solid waste; HP; distributions; laundering and pot washing; monitoring and feedback; staffing; capacities and strategies. Refer to **Sections 4 to 6** for the key findings, including findings from the documentation review, discussions, visits and observations.

4. Scale of the response and the focus and structure of the report

4.1 Scale and stages of the response

WASH support in the Rohingya humanitarian response has been huge. By the end of April 2018, it was reported[10] that over 47,750 latrines had been constructed, around 3,700 latrines had been decommissioned as too poor, unsafe, at risk in flood-prone areas, or non-functional and around 15,000 had been de-sludged. The de-sludging process and management of the faecal sludge in the difficult topographical context of the camps and at this scale has been a global first. It was noted in the same analysis that the Strategic Executive Group (SEG) estimated in 2018, that an estimated 50,000 new latrines would be needed with more reliable sub-structures and maintained and at least 30 sludge management facilities to process more than 420,000 kg of faecal sludge per day. As another indication of the scale of the challenges, in data from a rapid assessment report in just one of the camps, Camp 15 (Jamatoli)[11], there are currently around 1,900 latrine facilities of which 819 are not functional and 605 which need de-sludging. Out of around 660 water points, 303 are not functional and there is an estimated need of another 336 water points.

In the early stages of the response, descriptions from the first responders indicated that initially all attention went on to keeping people alive. This included transporting water by bottles in boats, sometimes having to transfer it between several boats to reach people walking through the complex environment in between Myanmar and the relative safety of Cox's Bazar. It was about making sure that people did not dehydrate on the treacherous journey by providing a constant supply of oral rehydration solution. The situation was chaotic and traumatic and people were dying as they walked several days to try and reach safety. At this time consulting and responding to gender, GBV and inclusion needs would have been very difficult except in an ad hoc way, such as in prioritising support of water and ORS for individuals considered most vulnerable.

But as soon as people started to settle and as time progressed, attention that should have increasingly been given to consultation and to responding to the needs of different groups of people, including to respond to the global WASH sector's *"Minimum commitments for the safety and dignity of affected populations".* Some efforts were made by the sector coordinators to encourage this to happen within a few months of the start. But it seems to have been neglected by most actors, or not fully understood, or efforts ineffective. And this has resulted in a situation where many women and girls and people with disabilities and older people are not using, only using at night, or are struggling to use the WASH facilities that have been constructed.

Hence, the proposal for this WASH, Gender, GBV and Inclusion audit and capacity development assessment to reflect on the current situation, to assess the current capacities and plan the way forward.

[10] Swiss Centre for International Health (2018) *Protocol (Inception Report); Baseline survey to determine the current status of knowledge, attitude, behaviours and practice (KABP) relating to water supply, sanitation services and hygiene amongst Rohingya refugees in Ukhia and Teknaf Upazilas Cox's Bazar district,* UNICEF

[11] Kindly shared by the WASH Focal Agency for Camp 15, World Vision

4.2 "5 WASH minimum commitments for safety and dignity"

In 2015, the Global WASH Cluster established a set of "5 WASH minimum commitments for the safety and dignity of the affected populations" (referred to in this report as the '5 Minimum Commitments') which are reflected on throughout this audit report:

1. **Assessment** – Consult separately with girls, boys, women, men and people with disabilities
2. **Design** – Ensure girls, boys, women and men including older people and people with disabilities have access to appropriate and safe WASH services
3. **Implementation** – Ensure girls, boys, women and men including older people and people with disabilities have access to feedback and complaint mechanisms
4. **Response monitoring** – Monitor and evaluate safe access and use of WASH services
5. **Across the response** – Give priority to girls (particularly adolescents) and women's participation in the consultation process

4.3 Focus and structure of the report

The success in terms of the numbers of facilities provided in a difficult, fast moving and complex humanitarian situation, in a difficult topographical and political context and how many lives were saved is recognised and not being questioned. The focus of this audit and capacity development assessment is how well the WASH sector has considered the needs of different users, how well it has involved them, and whether the resulting WASH services are fit for purpose? It also looks at the capacities of the WASH sector actors and makes recommendations for moving forward.

The findings and conclusions sections of the report are structured:

a) **Section 5 – Findings and discussion – programmes**
   - 5.1 – How programmes are responding to the needs of different groups of people
   - 5.2 – WASH facilities, NFIs, MHM and incontinence
   - 5.3 – Hygiene promotion, community engagement, consultations and feedback

b) **Section 6 - Findings and discussion – capacities, coordination, strategic, institutions**
   - 6.1 – Capacities, commitment, leadership and pride
   - 6.2 – Sector strategies, guidance, assessments, studies, monitoring & learning
   - 6.3 – Cross-sectoral linkages related to gender, GBV and inclusion
   - 6.4 – Donors including AFAs, partner agreements, budgets and enforcement
   - 6.5 – Codes of conduct, PSEA and referral systems
   - 6.6 – Human resources, staff and female-friendly work environments

c) **Section 7 – Conclusions and recommendations**
   - 7.1 – Conclusions – WASH, gender, GBV and inclusion audit
   - 7.2 – Conclusions – Capacity assessment of skills in gender, GBV and inclusion
   - 7.3 – Conclusions – Challenges and barriers going forward
   - 7.4 – Recommendations – Roadmap

5. Findings and discussion – programmes

5.1 How programmes are responding to the needs of different groups of people

Key learning from this section:

Older people and people with disabilities:

1. Consultation with older people and people with disabilities in this response have been mostly overlooked and not prioritised. It has been relegated to "when we have time".
2. Queuing and distance are difficult for older people as they cannot hold in their urine the same as younger people. They may need to go to the toilet several times a night and hence need additional NFIs such as torches and urine containers.
3. There are people with disabilities who are urinating on the floor of their shelters and defecating into water buckets, because no-one has supported them with accessible toilet facilities.
4. Many people with disabilities, older people and their carers are struggling with accessing water for their needs. This may be due to the distance and topography, the containers they have or the design of the facilities.

Children:

5. The safe management of child faeces is an area that still needs significant work.
6. Some children are fearful of collecting water and using the toilets and bathing facilities.
7. Gender, GBV and inclusion must be considered in all CFS, Learning Centres, schools and madrassas – there are currently gaps including those posing GBV related risks.

Women and girls:

8. Many women and girls are fearful of using the water points, toilets and communal bathing facilities. Some only use the facilities at night. Over 50% of all households have built bathing facilities in their shelters. Some defecation is also happening with the shelters.
9. Most toilets and bathing facilities are not gender-segregated (by distance or screening) leading to females and males having to queue together to use them.
10. One study indicated that women noted that three of the most dangerous activities they did in the camp were collecting water, accessing bathing facilities and accessing latrines.

Men and boys:

11. Bathing facilities seem to have in many cases been constructed only for women and girls, which may be leading to men and boys washing at water points.
12. It is not clear how much consultation and discussions have been held with men and boys on not using the female facilities. More attention is needed to this area.

People with additional vulnerabilities:

13. People with additional vulnerabilities may need additional support – such as older person-headed households; widow-headed households; households with people with disabilities; older people living alone.

5.1.1 Older people and people with disabilities

Overlooking of older people, people with disability - Recognition of the presence of and WASH needs of older people and people with disabilities within the Rohingya response has been mostly overlooked and not prioritised. In the Joint Response Plan, 2018, the issue of inclusion was only occasionally mentioned; and the focus by the Gender in Humanitarian Action (GiHA) cross-sectoral group has been to encourage sex and age disaggregated data, but it has overlooked data on disability. Officially it is estimated that the number of people with disabilities in the response is between 3-4 percent, but the disability specialist organisations estimate that it could in reality be as high as 13-14 percent of the affected population[12]. Even if the figures are that 3% of the overall affected population have disabilities, this is still a huge number of people of 36,000 in an affected population of 1.2 million.

Lessons identified by senior WASH sector leaders after meeting older people and people with disabilities

1. There are many people in the camps who have some form of WASH needs that prevent them using the standard facilities – older people, people with disabilities, people who are ill etc.
2. The numbers are staggering, in the Age Friendly Space, 80 – 100 people use it per day. Older people and people with disability have been a huge oversight, not just in WASH but also in other sectors. One 70-year old man struggles to leave his house. His shelter is on top of a hill. His wife is also over 60 years. She has to sell their food rations to get youth to carry him from the house.
3. How easy it is to manage WASH depends on luck, and how near or far you are from the facilities. Some women met are very old and fragile and have fallen. They are very resilient people.
4. When someone has ill health, disability and is older, this compounds vulnerability.

As an example of the breakdown of the population - official camp data from Camp 15, Jamtoli camp (Nov 2018), indicated that it is estimated that there are approximately: 51,000 people, of which the there are approximately: 8,500 (17%) are children 0-6 years old; 8,600 (17%) are children 6-12 years; 1,900 (4%) older people of 60+ years old; 500 (1%) people with disabilities; 900 (2%) orphans; and 1,500 (3%) pregnant women. Whereas one study by CARE in the early stages of the response (Oct 2017)[13] in Balukhali makeshift camp, indicated that 49% of families had an elderly member with them and 17% had family members who were currently wounded. The data varies quite significantly depending on the phase, location and data source.

[12] Discussion with Handicap International / Humanity and Inclusion and CBM

[13] CARE Bangladesh (2017) *Myanmar Refugee Influx Crisis from August 2017, Rapid gender analysis report, CARE Bangladesh, Balukhali Makeshift Camp, Ukiya, CXB, Bangladesh*, 18 Oct 2017 (version 3)

Older people in the Rohingya communities

HelpAge data from a study in camps 8E, 13 and 15[14], indicates that:

- Of the people over 50 years old, 53% are between 50-59 years old; 32% are 60-69 years old; 11% are between 70-79 years old and 4% are 80 years or above.
- Of older people of different ages, the following have disabilities: 30% of 50-59-year olds; 55% of 60-69-year olds; 82% of 70-79-year olds; 91% of the 81+ year olds.
- 68% of older people have difficulty with mobility, with 14% of older people having severe or moderate difficulties.
- 12% of older people (over 50 years) are living alone, or as a couple of older people living alone.
- Risks facing older women and men include: isolation; financial abuse; emotional abuse; physical abuse; trafficking; theft; sexual abuse; denial of services; threats of violence; harmful traditional practices.

Invisible - In many contexts people with disabilities and older people tend to be hidden, may not have the self-confidence to ask for or demand support, and are often not consulted as part of standard processes. This means that they are often 'invisible' in terms of the humanitarian actors, who due to competing demands on their time, often speak to the people who are the easiest to speak to. This often ends up being men and male leaders of the community.

The Government of Bangladesh data on older people classifies them as people over 60 years of age. HelpAge also supports older people over 50 years old. This is because they have found that people over 50 years old are often ignored and humanitarian responses tend to focus on people of reproductive age.

WASH support - It is the impression from talking with the specialist agencies, a wide range of organisations working on the response, and hearing from older people and people with disabilities or their carers who were met, that most people with disabilities and older people have not received targeted support for their WASH needs to-date. This is also evidenced by the small numbers of people who have been supported by the few agencies which have provided support (15; 8; 20 etc); and the fact that the main disability specialist organisations do not have WASH programmes, so have only provided occasional WASH support. A few examples have been observed where people have made their own solutions, such as adding ropes to guide a person who is sight impaired in Camp 18.

[14] HelpAge (2019) Presentation on older people and people with disability inclusion gaps, HelpAge International, Cox's Bazar, Bangladesh, 2019

Major concerns and challenges related to WASH –

Concerns of older people related to WASH

HelpAge[15], indicates that:

- 35% of older people feel that they have no safe access to toilet facilities.
- 30% of older people feel that they have no safe access to water facilities.
- Older people may need to go to the toilet several times a night.

Difficulties faced by people with disabilities in accessing WASH

Handicap International data from a study of 63 people with disabilities in Jadimura camp and 11 service providers (2018), indicated that:

- **Difficulties accessing drinking water** – 5% have no difficulty; 13% have some difficulty; 39% have some difficulty; and 43% cannot do it at all.
- **The barriers to accessing water points** – 97% have difficulties pumping water; 80% as the facilities are physically not accessible; 25% water points are too far; 3% because of negative attitudes.
- **Difficulties accessing latrines** – 11% have no difficulties; 25% have some difficulty; 56% have a lot of difficulty; and 8% cannot do it at all.
- **The barriers to accessing latrines** – 96% because the latrines are not adapted; 14% as they are physically not accessible (topography); and 2% are not used to using latrines.
- It is interesting to note that the issue of accessibility and not having adapted latrines is by far the biggest issue raised. No respondents reported the following factors as liming their access to latrines: latrines too far; no female appropriate latrines; don't know where latrines are; latrines not clean; long lines at latrines; no locks; no lights; or feel unsafe.

As is common in many contexts, it is understood that people with disabilities have expressed that one of their major concerns and priorities relates to how they can manage their WASH[16]. Meetings with separate groups of older men and women indicated a range of challenges that they are facing. These include: challenges with being able to reach water points, particularly in the difficult topographic context of the camps; challenges with not being able to queue for using the toilets particularly during peak hours, as they not able to stand and hold their urine and faeces for as long as younger people; and problems with using the squat facilities which have not been made

[15] HelpAge (2019) Presentation on older people and people with disability inclusion gaps, HelpAge International, Cox's Bazar, Bangladesh, 2019

[16] HI reported that this was one of the top two concerns for people with disabilities in a recent study they have undertaken in Jadimura area, together with access to food.

accessible. One man explained how he tried to put his commode chair into a shared latrine unit, but his neighbours complained that they didn't like it as they also wanted to use the latrine unit and so it was removed. They also said they knew of older people who are struggling with incontinence. This is discussed further in **Section 5.2.10**. They also expressed similar concerns to other women and men of different ages, in relation to the distance to facilities, a lack of facilities, too many families sharing the facilities, lack of gender separation of the WASH facilities, of broken facilities, or poor-quality water, dropping water tables, and facilities that needed emptying.

Possible solutions - They suggested the solutions could be:

- To provide a water tank and toilet near to their home
- To support bathing facilities in their homes
- To set up a system where carers could support daily to collect water from distant locations and to empty buckets of faeces after they have used them with their commode chair in their house. This is particularly where they live some distance from the toilet facility
- To separate male and female toilets and bathing facilities and have separate ones for male and female older people that are accessible

> *"It is important to remember that personal circumstances change – people who look healthy today might fall ill or have an accident in the future and their degree of vulnerability may change – this is why design should incorporate special needs".*
>
> (Observation by a stakeholder in the Sanitation and Hygiene TWGs workshop session)
>
> *"Age-friendly WASH arrangements can be assured by available local materials which are cost effective as well. The only thing needed in addition is a little attention, guidance and effort"*
>
> (HelpAge)

Specialist organisations - There are three key international specialist organisations working in the response, HelpAge, Handicap International (Humanity and Inclusion) and CBM with their local and international partners. Local partners include: Resource Integration Centre (RIC), Young Power in Social Action (YPSA) and Centre for Disability in Development (CDD). They coordinate together and try to cover areas where they are not working but, their logistical capacity and reach is not adequate to cover the needs of all older people and people with disabilities in the affected population. HelpAge and CBM as the key international disability organisations also do not have WASH programmes. See the table in **Annex IV,** with their areas of operation, geographical and sectoral areas of focus. The three international specialist organisations provide some WASH support, but they are restricted in scale by their own logistical limitations. They have tried to engage directly with some sectors at sectoral level, particularly with protection and livelihoods, but due to limitations in their time, have not to-date engaged much with the WASH sector at sectoral level. Both HI and CBM have started partnering with a few specific agencies. See **Annex IV**. With 50 operational agencies in the WASH sector, it will be very difficult to rely only on these few organisations with their current staffing levels, to scale up capacity building for the sector, without additional resources.

Identifying people with disabilities to provide support - HI expressed some reticence to share information on where people with disabilities are living for WASH partners to be able to provide support; and second-hand information also indicated that when presenting at a sector TWG, the UNHCR protection team expressed the same reticence. This is probably related to protection concerns, but there will need to be a strategy to work out how the two sectors can work together to provide accessible WASH support at a much bigger scale than is happening at present. The WASH actors already engage with people across the response and can also gather this information directly, but it would make more sense where information is known, that the two sectors should work together to effectively target WASH support at scale. As the disability and older person agencies are small and only work in a few camps each, it will not be possible for them to do all of the identification themselves in all 34 camps. Therefore, the WASH agencies will need to be involved in identification, whilst following protection principles. It is understood that the DPHE has already been involved in a process to identify 7,000 people with disabilities.

Support provided for WASH to-date - Some support has already been given to people with disabilities and older people with their WASH needs. For example, NGO Forum with UNICEF funding has been supporting some older people and people with disabilities to have their own dedicated toilet / bathing facility units. They have so far completed 15 units. The British Red Cross have also supported 7 people with disabilities to have accessible toilets. HelpAge and their partners RIC and YPSA have been providing support such as commode chairs, accessible bathing facilities, awareness raising and the provision of some bed pans and urine containers. Not all of the commode chairs that have been distributed have been used as of yet, as people are not used to using them. It will be interesting to investigate what kinds of adaptations they may have used in Myanmar, to see if there are ideas that could also be translated here. HI support assessments and designs of WASH facilities to meet the specific needs of the user and their particular impairments. They have a trained engineer that they offer to support capacity building related to accessibility to try and increase mainstreaming of the needs of people with disabilities. See the images below for examples of solutions which are being supported at present by RIC/HelpAge and NGO Forum/UNICEF and the British Red Cross.

Case study of challenges being faced by a person with disabilities and her carer - A case study is also included below of some of the challenges that are often unseen by the WASH sector, for people who are facing particular vulnerabilities and multiple challenges in managing their WASH needs, or those of their families. These are the people that the WASH sector needs to pro-actively seek out to hear their challenges and help to find solutions for.

Plastic commode chair with chute for placing over a bucket or a squat hole supported by RIC/HelpAge

Fold-up commode chair with chute for use with a bucket or placing over a squat hole supported by RIC/HelpAge

Accessible hand-washing facilities with stools and ropes with handles for an older person to help themselves sit and get up after sitting – in Age Friendly Space in Camp 18 supported by RIC/HelpAge

An accessible latrine in Camp 6

This was provided for an older person just outside their shelter. Includes a chair with chute, hand-washing / anal cleansing water, soap and a rope for assisting the person to sit and stand. Supported by NGO Forum/UNICEF

The team met a woman who looks after her four children, her husband who was shot in the leg and has a weak arm and is unable to pick things up, and her mother who has one leg amputated.

Her mother sleeps on this blanket on the floor which she finds very hard and she urinates and bathes on the floor in the space to the top right of the room. To defecate she balances on a water bucket with the help of her daughter.

The mother who cares alone for all seven people in her family, has to walk down a steep hill to get water. It takes her around 20 minutes to get one bucket of water and after each trip she has to lie down as she is so exhausted. She has to get 7 to 8 buckets a day as well as cooking for the family and undertaking all other care needs. Her workload is very large and she is exhausted, but she has no choice.

Handrails to entrance

(Credit: K. Gbonsike / British Red Cross)

Two pans in one latrine – one raised for a person who cannot walk and moves across the floor

(Credit: K. Gbonsike / British Red Cross)

5.1.2 Children

A large proportion of the population affected by this emergency are children. Children have faced significant trauma and there are a large number of orphans living in the camps.

Child friendly spaces and learning centres - Significant efforts have been made to construct and run both child friendly spaces (CFS) and learning centres, but they are restricted both in the language they are allowed to use for teaching in the learning centres (only English and Burmese are permitted to be used) and also the space allocated for the centres. By June 2018, there were nearly 1,200 learning centres in the camps and over 2,600 teachers. By Nov 2018, there were 2,000 learning centres all over the camps and 439 Child-Friendly Spaces (CFS) supported by all actors and also a range of adolescent clubs[17].

Some centres have appropriate gender segregated WASH facilities integrated into them, but others do not yet have any, or the facilities are not ideal. REACH facility mapping assessments in the first half of 2018 indicated that only 11% of the learning centres had latrines on-site and 75% using off-site facilities, with only 39% having hand-washing facilities on site and 39% using off-site facilities. The situation will have improved by the end of 2018, but this data provides an overview of scale of the gaps[18]. It was reported that an assessment by the Education Sector, indicated that public latrines were perceived as dangerous places for children and that students and parents raised the poor WASH as a specific challenge to their attendance at the learning centres and concentration during their studies.

One facility visited which is facilitated by BRAC, has nicely designed WASH facilities with toilets with units separated by male and female with soap, water and containers inside the unit and in addition

[17] UNICEF (2018, draft) *WASH in Learning Centres and Child-Friendly Spaces Concept,* UNICEF Rohingya Refugee Crisis, 7 July 2018 and information from the UNICEF Education team

[18] UNICEF (2018, draft) *WASH in Learning Centres and Child-Friendly Spaces Concept,* UNICEF Rohingya Refugee Crisis, 7 July 2018

separate hand-washing facilities for general use in the main room. The only issue with them was that the entrance to the male and female door were together and behind a wall which also included having to walk by the female door to go to the male urinals. If the entrances were separated, this would allow separate access to each. Such minor issues should be modified. Another centre visited had a block of toilets along the opposite side of the road with the doors opening on to the road no separation to the male and female units. It is reported that efforts are being made to integrate hand-washing in the teaching in the centres and that children are encouraged to wash their hands, on arrival and before departure to encourage the practice. A request was made by Child Protection specialists that more direct engagement of the WASH sector in supporting WASH in CFS would be appreciated, rather than leaving the Child Protection actors to manage the process of design and construction of these facilities.

UNICEF and CBM were (Nov 18) at the start of a partnership to trial making some of the learning centres inclusive and accessible. This will be a 6-month pilot and then will be scaled-up. They will also support some children at home, including with some assistive devices, including for WASH.

Madrassas and schools in host communities – WASH has been supported in some schools and madrassas in the host communities in the response. A visit was made to a madrassa in a host community. The madrassa has 450 students including 300 male students (from 7 to 20 years) and 150 female students (up to 10 to 11 years) and including some orphans. Boys board at the school and the girls go home. There are 18 teachers, all of whom are male. They have an ablution block and water tanks. These are not considered large enough, as they only last for one round of ablution before prayers. They also have several handpumps, one electric powered pump and two open makeshift urinals. When the WASH was supported for this madrassa, it is clear that gender or GBV was not considered. It was reported that girls used a couple of specific toilets and males use other units directly next to the female toilets. But girls were seen coming out of a different block and the clay balls called *'Daila',* that males use for drying their urine, were seen on the floor of the toilet units reported to be used by the girls. Hence it is not clear that any division is in reality being kept. Two of the newer constructed and functioning units were locked and being used by the teachers – one by the teachers of the Koran and the other by the other teachers. Several of the other units were broken. In relation to gender and GBV, the biggest concern is protection related and was that all of the toilet units for male teachers, male students and female students were together in an open and secluded area behind the madrassa buildings. There are also two makeshift open urinals that were directly next to the toilet blocks (see image below). Hence any girl who wants to use the toilet needs to go into the secluded area and be at risk of being there are the same time as male teachers and boys, including some using the open urinals. Desludging was in process during the visit supported by NGO Forum. The madrassa does not at present provide any support for MHM. The girls finish at the school at 10 or 11, but it is possible that some may have already started to menstruate; although at this point it is also possible that they may be then taken away from school or asked to leave? Girls who are in schools or learning centres when they start menstruating, may also be restricted from attending school or touching the Quran at this time.

It is essential that gender and protection related concerns are integral to any WASH response in schools, madrassas, learning centres and CFS in this response. Both the Education Sector and the WASH Sector have responsibilities for WASH in schools, CFS, learning centres and Madrassas. So there is a need to agree on principles, minimum standards and monitoring procedures.

Child faeces – In the REACH survey in April 2018[19], it was reported that children under-5 "usually" defecate in the open, with 95% reporting that this "sometimes" happened. From the REACH survey of Aug - Oct 2018[20], it is reported that 36% of all households (which is 56% of all households with a child under 5 years old), reported using safe methods for disposing of children's faeces. Safe methods are considered as collected, rinsed and disposed in latrine, or collected and disposed in latrine, but not rinsed. 28% of all households (which is 44% of all households with a child under 5 years old) report using unsafe methods (most of which involve collection and disposal of the faeces in an open area). A few reported disposing of it with other garbage, a few reported open defecation and some actors and that some are disposing of their faeces in plastic bags and then putting them in the waste bins.

Female toilet unit in a Child Friendly Space in Camp 2

Open urinals in a Madrassa in a host community

This has been supported with WASH as part of the response. Both male students and teachers and young girls have to go to a secluded space at the back of the madrassa to use the toilet and these open urinals are directly next to the toilets.

[19] WASH Sector Cox's Bazar & REACH (2018) *Water, Sanitation and Hygiene Baseline Assessment, Cox's Bazar, Rohingya Refugee Response*, April 2018
[20] REACH (2018) *WASH follow-up assessment, Monsoon season – all camps in Ukhia and Teknaf Upazila (Aug - Oct 18)*, WASH sector and DPHE

Locally procured child's commodes (potties) provided by the response to a host community

Ablution unit in a madrassa in a host community, which is also used for bathing for the male students who reside in the madrassa

NFIs to support the management of child faeces – The WASH Sector Strategy from March 2018, includes a recommendation to provide reusable nappies and potties and some organisations have reported providing one or the other. See the photo example above of potties shown to the team in a host community which had been provided by NGO Forum. The host community reported that they had not previously used them before the humanitarian intervention, but they find them useful. However, it should also be noted that the community visited still have households which do not have toilets. Hence, it is not clear where the faeces collected from the children in the potties will then be disposed of? The women reported to be defecating in a hole or using other household's toilets, but it is still possible that open defecation is still being undertaken.

Some organisations (such as VERC and ACF) reported also distributing potties to households in the camps and that post distribution monitoring indicated they are being used. Some other rumours exist of some of the Rohingya community, selling their potties in the local market for cash and then host communities purchasing them. Whilst the use of potties would be a positive step forward for the management of children's faeces, as the Rohingya communities are in need of income for other household needs, including for fresh food such as fish and meat, the selling of any items that do not seem essential to the households, is understandable. It is understood that children's faeces are being picked up from the ground using either a cloth, or using a building implement (such as a hoe[21]). No mention was made of scoops being distributed, or items such as plastic pants to protect leakage from the nappies.

Child-friendly facilities – It has been noted that NGO Forum has built some child-friendly facilities, but the details are not known.

[21] *The name sounds like 'Kodal' in Bengali.*

Hand-washing before feeding children and after handling their faeces – A post-monsoon assessment on the WASH situation in Oct 2018[22], indicated that household respondents[23] identifying different times when someone can wash their hands (multiple responses were permitted) – were 37% for 'before feeding children' and 15% 'after handling child faeces'. This clearly indicates a gap in knowledge or focus of carers of children and requires additional effort and attention. The full report after the monsoon also indicated that male respondents had better knowledge than female, presumably as more males had attended the HP sessions.

Orphans – There are a significant number of orphans in this response. One assessment by CARE undertaken in the Balukhali Makeshift camp (Oct 2017)[24] indicated that about 20% if the households had taken in unaccompanied children who have lost parents and that they are now in the care if relatives or other community members. This audit did not manage to investigate their current living situation and the WASH services provided to them or challenges they face. It is encouraged that the WASH sector should work with the protection sector to investigate their situation and whether any specific support is required that is currently being overlooked.

Children and adolescent girls' concerns about use of WASH facilities

'.. in the safety audit children and adolescents raised issues about safety when accessing WASH facilities. Girls (both children and adolescents) raised concerns that latrines were being used by both men and women, which often prevented them from using these facilities, due to the lack of segregation and privacy. Girls also complained about long queues, overcrowding and the lack of lighting at night, all of which inhibited their ability to use latrines.

Boys (both children and adolescents) raised concerns around the proper maintenance of latrines (e.g. bad smell, full pit) and lack of lighting. Of the boys surveyed, 37 percent felt that tube wells themselves were safe from the point of view of drinking water quality and construction (e.g. floors are made of concrete slabs). However, a majority felt unsafe when using these wells because of the long queues (which children must join).

All girls surveyed felt that fetching water from tube wells was unsafe, as most wells are located far from home. Adolescent girls emphasized that the presence of men at wells made them feel uncomfortable, and there have been cases of adults preventing girls from collecting water and even extorting money from them'[25].

Children being used to collect water and violence at water points – For people who are struggling to manage their WASH needs, such as older people living alone or single headed households, or households with lone adult carers, it is quite possible that as no other support is being provided by the response effort, that children are being asked to collect water from the water points to assist. Whilst this may be a common practice for children to help with household chores, it should also be

[22] REACH (2018) *WASH follow-up assessment, Monsoon season – all camps in Ukhia and Teknaf Upazila (Aug - Oct 18)*, WASH sector and DPHE
[23] 29% of the households were headed by women, the rest by men, but some other respondents may also have been women
[24] CARE Bangladesh (2017) *Myanmar refugee influx crisis from August 2017, Rapid gender analysis report, CARE Bangladesh, Balukhali Makeshift Camp, Ukhia, CXB, Bangladesh*, 18 Oct 2017 (version 3)
[25] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*

borne in mind that water points are particular points of stress and friction and where people report feeling particularly unsafe as highlighted in the box above.

5.1.3 Women and girls

Extreme experiences of violence – The level of violence that has been faced by all members of the Rohingya community has been extreme, which includes for women and girls. '*According to community leaders and interviews with refugees, almost every woman and girl in Balukhali makeshift settlements in Cox's Bazar is either a survivor of or a witness to multiple incidences of sexual assault, rape, gang-rape, murder through mutilation or burning alive of a close family member or neighbour'*[26]. A report from the Office of the High Commissioner of Human Rights in 2017, indicates that a large percentage of the population (female and male) have reported being witness to killings, disappearances, beatings, rape, sexual violence, being shot or stabbed, burning and other destruction of property, looting and theft of property[27]. Trafficking is also understood to be an issue in the camps.

Culture, dignity and practice of *Purdah*[28] – The culture of the Rohingya people is conservative and patriarchal with women having limited access to public spaces and little meaningful involvement in public decision-making prior to their arrival in Bangladesh[29].

The practice of *Purdah*

The practice of *Purdah* is followed to varying degrees within the Rohingya community. This requires physical segregation of the sexes and a requirement that women cover their bodies to cover their skin and conceal their form. It is understood to be a key feature of dignity for the Rohingya people, as considered by both males and females, and when the women and girls are unable to practice it, it can be a particular stress point and leads to feelings of shame for women, girls and their families[30]. It is reflected that in a study with Rohingya refugees in 2015, 42% of the women respondents reported spending between 21 to 24 hours a day inside their houses[31]. In one study prepared one year after the start of the emergency[32], women reported the following in relation to being able to move outside of their home: without restriction – 62%; no movement possible - 18%; only accompanied by another woman – 12%; only accompanied by a male relative – 7%; Other – 1%.

Reasons given for why women do not feel safe walking around the camp alone included: I don't trust other community members – 51%; there is no privacy – 35%; there is no punishment if someone commits a crime – 35%; other – 10%.

[26] UN Women (2018) *Gender Brief on Rohingya Refugee Crisis Response in Bangladesh*
[27] Noted in the: *CARE (2017) Rapid Gender Analysis, September 2017*
[28] *"**Purdah** is the term used primarily in South Asia, (from Persian: پرده, meaning "curtain") to describe in the South Asian context, the global religious and social practice of female seclusion that is associated with Muslim communities. Due to Islamic influence, it is also prevalent among some Hindu communities in the northern part of South Asia. It takes two forms: physical segregation of the sexes and the requirement that women cover their bodies so as to cover their skin and conceal their form". (Ref: https://en.wikipedia.org/wiki/Purdah)*
[29] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*
[30] Holloway, K and Fan, L (2018) *Dignity and the Displaced Rohingya in Bangladesh, August 2018, ODI*
[31] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*
[32] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*

It is reported that for adolescent girls once they hit puberty, some have to start wearing an Abaya (see below), stop going to school and stop talking to boys. They have their mobility limited even more than married women and spend most of their time in their shelters. This restricts their movement to even participate in safe spaces, such as female-friendly spaces.

Safe spaces

'When asked where they felt safe, both boys and girls mentioned safe spaces for play and learning. Children and adolescents reported that they felt safe there as they had the opportunity to learn, and because of the teachers and the accessibility of these spaces. Adolescent girls also emphasized the benefits of the enclosed environment of girl-friendly spaces, which contributed to a feeling of safety'[33].

It is also understood that for some women they are restricted from leaving their shelters because they do not have their own Abaya[34], the long flowing gown that covers the body and is usually worn with a *niqab* style face covering, with only the eyes visible. Some only go out when they can borrow one from their neighbours. To respond to this restriction on mobility, the OXFAM protection team have provided some households with fabric and tailoring vouchers so that women and girls can chose to have Abaya's made for them[35] if they feel this would be helpful.

Traditional and changing roles and domestic violence - Women's traditional role is understood to be in the home to cook, clean and care for the children, although there is some indication of some shifting of gender norms in the response, with men taking an increased role in water collection, childcare and children's education[36]. Domestic violence is reported to be seen as the norm, with beating by some husbands reported if his wife does not perform care work. Domestic violence is seen to be increasing since the 2017 displacement. This has been attributed to *'the fact that men have no employment and financial pressure if putting extra strain on them and their families'*[37].

Female-headed households and widows – Approximately one in six households are headed by women. Women heading their households are reported to have more opportunity to engage in the public sphere, but this is also perceived as adding to their vulnerability, as they are breaking traditional gender norms[38]. It is also reported that female-headed households can be isolated and are particularly vulnerable to abuse by powerful men through the expectation of 'favours' in return for services, including by *Majhis*. This raises particular issues for the WASH sector if relying on Majhi's alone to develop distribution lists or relying on cards distributed by *Majhis* for the basis for distribution[39]. It was reported by more than one actor that there are a few communities of widows

[33] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*

[34] *'The **abaya** "cloak" sometimes also called an aba, is a simple, loose over-garment, essentially a robe-like dress, worn by some women in parts of the Muslim world including in North Africa and the Arabian Peninsula. Traditional abayas are black and may be either a large square of fabric draped from the shoulders or head or a long kaftan. The abaya covers the whole body except the head, feet, and hands. It can be worn with the niqab, a face veil covering all but the eyes. Some women also wear long black gloves, so their hands are covered as well'*. (ref: https://en.wikipedia.org/wiki/Abaya)

[35] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*

[36] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*

[37] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*

[38] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*

[39] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*

being supported in the camps, where widows and their families are living together and have been in at least one case been supported with WASH services. However, this information was not known by some other key actors, so the situation of these communities was not confirmed.

Challenges using toilets, bathing facilities and water points – Women and girls in various studies have noted feeling uncomfortable standing in queues together with men to go to the toilet or bathing cubicles and they are ashamed to go to the toilet and take a bath during the day time. This is also reported for some when wearing an *Abaya*. This was raised in responses in FGDs across studies and also in almost all of the discussions held during the audit with male and female community members, community volunteers and leaders. They highlighted that a lack of sex segregation of the facilities and having to queue alongside men is a major concern for women and girls. This issue is also reflected in the quantitative surveys, but the issue has tended to be highlighted by between 13 to 19% of respondents; although it is reported that a Needs and Population Monitoring study in 2018 that 68% of respondents (who were male block leaders) raised this as an issue. The reason for the difference is not fully understood, but could possibly relate to other issues also being of significant concern, such as: too many people using the latrines, the distance to reach them, or that they were full. Some facilities are also located near to Mosques, shops or roads where men are present which can prevent women and girls using them.

Feelings of safety when using the WASH facilities – Feelings of safety were also investigated by different studies. The WASH sector gender analysis study[40] that was published one year after the start of the emergency, went into some depth in asking the question about safety and reasons why facilities were considered unsafe. But sadly, the way the data has been presented leaves some confusion for the reader. This is as the numbers for the reasons for male and female respondents each add up to 100%. This means that either only one response was allowed, or the data has been misrepresented, as it is likely that people may have more than one reason for feeling unsafe. But in terms of the responses given for females (which add up to 100%) – the order of magnitude is: not secure at night (22%); latrine in unsafe space (21%); no separate toilets for males and females (17%); no latrine at all (14%); no privacy (13%); other (5%); no locks on the doors (4%); no lighting (4%). The responses from males and for bathing facilities are roughly in the same degree of magnitude, but with some minor differences.

In the REACH survey in Oct 2018[41], the heads of households were asked who in their families would feel unsafe using the latrines at night. The majority of households noted that adult women would feel unsafe (57%), with around one quarter reporting that elderly women and children of both genders would also feel unsafe. In the OXFAM protection monitoring report of August-Sept 2018[42], a question was asked: *"What is the most dangerous activity you do in the camp?".* **Three of the top four responses were: collecting water; accessing bathing areas; accessing latrines, with variations on feelings of safety by day and night.** The fact that in the most recent REACH survey over 50% of

[40] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*
[41] WASH Sector Cox's Bazar & REACH (2018) *Water, Sanitation and Hygiene Baseline Assessment, Cox's Bazar, Rohingya Refugee Response*, April 2018
[42] *OXFAM (2018) Protection Monitoring Report, September – October 2018*

all respondents noted that the females in their household bathe in their shelters, is a clear indication that the alternatives of communal bathing facilities are not considered as the most suitable options for many women and girls.

A research briefing by BBC Media Action on violence against women in the Rohingya community (2018)[43] noted that *"Male participants felt the risk of sexual abuse was low in the camps because people would notice what was happening in the crowded conditions. However, female participants said they were teased by male members of the community if they went outside the shelter, and men made holes in the polythene walls of the latrines to watch them. Women reported only using latrines before dawn and in the evening, and some families made latrines in their cramped shelters to avoid their daughters facing these issues"*.

Another actor shared verbally, that an older person had expressed concern around the problems of latrines filling up. They shared that they are fearful that they are at risk of sexual abuse when they are forced to use their neighbour's facility when theirs is full and needs to be desludged.

One stakeholder noted that there have also been reports of males[44] holding phones over the top of bathing facilities to take photos when women or girls are using them. In addition, some stakeholders suggested that if the toilet is in an isolated position this could also pose problems for females.

Refer to **Section 5.2** - for further discussion on each components of WASH, and **Annex V** - which tabulates a number of findings from a number of key studies.

Consulting with women and adolescent girls – Discussions with the HP CFT, indicated that there seems to be an increasing awareness of the need to consult with adolescent girls separately to women, if the adolescent girls are to be able to speak. This is common in many contexts, but particularly important in the Rohingya communities which are highly conservative in relation to adolescent girls. But gaining access to adolescent girls is also difficult.

WASH during pregnancy and maternal and neonatal health – More attention is needed to look at pregnancy and maternal health, including the training of traditional birth attendants (TBAs) on good hygienic practices and how they can share good practices with mothers. A discussion with a group of TBAs highlighted that many women in the camps are having their babies in their shelters, where there is often not ideal access to WASH facilities and services. This is an area where increased collaboration between the WASH, health, gender and GBV actors/sectors would be positive. Participants in one of the sector workshops, noted that it is possible that women who are pregnant may be at risk of aborting their babies if they are carrying water for long distances.

Decision-making and access to information – It is clear that in the Rohingya community women and girls have a much less opportunity to engage in the public space and hence receive information or be involved in community decision making. This is particularly challenging for women and girls

[43] Mamun, A. A. & Bailey, N, Azam, M. A., and Rahman, F (2018) *Violence Against Women Within the Rohingya Community: Prevalence, Reasons and Implications for Communication,* BBC Media Action

[44] It is not clear if this report is of males from the community or humanitarian actors.

who spend most of their time in their shelters. Even for distributions of items such as dignity kits and menstrual hygiene items, it is reported that sometimes husbands or sons collect these items. It is usually considered good practice that information is given as part of the distribution process on how to use such items, but in this circumstance, it is difficult to see how this information on the use of the items could be given appropriately and will effectively reach women and girls. See **Section 5.2.9** - for more discussion on menstrual hygiene.

In the one host community visited as part of the audit, most of the community leaders and elders appeared to be male, but female representatives said that some men do listen to them.

It was regularly noted that UNHCR have supported the leadership body in one camp to elect equal numbers of male and female participants (which is an unpaid role), but feedback has not yet been disseminated on how this is progressing and this has not yet become the norm. Most *Majhis*, who are the government of Bangladesh appointed leaders for sections of the community, are mostly male. They play a significant role in resolving disputes and in being the link to humanitarian providers. But concerns have also been raised about their level of power and the influence this can have on the more vulnerable members of the community (see **Section 5.1.4** and **5.1.5**) and also in relation to the possible resolution of GBV related incidences (see **Section 6.5**). Humanitarian actors are being encouraged to work out ways that more women can be encouraged to take on leadership positions, such as through the involvement of female *Hafes* (who have completely memorised the Qur'an), or other respected females within communities. Older women who have more independence and respect and relatively greater voice in the communities and their families, could also be effective leaders.

The increase in use of both female and male volunteers is very positive in terms of reaching women and girls with the associated increase in household visits. Also, where focus group discussions and small groups meetings have been held in each other's houses, these also seem to have been appreciated. The use of loudspeakers to disseminate information, is also seen as one positive way for women and girls who are restricted to their houses to be able to access information.

5.1.4 Men and boys

Access to information and decision-making - As noted above, men and boys in the context of the Rohingya communities have more opportunity to engage in community-based decision-making.

Men bathing at water points and using female facilities - It is clear that men and boys are mainly bathing at water points and comments have also been repeatedly been made about men and boys using the bathing facilities and toilets allocated women and girls. The men bathing at open water points may be considered to be culturally acceptable to some men and boys, but it poses a problem for women and girls and has been raised as a particular concern for adolescent girls. Effectively what women and girls are being expected to do is to see men and boys washing their bodies, which also includes washing their genitals, in a public open space. This would be an uncomfortable experience for most women and girls globally, but it is assumed particularly difficult for women and girls where the community has strict rules on gender segregation and the practice of *Purdah*. It is

therefore not surprising that women and girls might chose to only collect water at night when less men are likely to be bathing at the water points; but which in theory could increase the risk of GBV if they are collecting water alone at night.

It seems that some (possibly most) humanitarian actors have only built bathing units for females[45]. Some WASH sector actors have considered that this is the WASH sector approach, but this is understood to be a misconception as the strategy was to provide for both females and males. This is likely to have contributed to the problem. What is not clear is whether most or any humanitarian actors have taken the time to engage with men and boys about this issue, or considered that their lack of support for male bathing facilities will have contributed to additional problems for women and girls. Most WASH sector respondents during the audit who were asked, indicated that they have not engaged as much as they should have with men and boys. In discussion with one men's FGD and one group of male *Majhis* and *sub-Majhis*, the problem of men using female facilities was raised. They both indicated that if discussed with the men themselves, or if the issue is raised with the *Majhi's,* the issue could be resolved.

A block of male toilets constructed along a roadway (with no handwashing facilities)

Is this global icon representing female, in the context where women wear Abaya's or other clothes which reach the ground, or a man wearing a *Lungi*?

Global icons being used for labelling on latrine and bathing facility doors – Another issue that was highlighted in various studies and during the audit was the issue of the labelling of toilet and bathing facility doors using global male and female icons, with men wearing trousers and women wearing skirts. A number of differing opinions were raised on this issue. Some noted that they believed that the humanitarian actors just stuck the labels on the unit doors, but did not discuss with the households to involve them in decisions on how the different units should be used, or what the labels meant. This is assumed to be where some of the confusion has occurred.

Others indicated that as the language the Rohingya people speak is not a written language, that people may not be used to seeing images and knowing what they mean? Others highlighted that

[45] Although at least one respondent noted they had built them for men

the global icon images are not suitable for the Rohingya communities, as men often wear a *Lungi* (which is similar to a skirt in shape) and women wear an *Abaya* or other long skirt down to the ground (which is not like the skirt indicated in the global icon). However, it was also reported that Solidarités have undertaken some discussions in relation to these images[46] and that the general consensus from the Rohingya respondents, was that the global icons are understood and acceptable. This is an area that might be worth further discussion, where the men and women and people of different ages and with disabilities can consider the suitability of the global icons versus also alternatives that might be considered more applicable to the affected community[47].

Male and female involvement in hygiene promotion activities - The women in a host community visited, noted that only the women and girls had been involved in hygiene promotion activities and hence men and boys were not in receipt of such training and information. It is not clear how widespread this practice is across the camps and host communities to only focus on the women and girls for hygiene promotion. Data from REACH post-monsoon study indicated that males have better hygiene knowledge, which is probably due to more men taking part in the hygiene promotion activities, so this is opposite.

A hygiene promotor (HP) commented that when a female HP interacts with the household, she can talk to both the women and men in the household, as men are open to listening to women. But male HPs can only talk to the men in the household and they have no access to the women and girls. Male HP and HP volunteers also noted that they focus on undertaking HP in Mosques and with business owners, rather than at household level. These are also important issues that need to be acknowledged and considered by NGOs in trying to prioritise and support more female HPs. See also **Section 6.6**.

Involvement of men and boys including male youth as champions for women and girls – More men and boys, including male youth, can become great champions of women and girls if they are encouraged to do so through dialogue with the humanitarian actors. Sometimes there has been a tendency to assume that men and boys are the problem, rather than part of the solution. This includes in the work of the WASH sector, through increasing dialogue and engagement with men and boys and this includes on challenges that are being faced by women and girls.

5.1.5 People with additional vulnerabilities

Core characteristics of vulnerable and highly vulnerable households – A study was undertaken on vulnerability from the food security perspective in 2017, after the new influx and considering new arrivals, older unregistered refugees, older registered refugees and the host communities. In this study core characteristics of vulnerable and highly vulnerable households were considered to include:

[46] Reported second hand and not discussed directly during the audit

[47] The example icons included on the front cover of this report are just samples for discussion. They would need to be discussed, modified and agreed with the Rohingya people from different groups if they were to be considered for widespread use

- **Demography** - Female-headed households; households with larger size or high number of children; presence of single mothers; presence of pregnant and lactating women; presence of unaccompanied minors.
- **Education** – Low education level for male or females.
- **Working capacity** – Households with higher dependency ratio; presence of working women; absence of working men; no access to remittances.
- **Asset ownership (from own purchase only)** – Do not own household goods; do not own electrical devices; no savings; do not own productive assets; no livestock.

In relation to the audit process, the following groups of people were mentioned either in discussions or in report and are considered to have additional vulnerabilities. These may include:

a) Orphans and child-headed households
b) Older people living alone
c) Families with members with disabilities, where there is only one adult or no adults as carers
d) People with mental health conditions
e) People who are chronically ill
f) Widows and widow headed households
g) Other female-headed households
h) Male single headed households[48]
i) People from minority groups such as minorities by religion, ethnicity or as sexual and gender minorities (SGM)

It is difficult to rank the degree of vulnerability as this will vary depending on the circumstance of the person or family (access to assets; existence of extended family members etc).

One participant of a workshop noted how he had met a family with a child with a mental health condition and how the child was not involved in community activities. He encouraged the family to take the child out to be involved in more activities.

Adolescent girls also face particular vulnerabilities. See the box below.

[48] Whose families may also face specific vulnerabilities due to the multiple roles of the male head, including caring for children as well as community and productive roles

Just switching the gender of an adolescent… moves them from facing 'least' to 'most' difficulty in managing their WASH

During one of the workshops, the participants undertook and exercise where people were asked to line up participants holding cards of different people (older man; woman who is blind; adolescent girl; older person looking after five grandchildren, etc) in order of the difficulties they face managing their WASH. One participant observed that she was holding the card of an adolescent boy and was at the far end indicating that he has the "least difficulty". But earlier in the exercise a male participant had moved the adolescent girl to the other far end as indicating that she was the person who faces the "most difficulty". The female participant observed it is quite striking how just switching the gender of the adolescent girl/boy, the position in the line goes from one extreme to the other. It was a very powerful point and very striking, representing the significant challenge that gender rules and expectations can pose to certain groups, particularly adolescent girls.

Working with protection specialists, the groups of people above, will need particular consideration and potentially additional support to ensure that they can access WASH services and manage their WASH needs easily, safely and with dignity. For all groups in this list, advice and guidance should be taken from protection specialists as to what support might be appropriate and how to give it in a safe and dignified manner. People who have additional vulnerabilities, can also be more vulnerable to sexual and gender-based violence, including sexual exploitation and abuse. Hence, they need particular protection when individuals from outside of their care structure engage with them. There are understood to be at least two communities where widows and their children are living together and being supported with services. One of these has been supported with the provision of water services by the sector organisations.

For the last group (i), people from minority groups, including people who are SGM, particular care should be taken. Communication should always be undertaken by Protection Sector specialists and not the WASH Sector and guidance sought from them on specific responses that are safe and appropriate. See below.

Sexual and gender minorities (SGM)[49] – People who are SGM often face a high level of harassment, abuse and violence in their daily lives, which in some contexts globally can lead to them being arrested or killed. In Bangladesh, there is an official third gender, with male, female and other being indicated on official documents. Participants in the Rohingya response gender analysis (Aug 2018) [50] were asked about particularly vulnerable people in the community and as part of this, researchers specifically asked if they knew of any transgender people in the community? The majority of respondents did not know of any, but 7 percent of respondents indicated that they did. Of those who

[49] SGM is an alternative term for Lesbian, Gay, Bisexual, Transgender and Intersex (LBGTI) and the increasing range of terms being identified for people of other sexual orientation or gender identities. The term SGM is often preferred by organisations which represent people who are SGM rather than LGBTI, because it covers a wider range of people and is seen less of a 'Western Concept' than LGBTI which results in a higher level of rejection and aggression.

[50] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*

knew of transgender people, 62% indicated that their response was usually to make jokes about them. 12% indicated that they would also be discriminated against by others. Only 11% indicated that they would accept them normally.

In discussion with a senior representative of the Protection Sector, it was agreed that the best solution for the provision of WASH services for people who are SGM would be the provision of household toilets and bathing facilities. However, provision to only households with people who have people who are SGM in them, could also put these individuals and families at risk, by making them more visible. Hence, the priority should be to support all households with household services as soon as possible. In the meantime, it is strongly recommended that the WASH sector should not be identifying people who are SGM themselves - due to the increased risks of harassment or abuse, that this could cause the individuals. The WASH Sector should let the Protection Sector take the lead in any communication and to ask for the WASH sector's support on a case by case basis.

5.2 WASH facilities, NFIs, MHM and incontinence

This section covers WASH facilities, NFIs, MHM and incontinence. Hygiene promotion as a technical field more broadly, has been covered in **Section 5.3**, together with community mobilisation and feedback, which all link across all other components of WASH. The box which follows provides some key learning from this section. It builds on the similar box in **Section 5.1** which looks at the findings from the perspectives of different groups of people within the affected communities.

Key learning from this section:

1. The post and pre-monsoon surveys have shown that there is a positive trend for how satisfied people are with toilets and water points, from before to after the monsoon, which is positive.
2. There is some progress with improving the lighting situation in the camps, with increased lighting on pathways. The WASH facilities are generally however still not lit up.
3. Whether women and girls would prefer the lighting to be provided: a) inside the latrines and bathing facilities, b) over the top of them, or c) only on the paths going to them may vary. Please read the report *"Shining a Light; How lighting in or around sanitation facilities affected the risk of gender-based violence in the camps"* (WEDC, Humanitarian Innovation Fund and OXFAM) for more in-depth analysis of lighting, including in the Rohingya camps.
4. Drainage seems to be a particular stress point for people living in the camps. It seems to be unclear as to who has responsibility for it and who is taking that responsibility. It is important for well-being and health and increasingly important to support the household bathing facilities.
5. Access to hand-washing facilities and soap by communal toilets varies, as does who has received the basic hygiene kit with the water containers – there seem to be some big gaps.
6. Different hygiene kits are being provided by different sectors – WASH, protection / GBV, livelihoods / nutrition. This may lead to some duplication, which is not such an issue, but also gaps, contributed to by lack of mapping on who has had what.
7. Various actors have started working on menstrual hygiene management (MHM) and are raising awareness on this issue. There are some inconsistencies in the materials being provided (including reusables vs cloth) and a few errors seen in training information.
8. A range of different people are living with the challenge of incontinence (not being able to control their urine or faeces), either their own or their family members. It is a very stigmatising, embarrassing and limiting condition to have. It is very difficult to manage and results in additional WASH needs, including a need for easier access to a toilet and more soap and water.
9. There is an informal MHM and incontinence working group which is cross-sectoral. There is a need to use this group to try and come up with one response wide set of materials and guidance on MHM and to do more learning on how to support people with incontinence.

5.2.1 Toilets

Scale of response - As has already been noted in **Section 4.1**, the number of WASH facilities including toilets constructed have been huge, with over 47,000 being constructed, with a range of the earlier ones being decommissioned and replaced, as well as an ongoing system established to de-sludge the latrines and treat the faecal sludge at scale.

Level of satisfaction with water access before and after the monsoon

The level of satisfaction with toilet access after the monsoon increased in comparison to before the monsoon, as indicated by the quantitative household survey data[51]:

- April – 4% very satisfied; 46% satisfied; 37% unsatisfied; 13% very unsatisfied.
- October – 14% very satisfied; 70% satisfied; 17% unsatisfied; 2% very unsatisfied.

Interpretation of data: This is very positive in that it shows a definite positive trend with improvements. However, care must be taken when interpreting quantitative data, in the sense that people who are responding are likely to be considered the head of the household or the most active female in the household. The respondents are less likely to be the person with disabilities or the older person or adolescent girl, who cannot leave her house. People may also be nervous to say negative things in response to the questions, with the fear that they may have the services taken away from them or they may be repatriated. Hence such data whilst very useful, should also be interpreted alongside qualitative data, where it is often easier to pick-up and understand differences and specific challenges.

Gaps in the current provision of toilets - The toilets have been one of the main areas of concern for women and girls and older people and people with disabilities. Particular issues that have been raised by women and girls and men and boys and documented in various assessments and analysis, include (see **Section 5.1** for further details):

- How insecure they feel using them, including for women and girls having to queue with men
- The number of households sharing them
- The distance to them
- Lack of lighting
- Lack of accessibility features making them difficult to use for people facing mobility challenges
- The need for repair and desludging

It is clear from observations in various camps and host communities that the current set up of the latrines, bathing facilities and water points are different in each location. This includes the numbers of facilities, their proximity, the space available and the number of households using them. Only a small proportion have been constructed for a few families to share, with most being constructed

[51] REACH (2018) *WASH Follow-up Assessment, Monsoon Follow-Up –Cox's Bazar, Rohingya Response, Oct 18*, WASH sector and DPHE

for use by multiple families. This has led to particular concerns on queuing at peak times, males and females having to queue together, privacy and cleanliness.

Stages of construction and design and consultations - The latrines have already gone through a process of redevelopment, from the earliest quickly constructed emergency latrines, to the large-scale numbers of what are known as "army latrines" and to the 'unified' designs. The post-Monsoon monitoring by REACH indicated that when asked to compare changes in access to latrines after compared to before the monsoon season, 39% of households reported the situation was better; 50% reported no change; and 9% worse. So there has been some progress. This is probably due in part to the roll out of the unified designs (see below).

It is understood that some consultations were undertaken even in the earlier stages, such as in relation to the implementation of what have become known as the 'army latrines'. But it appears that the impact of this on usage by women and girls has been limited. This is discussed further in **Section 5.3.2** on "Consultations".

Urinals – Some of the bathing facilities are being used as urinals, including it is assumed by women. This poses the question as to whether separate urinals would be useful for both males and females.

Latrine block in Camp 2 with handwashing drum present

Latrine block in Camp 6 with no hand-washing present

Unified designs – The "Unified designs" were developed and approved in February 2018[52], by the DPHE and RRRC with support of the sector to try and overcome the challenge of varied quality of the initial designs and latrines constructed. They include improvements to the earlier toilet designs in having a more significant substructure and solid walls and doors and so are a good step forward. But they do not consider either accessibility for people who face mobility challenges, or how to make the units more female- and user-friendly. It is understood that originally the unified designs were meant to be a minimum standard and not the only versions permitted. The existence of the

[52] Government of the People's Republic of Bangladesh, Office of Refugee Relief and Repatriation Commissioner (RRRC) Cox's Bazar (2018) *Unified/standard design for latrines in Rohingya settlements - BofQs*

unified designs has also sometimes been used as an excuse as to why accessibility or female-friendly features have not been included.

Screening

One of the most obvious gaps that has been overlooked throughout the response has been the lack of use of screening to provide privacy for women, girls, men and boys when entering the units and to provide separate waiting areas for males and females. The request for such screening has clearly been stated as a request by the women consulted as part of the OXFAM facilitated 'Women's Social Architecture Project (Pt 1)'. Adding screening at the entrance or around facilities should always be discussed with women and girls before using it throughout a response, to check they feel it will add to their privacy and feelings of safety. But it is an obvious design feature that is likely to have been beneficial, considering that a large proportion of the community supports the practice of *Purdah*. It is a significant oversight for this response.

However, with screening, care is also needed to make sure that it doesn't potentially make the situation worse by screening both the male and female units inside the same screen. The purpose is to provide privacy and dignity and to increase the feelings of safety and not being watched when entering, exiting, or using the facilities. When considering screening, it is also important for both female AND male blocks to be screened. This is for several reasons: a) to also provide privacy for men and boys; b) so that women and girls also do not have to see the men queuing and going into and out of toilet units. Screening can also be used to direct people to use handwashing facilities they are the placed on the exit of the screening.

Women and girls and men and boys will need to be consulted on the options for improving their current facilities and before the installation of any facilities for all works to go forward, including for the use of screening or otherwise. See **Section 5.3.2** for more discussion on consultations.

OXFAM has also noted that they have also been requested by women to also add screening to block off their houses from work sites when construction activities are being undertaken.

Accessibility of toilets – The lack of focus on accessibility in the 'unified designs' and this being used as an excuse for not including these in the units constructed, is a big lost opportunity and a major gap. This is a bit surprising particularly as the Government of the People's Republic of Bangladesh's own 'Operational Guidelines for WASH in Emergencies' includes a number of simple options for increasing accessibility. See the images below.

Extracts from the Government of the Republic of Bangladesh's, Operational Guidelines for WASH in emergencies [53]

A toilet recently constructed in a host community for sharing by several families (related) in line with the unified design

Modifying the existing toilet units to improve accessibility, safety and usability - Even simple adaptations to the unified designs, including those communally used, such as adding more space to allow a commode chair to be lifted on to or off of a squat hole, or simple handrails or ropes to assist a person getting down and up from squatting, could aid in accessibility. The global UNICEF WASH and Education Innovation Supply Division are globally developing accessible latrine designs that can be used from the initial stages of the emergency. They are planning to undertake some trials in the Rohingya camps through the CARE programme. This is a great opportunity for all sides.

Also see **Section 5.1.1** for more discussions, including on existing aids and adaptions that have been supported to-date by a number of organisations to improve accessibility. A wide range of guidance is also already existing in the global WASH sector on simple adaptations to improve accessibility, such as prepared by WEDC and WaterAid[54] – see the references in **Annex VII.** HelpAge, CBM and Handicap International also have specific designs or aids that they use and support. CBM also has an online app link to guidance for WASH in emergencies: https://hhot.cbm.org/. The RECU method

[53] Government of the People's Republic of Bangladesh, Ministry of Local Government Rural Development & Cooperatives, DPHE and Department of Disaster Management (2017) *Operational Guidelines for WASH in Emergencies – Bangladesh, Second edition, 2017*, WASH Cluster

[54] Such as: Jones, H & Wilbur, J (2014) *Compendium of Accessible WASH technologies*, WEDC, WaterAid, SHARE; Jones, H. and Reed, R.A. (2005) *Water and Sanitation for Disabled People and Other Vulnerable Groups: Designing services to improve accessibility.* WEDC, Loughborough University, Loughborough

for establishing equitable access as shared by HI during the workshops in Feb 2019, is seen in the box below.

RECU method for equitable access[55]

1. Can the person **REACH** the wash facility independently and safely? (accessible pathways, handrails, signs, lighting, close to homes of people with disabilities…)
2. Can the person **ENTER** the facility independently and safely? (Main entrance measurements, positive attitudes…)
3. Can the person **CIRCULATE** around safely? (Leveled surface, sufficient measurements for wheelchair users, protection from falling for people with visual impairments…)
4. Can the person **USE** the wash facility independently? (permanent spaces for sitting, easy enough pump handling, heights, lights, …)

In relation to making the units friendlier for use by women and girls, the recommendations from the 'Women's Social Architecture Project (Pt 1)' can be used as a useful starting point for discussions with women and girls and men and boys, as are the 'Minimum standards checklists for toilets and bathing facilities' developed earlier in 2018 for the WASH sector in this response. Suggested simple adaptations include: adding screens to increase privacy, checking locks and how well doors fit, adding hooks, shelves and mirrors for usability and adding lighting (see **Section 5.2.4** for more discussion on lighting). OXFAM are planning to trial two new communal blocks to be constructed for women and girls and also some of the options for improving the existing arrangements.

Discussions on options for going forward for constructing new, and in particular, also improving the existing set ups of facilities, needs to be undertaken across all camps and communities by all agencies, not just by one or two agencies. It is also recommended that older people, people with disabilities, and adolescent girls should also be included in these discussions as well as consulting with children, and that any adaptations should also be made for both females AND males.

See **Section 5.3.2** for further discussion on the consultation process and possible positives and negative of various adaptations that will need to be discussed with the women, girls, men and boys as part of the decision-making processes. This section also discusses the options for household, shared or communal facilities going forward and summarises the recommended improvements.

Sanitation master planning – A presentation given to practitioner's at CXB level, was shared updating on the options for sustainable sanitation solutions going forward[56]. This looked mostly at the technical aspects of sanitation management including the collection, treatment and sullage and drainage; and appears to propose that from the perspective of the limited space and topography that installing a waterborne sewerage system and larger treatment systems such as anaerobic systems or ponds would be a preferred option. If these technical options could be feasible, this

[55] Villa, B (2019) *Accessibility in WASH (including Jadimura Camp Study)*, PPT, Humanity & Inclusion
[56] UNHCR (2018) *Sustainable Sanitation Solutions for Forcibly Displaced Myanmar Nationals*, PPT presentation, Update: Dhaka, September 2018

could also mean that household facilities would also be more feasible, which would have multiple benefits from the gender, GBV and inclusion perspective. But they would also require a significant increase in water supply and higher technical level of operation and maintenance to support them.

5.2.2 Bathing facilities

Gaps in the current provision of bathing facilities - A number of the issues related to bathing facilities have already been discussed above in **Sections 5.1.3** and **Section 5.1.4.** These include that:

1. Similar concerns have been expressed about communal bathing facilities as with toilets, in that sharing with too many neighbours and queuing alongside males and females are considered problems.
2. Problems with the distance between the water points and the bathing facilities have been raised, which is particularly difficult for people with high workloads, such as caring for several children or for older people, and for others who face mobility difficulties.
3. It is reported that over 50% of women bathe in makeshift bathing facilities in their shelters.
4. In some cases, only communal bathing facilities have been constructed for women and not for men.
5. Many men are bathing at the waterpoints, which poses problems for women and girls.
6. Some men are using the bathing facilities allocated for women (possibly because they have not been allocated similar facilities for men, but this needs further discussion).
7. It is understood that some bathing facilities are also being used for laundry and in some cases as urinals. It is understood that it is probably women and girls who are using the facilities as urinals, although this would need more investigation as well, as to why they are doing so rather than using a toilet. Maybe it is because of the queues in the morning and evening?
8. When the bathing facilities are being used for laundry, the wait for others to use the facilities can be longer, also causing frustration with neighbours.

Bathing facilities self-constructed in shelters – Clearly the current arrangement for the communal bathing facilities is not adequate for the needs of many affected populations, particularly women and girls. The latest REACH survey data post monsoon indicates that over 50% of women and girls are bathing in their shelters, which is probably not surprising considering the inconvenience and lack of privacy related to having to queue with males and females together and wait to use communal facilities. Three examples of household bathing facilities constructed inside shelters are shown below. Another image shows one external shelter constructed next to a toilet block as the users felt the more solid ones that were constructed for their use were too far away.

It is worth humanitarian workers considering if they were in the same situation for a long period of time, including possibly years, if they would be likely to choose to do the same and wash/bathe within their shelters? As the consultant writing this report, I am pretty sure that I would.

This bathing facility was constructed next to a latrine block

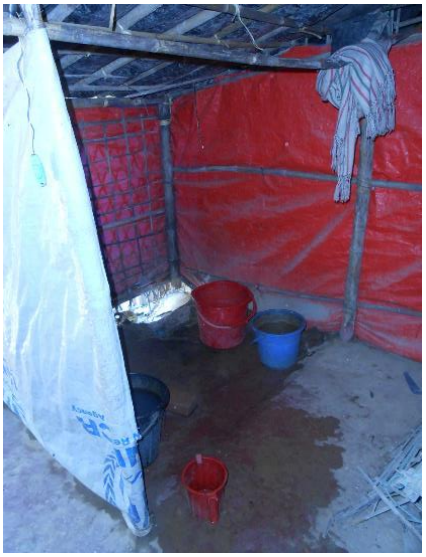
It is understood that it was constructed because the bathing facilities which the household were meant to use were considered too far from the household. The water drains over the surface of the ground over the edge, as seen in this image. Interestingly the facility does not have a door, which also raises the consideration that possibly this unit might be used for laundry instead of bathing?

This bathing area is inside a shelter

It was constructed with the support of Solidarités in support of a man who has difficulty walking due to an infected foot. The water drains into a drain that runs alongside the shelter.

Self-constructed bathing facility inside a shelter next to the cooking area

The floor has been covered in cement mortar and a dish shape formed to keep the water inside a set area. A screen has been constructed using a rope and curtain. The water drains via a pipe into an outside drain.



Self-constructed bathing facility inside a shelter

It is reported that it is sometimes also used for urination. The water drains directly outside the house over a ledge and down to the edge of a water point. It is on plain earth with no cement covering.

Whilst the audit team only went inside a few shelters, those that they did go into were mostly orderly, clean and well looked after. Most of the bathing spaces constructed had a cement mortar floor to prevent the water making the floor muddy on use. The bathing areas were also generally simply designed and looked clean, and in all but one case, with a clear space for the water to be directed and taken out of the shelter into an outside drain.

However, the main problems / issues with the bathing spaces inside the shelters are:

1. That some are constructed directly next to the kitchen, which is not ideal in terms of the risk of splashing and contaminating food or dishes. However, they are probably put there for the practical reason, that people also need somewhere to wash their dishes.
2. Another issue of concern is that some women and girls and other people, including some people with disabilities who cannot reach toilet facilities, are known to also be urinating in the bathing spaces in the shelters. It is also suspected that some people may also use them for defecation and washing the resulting water and faeces mix into the drains, although this is not confirmed. It is understood that some are using buckets and others may be using plastic bags.
3. Other challenges were also observed with erosion, where water from informal bathing facilities attached to the outside of shelters had led to collapse of the ground. See the image below.

This household facility infrastructure was attached to a shelter in Camp 6

It is not clear if this was constructed as a bathing facility or as a toilet. But it has clearly led to collapse and a safety hazard for people falling into the resulting hole.

It was reported that in some cases the camp management was breaking down the household showers constructed by individual households because they were taking up public space.

Simple adaptations such as adding a solid screen in between the bathing space and the kitchen area, improving the solid nature of the floor to capture the water, improving the external drainage and protection from erosion, would strengthen and improve these units.

It is recommended that wherever possible in-shelter bathing spaces should be supported for all households

Women have stated that having in-house bathing facilities is also helpful for them as they do not need to leave their children to use external facilities[57]. It will also benefit people with disabilities, older people and people from minority groups. If men were also encouraged to use them, this could also help to reduce the problem of women and girls not feeling comfortable to use the water points, because men and boys are bathing at them. However, the other challenge with the use of household bathing facilities, is that this requires additional effort to bring the water to the household for bathing, which can be difficult for people with disabilities and older people. It may also not be preferred, particularly by men and boys, when they have the option of bathing at a water point with water on the spot. Discussions would also be needed with the government related to any restrictions / guidelines on shelters with their own bathing facilities to facilitate this to happen.

For further discussion on the issue of urination and defecation also possibly happening in the bathing spaces in some shelters, see **Section 5.2.10** on incontinence.

Shared or communal bathing facilities – It is therefore recommended that as well as supporting household bathing facilities in all shelters, if the households decide this would be appreciated it is also recommended to continue supporting gender-segregated shared or communal bathing units outside of the shelters. These can then be used for bathing or laundry as preferred and can also be used for drying clothes or other items if felt appropriate. This will then give people options to suit their needs, which also adds an additional level of dignity to the response. However, like toilets, it is recommended that the existing ones should also be adapted to make them more accessible and user-friendly through the additions of items such as: screens, hooks, shelves, a seat and rope or handrail, checking doors fit well, lighting (see **Section 5.2.4** for more details on lighting), etc. Wherever possible they should also be built as close as possible to water points, but also considering issues of distance from the households and gender-segregation. For further discussion on the options see **Section 5.3.2** on "Consultations".

Combined screened toilet, bathing and laundry units – The 'Women's Social Architecture Project (Pt 1)'[58] which involved female student architects facilitating discussions with 38 women, came up with a suggested design for a combined screened unit for toilets, bathing and laundry facilities, including a space for the drying of menstrual cloths. Two of these blocks are currently being constructed as a trial. Similar screened combined blocks were also constructed for both females and separate ones for males in some camps in the Pakistan earthquake response back in 2006 and

[57] UNHCR (2018) *Refugee Preference for Location of Bathing Spaces and Toilets*, UNHCR Protection, Shelter, WASH Cox's Bazar, October 2018
[58] Farrington, M (2018) *Women's Social Architecture Project: Phase 1 Final Report, OXFAM Rohingya Response, Cox's Bazaar,* September 2018

feedback was generally positive. Two different versions were known in this response, one set that used simple tarpaulin construction and includes a covered laundry area (only inside the women's screened units) was supported by OXFAM, and another more significant set of units was supported by ACF in a number of camps. These ones were managed combined laundry and bathing units, which were constructed using corrugated sheets and included the provision of hot water. Large screened laundry areas were included in both the female and male units. Details of both can be seen in Module 6 and Toolkit 6 of 'Menstrual Hygiene Matters'.[59] It is also reported that some screened and combined units are currently being constructed for women by the Turkish Red Cross in the Rohingya response, but it is not clear if the bathing facilities offer privacy using single compartments, or it is just one large unit.

5.2.3 Laundry and pot washing

The washing of pots and pans from cooking has not so far been reported on much in assessments and studies, but probably is done in similar locations to the laundry. One consultation by the GBV sector found that women reported washing pots outside the front of their shelters.[60]

The REACH post-monsoon monitoring report (Oct 2018)[61] indicated that the percentage of households reported using the following spaces for doing their laundry included: tubewells (35%); communal bathing facility (34%); and inside their shelter (31%).

The challenges when washing pots of pans is that there are often solid and fats in the waste water. Hence, areas used for this purpose should ideally also integrate a grease trap of some kind that can be intermittently cleaned out.

	This image from Camp 2, shows laundry being done at a water point and communal shared drying lines being used. Directly next to the water point also appears to be two large rooms, which are understood to be bathing facilities. These were not checked if they were indicated for male or female, or if they are meant to be shared spaces for bathing, versus just large individual units. Note also that the drainage has been constructed from concrete which will make it easier to keep clean. But to the top right of the drainage system it can be seen that the drain is starting to build up food wastage, probably from washing of pots and pans at the water point.

[59] See Menstrual Hygiene Matters (2012) (www.wateraid.org/mhm – Module 6 - page 127 and pages 146-149 and Toolkit 6 - pages 305 to 308).
[60] Consultations by the GBV Sub-sector (CARE, PULSE & PIN) – on preferences of women and girls regarding bathing facilities, October 2018
[61] REACH (2018) *Water, sanitation and hygiene follow-up assessment, Monsoon season (August – October 2018), All camps, Ukhia & Teknaf Upazilas, Cox's Bazar District*, Bangladesh

5.2.4 Lighting

Preference for lighting or otherwise for toilets, bathing units and water points - Mixed views were shared by key humanitarian response actors, or observed in documents, with regards to lighting. This is whether users have expressed a preference for lighting of bathing, toilet or other WASH facilities or otherwise, and what the plans are for going forward. For example:

- **Energy (UNHCR)** – There is a plan to light all main roadways and for communal toilet and bathing blocks being constructed in Camp 4e extension, but not for all units across the camps. This is being discussed with community members, but with guidance for lamp placement based on technical requirements.
- **Site planning (UNHCR)** – There is a plan to light everywhere, including near to the toilets / bathing facilities. But women do not want lights directly over the toilets in case it would mean that others would be able to see them inside them. Hence the lighting would only be for paths nearby the units.
- **Women's Social Architecture Project**[62] – Noted that solar lights are wanted in all units.

IOM who also has a significant role in supporting lighting, and OXFAM, who are also known to support lighting, were not consulted as part of the audit process. The issue was also not discussed in much detail with community members.

It is generally accepted globally that lighting for bathing and toilet facilities is positive and useful, but only when the lighting covers a wider area and not just the toilet and bathing blocks. Just lighting the toilet or bathing blocks and particularly the females blocks, can result in men hanging around them in order to use the light, which then makes them feel less safe-spaces for women and girls. But it is also important to consider the issue of the materials that the units are constructed with. If they are constructed with tarpaulin, where shadows can be seen outside when a light is on inside the unit, then this could also cause a problem for usage. Likewise, if there are any gaps in the structure where people can look through, this could make users fearful that people would be able to see them using them at night. The range of views on whether lights are wanted: a) inside; b) over; or c) only nearby on paths, probably reflects this complexity.

> A very interesting and useful study has been published at the beginning of 2019, which includes some case studies from the Rohingya camps:
>
> *"Shining a Light; How lighting in or around sanitation facilities affected the risk of gender-based violence in the camps"* (2019 - WEDC, Humanitarian Innovation Fund, OXFAM).

Progress for lighting – It is felt that progress to lighting the camps is moving in a positive direction, at least from the perspective of the UNHCR supported camps (as this is the team who were met); although most humanitarian workers do not spend time in the camps at night and hence do not see

[62] Farrington, M (2018) *Women's Social Architecture Project: Phase 1 Final Report, OXFAM Rohingya Response, Cox's Bazaar,* September 2018

the situation in reality. The solar lamps are reported to be very expensive, with each one costing around USD 900, with USD 200 needed every two years to replace the batteries. UNHCR have started developing networks of solar panels that will hopefully offer a more stable supply for the communities going forward where these are being installed. Male refugees are being engaged in cleaning and replacing broken lights.

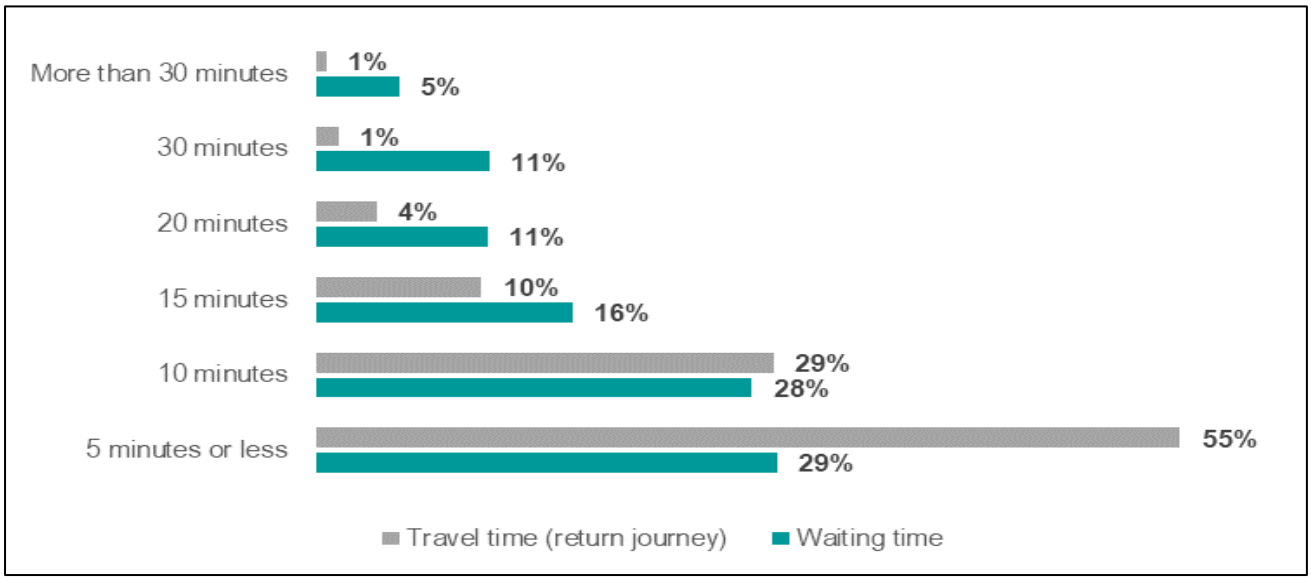
Torches and lanterns - Each family in the UNHCR programme areas received one solar lantern with a mobile charger. But a problem has been experienced that the house is then in darkness if it is used to go to the latrine etc. It is understood that some people are buying their own solar torches. The UNHCR energy team are not aware of problems with solar lanterns being stolen from roofs when they are being charged, but this might be a challenge worth investigating further. Some women met in Camp 15 noted that they use wind up torches. HelpAge have also been providing older people with torches to be able to go to the latrine at night. HelpAge have also been providing older people with torches to be able to go to the latrine at night.

5.2.5 Water points

Scale – The response has achieved huge numbers of water points, with over 9,000 taps and over 12,000 tubewells, including increasing numbers of deep tubewells to replace some of the more shallow tubewells, installed during the earlier stages of the response.

The following image from the post-monsoon assessment report shows the travel and waiting times for the water points. Note that waiting time is usually longer than travel time and there is a need to add up the travel and waiting time for one return trip. People will often have to do multiple trips per day, particularly if they do not have many storage containers.

Fig 2 - Travel and waiting time to reach and collect water[63]



[63] REACH (2018) *WASH Follow-up Assessment, Monsoon Follow-Up –Cox's Bazar, Rohingya Response, Oct 18*, WASH sector and DPHE

Level of satisfaction with water access before and after the monsoon

The level of satisfaction with water access after the monsoon, increased from before the monsoon, as indicated by the quantitative household survey data[64]:

- April – 8% very satisfied; 45% satisfied; 32% unsatisfied; 14% very unsatisfied.
- October – 9% very satisfied; 70% satisfied; 20% unsatisfied; 1% very unsatisfied.

Households reporting changes in access to water compared to before the monsoon were: 41% who felt they were better; 52% no change; and 5% worse.

Interpretation of data: This is very positive in that it shows a definite positive trend with improvements. However, care must be taken when interpreting quantitative data, in the sense that people who are responding are likely to be considered the head of the household or the most active female in the household. The respondents are less likely to be the person with disabilities, the older person or an adolescent girl. People may also be nervous to say negative things in response to the questions with the fear that they may have the services taken away from them, or they may be repatriated. Hence such data whilst useful should also be interpreted alongside qualitative data, from which it is often easier to pick-up and understand differences and specific challenges.

Feelings of safety when using water points - Water points are experienced as dangerous places. A recent OXFAM Protection monitoring report[65], noted that collecting water from water points were seen as one of the most dangerous activities undertaken in the camps (collecting water were reported as the most dangerous activity by 26% and 36% of respondents respectively when used during the day and during the night; against collecting firewood which was 27% and 13% day and night)[66]. Perception of how dangerous collecting water is varies by camp and location. Perception of danger at water points may relate to conflict between people, such as when water is only switched on for certain hours in the day, or due to queues at the tubewells at peak times, or also due to the risk of slipping on the difficult terrain, which increases during the rainy seasons. For women, their feeling of need to collect water at night may be partly caused by men using the water points as bathing areas.

[64] REACH (2018) *WASH Follow-up Assessment, Monsoon Follow-Up –Cox's Bazar, Rohingya Response, Oct 18*, WASH sector and DPHE
[65] *The monitoring was undertaken across camps 4, 12, 19, 22 and Wards 7 and 9 of Hnila Union*
[66] *OXFAM (2018) Protection Monitoring Report, September – October 2018*

		
Screen placed by household in between water point and path in Camp 15	**Screen placed around water point in Camp 6**	**Screen placed next to water point in a host community**

Screening of water points – The images above show examples of how people have attempted to screen water points. Two were in camp settings and one in a host community setting next to a house. Initially it was assumed that the screening was to put up a barrier, so that women would not have to see men bathing immediately in front of their houses. But it may also be that women also want privacy when collecting water, or themselves bathing at the water points. This was expressed a few times in discussions in the communities. The third image, where an attempt has been made to screen a water point, was in a host community. The handpump had been existing before the humanitarian response. The cement platform had been supported by actors in the response, as well as a toilet unit that is shared by several families (thought to be related and living in one household). The screen has been put up by women themselves, as they said it was to screen them when they bathed there in the early morning. The screening of water points on a more standard basis and with more durable materials, or offering this as an option for women and girls and men and boys to decide on, would be a positive way forward to offer another degree of dignity.

Allocation of male / female water points – The possibility of allocating separate water points for males and females has also been requested by communities as noted in a number of reports. This may be difficult to do, including to keep men from using the women's facilities, and also as it could then mean a further distance for people to walk to reach the facility. This would still lead to the issue of passing people of the other gender on route. But it is still an issue that should be included in the discussions with women and girls and men and boys. During the Water TWG workshop in Feb 2019, some suggestions were made for specific water points for the piped supply having a dividing wall, so that females could use one side and males the other, as well as an accessible tap for people with disabilities.

Rainwater harvesting – Another suggestion made during the Water TWG workshop in Feb 2019, was that we should support rainwater harvesting from roofs of the shelters, prioritising the shelters of people who are not as mobile, such as older people and people with disabilities. It is very difficult for some older people and people with disabilities to reach the water points, particularly if they are

unsteady on their feet. This then becomes even more dangerous during the rainy season, when the combination of the wet ground and the steep slopes can easily result in dangerous falls. Hence it was suggested that if they could have a rainwater supply for most needs during the rainy periods, this would reduce the number of times they would need to go to the water point. This is a great idea which should be supported. It is reported that some people are already trying to collect rainwater during the rainy season, so this would just build on this and improve the mechanisms for collection.

How the water services could better respond to gender, GBV and inclusion needs

In addition to discussions on the possibility of installing rainwater harvesting and whether it might be possible to install gender-segregated water points, the following are a selection of ideas also suggested by participants of the Water TWG workshop in Feb 2019:

1. Keep contingency funds to address the needs of people with special needs to be able to be flexible when budgeting – to ensure there are funds to modify the systems after the community consultations have been undertaken.
2. It is already proposed to have the water points under the master plan half way up the hills so there is less distance to walk.
3. Add in a "Very Important Persons" (VIP) line for older people and people with disabilities at water points.
4. Add an accessible tap on the new water points, which will be lower, will have a seat next to it and also a ramp access.
5. Focus the locations of new water points near to schools and learning centres, so children can collect water on their way home.
6. Use colour contrast for water point platforms to help people with visual impairments to see them and not the trip.
7. Provide options for water containers for people with different needs – such as smaller containers or containers that can be carried by rope from the shoulder.
8. Add laundry slabs with a rope or handrail to help people sit.

Boreholes and handpumps versus piped water – The water quality may be easier to guarantee through piped water supply, but the fewer water points and the piped water points, including if they only allow access to water for specific hours of the day, pose additional and significant challenges for some of the affected populations. These challenges include the risk of increased conflicts and fighting by requiring queuing for the water supply. This is also an issue and concern that has specifically been noted by children. See **Section 5.1.2**.

It also causes significant problems for people who face mobility difficulties, or have other impairments such as sight impairments; particularly if they have to walk further distances, including up or down hills. See also the case study of the woman who is caring for 7 people in her family and

the impact of a 20-minute return journey for one bucket of water down and up a hill in **Section 5.1.1.** Older people raised distance and the difficult terrain as a particular issue for them and in particular for older people who live alone.

The master plan for water supply and decommissioning of water points – Some efforts have been made in the development of the Master Plan to integrate a "Community Engagement" process into the Master Planning process for the water points (see Annex 2 of the Water Master Plan)[67]. This specifically encourages that different groups within the community are involved in choosing the locations of the tapstands and also that discussions are held on the different uses for different sources. In general, the idea for the community engagement is very positive and well laid out, although there are a few areas that would benefit from improvement. This includes:

1. The community engagement process says that as a minimum, discussions must be held with men and with women. It does not include discussions with older people or people with disabilities or adolescent girls in this minimum requirement. But as they are likely the people who will struggle the most with accessing the facilities, they should be consulted as a priority.
2. Hopefully such consultations with different groups will happen in all locations before agreeing on the locations of the water points. However, there is also the risk that only occasional discussions will be held and hence not all locations will be discussed and agreed, including with people who may find it more difficult to access them.
3. The initial master planning designs seem to have been done on a technical basis, based on the topography, with the community engagement parts planned for later in the process. It is not clear therefore if the donors' budget for the piped network, if they will add in enough budget to allow for the moving or additions of water points following the community consultations, including with older people and people with disabilities.
4. It is also not fully clear that if some of the shallow handpumps that do not have ideal drinking water will be decommissioned as part of the process, and if so, whether consideration will be made for the challenges this could pose for older people and people with disabilities by reducing access to water supply for other purposes (laundry, bathing, cleaning etc). This could potentially add to the risks for the spread of diarrhoeal diseases, due to reduced ability to perform hygiene tasks easily.

Water points are already being coloured based on water quality in the camps and coloured water points are common in Bangladesh due to the issue of arsenic contamination. It is recommended that this system should be expanded and advocacy is increased about the different usages while keeping as many tubewells open as possible for general use.

[67] WASH Sector, Cox's Bazar, OXFAM and UNHCR (version Feb 2019) *Annex 2: Community Engagement Process,* Safe Water Supply Master Plan for Rohingya Population in Ukhia Sub-District

5.2.6 Hand-washing facilities and mirrors

Availability of hand-washing facilities outside toilets - Hand-washing facilities were noted at some toilet blocks throughout the camps visited, but not all. This is not specifically a gender issue, except that women and girls have particular need for hand-washing when managing their menstrual cycle to wash off the blood. It also needs to be possible to be able to wash their hands in a private location where men and boys would not be present. This may also be one reason why most women and girls are reported to change their menstrual protection materials in their shelters (see **Section 5.2.9** for more discussion).

Mirrors attached to hand-washing units – See the box below.

Mirrors have also been requested in other responses, including in response to feedback on the screened toilet and bathing facility units in the Pakistan earthquake response in 2006. They have also been requested through the discussions with women through the "Women's Social Architecture Project".[68]

Mirror on handwashing facility

The attachment of a mirror to hand-washing units in Camp 15 was very positive to see. People in the camp who were asked, including adults and children, noted that they appreciated them and used them. People were also seen using them during the visit.

The handwashing drum in the image was however placed incorrectly in relation to the mirror; as the concept of adding the mirror to hand-washing units is to put them directly over the tap to encourage people to wash their hands by them wanting to use the mirror.

Sector actors noted that they had started replacing the glass mirrors with metal ones to reduce breakage.

They are a small item to add, but they are usually not added, with various reasons given as to why not, including that they may break. But adding them contributes a little more to dignity for people to be able to feel more human, in a context that can easily dehumanise people. If the mirror is also longer, it can also be used by women and girls to check for blood stains on their clothes during their menstrual period. But for this to be useful, it would need to be inside a bathing facility in a private space.

[68] Farrington, M (2018) *Women's Social Architecture Project: Phase 1 Final Report, OXFAM Rohingya Response, Cox's Bazaar,* September 2018

Management of handwashing facilities and availability of soap for communal facilities - Clearly the management of the handwashing facilities, including the filling up of the containers, will be a significant issue over the longer term. The sustained availability of soap for use for handwashing after using communal toilet facilities also poses particular challenges; and another reason why facilities for each house or shared between a maximum of 3 families would be more beneficial.

5.2.7 Hygiene items and distributions

Availability of soap - The recent REACH post-monsoon monitoring report[69] indicated that:

- **% of households reporting possession of soap** – 82% yes - and enumerators saw soap in the households they visited; 11% yes - but enumerators did not see soap in the households they visited; 7% no.
- **27% of households reported that they have challenges with accessing soap** – of these 19% said insufficient amounts are distributed; 17% said it is too expensive; and 8% said they prioritised other needs.
- **46% were able to identify at least three critical handwashing times –** although **see Section 5.1.2** for responses in relation to hand-washing before feeding a child or after the management of child faeces.

Hygiene kits - The same report in relation to hygiene NFI distributions:

- **% of households reporting having received a 'full' WASH hygiene kit (included non-consumables, including a water container)** – 4% in last month; 9% in last 3 months; 18% in last 6 months; 10% in last year; 54% never received.
- **% of household reporting having received a 'top-up' WASH hygiene kit (includes only consumables, such as soap and shampoo)** – 5% in last week; 5% in last 2 weeks; 13% in last month; 11% more than 1 month ago; 16% more than 2 months ago; 26% more than 3 months ago; 24% never received.

This data indicates the widespread variation of the provision of hygiene kits, with many people noting that they have never received them. The provision of kits from different sectors also causes challenges for mapping on who has received what. In Camp 15, kits were being distributed from the followings sectors:

- **Livelihoods or nutrition sector – baby kit** – Baby soap, towel, small bowl with spoon, tooth brush, baby lotion, 100ml, oil, plastic sheet (rexine paper so that water may not pass through), antiseptic savlon, mosquito net (small), sandals (pair).
- **Livelihoods or nutrition sector – neonatal kit** - This was also mentioned and is similar to the content of the baby kit.
- **Protection sector – dignity kit** – Bucket with lid, sanitary napkin, laundry bar, bathing soap, slipper, *orna (a traditional scarf)*, torch, *thami (a traditional dress for Rohingya women)*, *maxi (a kind of dress that covers the whole body)*, and underwear.

[69] REACH (2018) Water, sanitation and hygiene follow-up assessment, Monsoon season (August – October 2018), All camps, Ukhia & Teknaf Upazilas, Cox's Bazar District, Bangladesh

- **WASH sector – hygiene kit** – Bathing soap, laundry soap, nylon rope, nail cutter, non-disposable nappy, plastic banda potty, plastic bucket with lid, aluminium pitcher, jug, plastic, mugs and safety pin clips.

In some cases, the WASH sector may also be distributing menstrual hygiene materials such as cloth or reusable pads (or in some cases disposable pads) – see **Section 5.2.9** for more details.

It is a positive if people are receiving more hygiene items than they require, including as they can then sell the double items to pay for other items they need in the household. But it is worrying if people are not receiving basic things such as water containers, as this can limit the amount of water that can be collected and stored in their houses. There is a need for a comprehensive mapping of what has and has not been provided to be able to respond and fill in the gaps. But this would be a very complex and difficult task, considering the overlapping mandates and overlapping geographical areas of coverage and time-frames each organisation works in each area.

Distributions – Most distributions seem to be undertaken at distribution centres, which may be some distance from the household shelters. From brief questioning and viewing two distribution centres, it appears that there may be some gender segregation in lines in some centres, although males and females are still visible to each other. It isn't clear that separate distribution options are available to support people who may have additional vulnerabilities, or difficulties to queue, for example older people or people with disabilities. Although one person with a disability was seen entering a distribution centre to collect a water bucket and stand. He seemed to come out with the item quite quickly and hence there may be some prioritisation being done. The distribution process for WASH related NFIs should be reviewed from the perspective of distributions of WASH items, including to consider whether some house to house distributions could also be supported, particularly for people who may struggle more to reach the distribution centre and to stand and wait.

Additional hygiene items needed for the management of incontinence – For people who face incontinence, where they are unable to control or manage their urine or faeces or both, the access to water and need for hygiene items is much higher. See **Section 5.2.10** for more details.

NFIs from different humanitarian agencies should be actual needs based and assessments should be age- and disability-inclusive

HelpAge tries to provide NFIs based on the feedback they have received from older people on their priority needs. Older people often cannot hold in their urine and may need to go several times a night. So, they have provided torches for older people to enable them to go to the toilet during the night. They also provide some with urine containers.

They also note that *"Older people may have difficulties in accessing distribution centres due to mobility issues and need support"*, and hence encourage all humanitarian actors to consider this and how to provide support.

Market survey for hygiene items – The Hygiene Promotion Technical Working Group is planning to undertake a hygiene item market assessment in early 2019[70]. This is to be undertaken by REACH, managed by OXFAM and funded by UNICEF. It will consider hygiene item needs and availability, including standard hygiene items (such as soap, buckets etc), as well as considering menstrual hygiene items and items needed for incontinence.

5.2.8 Drainage and solid waste

Drainage – The situation of the drainage in the camps and stagnant drains and ponded water was an issue raised by a number of community members as a priority needing to be dealt with. As can be seen from the photo below, in some locations, it is resulting in an unpleasant living environment and is a dignity, health and well-being issue. The mix of poor drainage and piles of solid waste was also particularly visible in the market area of Camp 11, which then poses particular risks to hygiene and health, as it was in the environment where fresh food and raw meat was being sold.

The issue of drainage seems to have been falling through the gaps. When asking who is responsible for its management, the most common response given has been the camp / site management teams, although some also mention WASH. The situation is not helped by the new version of Sphere having removed the dedicated sub-section on drainage, preferring to just mention it in relation to specific facilities such as water points. However, general consensus[71] is that the WASH sector should be responsible for drainage for the water points and bathing facilities; and camp / site management for the major storm drains.

Some WASH agencies are supporting occasional cleaning campaigns, some on a regular basis such as monthly, and others just ad hoc. There are also some community volunteers from the Rohingya community known as 'cleaning volunteers' or similar names. But their job usually focusses on cleaning the WASH facilities such as toilets, bathing facilities and water points. In the occasional cleaning campaigns the community members are facilitated to do the cleaning, but it appears that they may not be given protective clothing in the same way as the regular volunteers who are paid an allowance.

[70] REACH (2018) *Research Terms of Reference, Emerging Market Mapping Analysis (EMMA) on Hygiene Items in Cox's Bazar District, Bangladesh; and* REACH, UNICEF and OXFAM (2018) *Hygiene Promotion Working Group Hygiene Item Market Assessment, Rohingya Response – Cox's Bazar*, WASH Sector Cox's Bazar

[71] This was recently checked with the global WASH Cluster by the coordinators of the Sanitation TWG.

	A point of stagnant water mixed with refuse around houses in Camp 7, resulting in an unhygienic and unpleasant living environment. The solid waste bin is currently empty. Whether it has just been emptied or is not being used is unclear. In some places it is reported that water from bathing facilities rushes into the homes of other people who live downhill[72].

The regular maintenance and cleaning of drainage is an important issue that someone needs to take responsibility for and to establish routine cleaning and maintenance. The drainage will also need to be improved throughout the camps to support more appropriate and better functioning household bathing facilities.

Solid waste collection and disposal - Linked with the drainage issue, is that of solid waste collection. It is understood that a number of small solid waste interventions have been supported throughout various camps, but the sector was waiting and hoping for a larger scale support from UNDP or one of the Banks (World or Asian Development) to support a large-scale disposal site and associated collection and management system. However in lieu of this happening in the near future the Sanitation TWG is currently in the process of working on a strategy for the next year. The Red Cross Movement recently supported a study by a consultant on the make-up of the solid waste issue and his report is in process[73]. This study has identified that quite a lot of the solid waste is currently being burnt for fuel, including plastics, which must also be problematic to health. But with the move to have all refugees to use liquid petroleum gas (LPG) for cooking, it is possible that the amount of solid waste being disposed of in the camps will increase. It was also suggested that it might also be difficult to sustain a system of cleaning of the drains until an effective solid waste collection and disposal system is set up and working; as if the drains are cleaned people may then start disposing of their waste more regularly in the drains with the understanding that it will then be cleaned away. This is a good point; although improving the cleanliness of the environment should still be a priority to work towards, looking at both of these issues, so as to offer people a more pleasant environment in which to live and contribute to their general well-being.

[72] Consultations by the GBV Sub-sector (CARE, PULSE & PIN) – on preferences of women and girls regarding bathing facilities, October 2018
[73] IFRC, personal communication

5.2.9 Menstrual hygiene management (MHM)[74]

Entry point to meet with adolescent girls - Menstrual hygiene management (MHM) is seen as a useful entry point to reach adolescent girls and can offer the opportunity for broader discussions on issues related to GBV and sexual and reproductive health. It is also key to self-confidence, freedom of mobility and an entry point to gain life-skills.

Informal MHM working group – There is an informal MHM working group that has been established under the HP TWG, which currently has members from WASH, protection, GBV and livelihoods. There are plans to also expand this group to include people from education, health and disability in the near future. The WASH sector is particularly keen to collaborate with the Health Sector and Sexual and Reproductive Health (SRH) Specialists for awareness-raising sessions to be able to provide advice on health and SRH issues if they are asked. This group has started a process of sharing useful information and mapping the learning on practices related to MHM in the Rohingya communities, as well as the activities and learning processes being facilitated by different agencies.

Training materials and awareness raising activities on MHM – A number of different agencies working across sectors have started undertaking some awareness raising activities on MHM. Some of which is understood as being based on written materials and guidance and other it is believed to be verbal. An MHM comic book is also understood to exist. There is some concern about the quality of the training materials being used and also knowledge and facilitation skills of some of the people being expected to facilitate activities and awareness raising on this issue. One set of training materials viewed included a recommendation to use 'antiseptic powder', which is not an appropriate recommendation, which confirms the concern being raised by various actors. A concern was also raised that not many engineers and technical staff had ever had the opportunity to be trained on MHM, but that effective MHM requires that they are understand the issues associated with it for women and girls.

As an attempt at response-wide and cross-sectoral support for MHM is still in its infancy globally and many organisations are still learning on this issue, it does not make sense that all agencies are trying to develop their own advocacy materials, guidance and training materials. It would make much more sense for the whole response to review what is being used by different agencies at present and to take the best parts from each and come up with a response wide set of materials. The only variations needed in this response-wide set would be any differences needed to respond to the needs of the host communities and the Rohingya refugees; as well as to include variations in materials for girls and women of different ages, for girls and women with disabilities where this may need to be adapted, and for men and boys.

Some organisations within the response have more in-depth experience than others from their work globally. The IFRC is the organisation that has taken this issue most seriously in the global

[74] Comment supported by the audit team's own observations and the findings from: Prabhakaran, P (2018) *MHM programming review in the Cox's Bazar response*, October, 2018, UNICEF ROSA

humanitarian context. This includes undertaking in-depth action research in a number of humanitarian contexts over a number of years[75]. They have a series of resources and case studies and have recently also released a series of global tools that the IFRC are planning to trial and adapt to the Cox's Bazar context. There is also the relatively new cross-agency published new 'MHM in Emergencies' toolkit (published in 2017)[76], which also refers on some issues to the broader cross-agency 'Menstrual Hygiene Matters' resource (2012)[77]. This includes both development and emergency contexts and covers some issues in more depth, including providing more practical examples of what different actors are already doing. Both are publicly available, as are a wide range of girls and teacher's books and a wide range of other materials including training materials. Refer to **Annex VII** for more details. It is also understood that Bangladesh is also updating its country guidance on this issue.

Research and learning on MHM practices and norms – There is a need to continue learning on existing MHM practices and norms to support the development of sector wide guidance and to understand how women and girls usually manage their menses and how they think this can be handled in a dignified and healthy way. Some has already been started and documented by UN Women and OXFAM[78], but will need to be built on.

Use and provision of sanitary protection materials - Menstrual hygiene materials to soak up and manage the monthly menstrual bleed, have been provided by a range of agencies. It has been mentioned that a decision was made across sectors (presumed to be earlier in 2018), to only support reusable materials, due to the problem of solid waste disposal that would be added to if women and girls are using disposable items. However, some agencies are still supporting disposable pads, in their hygiene or dignity kits.

The issue of materials used by women and girls has been included in a number of studies, the key findings of which have been included in **Annex V**. The various studies[79] indicated that: more women and girls used cloth before the displacement (noted as over 70%), but increasingly more are now using reusable pads (varies from 47 to 53%). Some women are also using disposable pads (varies from 25 – 37%). Some also just use underwear and it is also possible that some just bleed into their saris / skirts.

Provision of other NFIs – Different agencies across sectors have been distributing different non-food items to support MHM, but it is not clear how many have supported items such as buckets with lids for storage and soaking of soiled materials; ropes and pegs; or waterproof bags to hold soiled materials in.

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[75] IFRC Global WASH Team, Geneva (2018) *Period's don't stop in emergencies, Addressing the menstrual hygiene needs of women and girls,* Case study, August 2018

[76] Sommer, M., Schmitt, M., Clatworthy, D. (2017) *A Toolkit for Integrating Menstrual Hygiene Management (MHM) into Humanitarian Response (First edit),* New York: Columbia University, Mailman School of Public Health and International Rescue Committee

[77] House, S, Mahon, T, Cavill, S (2012) *Menstrual Hygiene Matters; A resource for improving menstrual hygiene around the world*, WaterAid/SHARE (co-published by 18 organisations), www.wateraid.org/mhm

[78] UN Women and OXFAM (2018) *Menstrual Hygiene Management Workshop*, Cox's Bazar, Bangladesh, July 2018; and HP Technical Working Group, informal MHM working group (2018) Mapping of lessons learnt / practices related to menstrual hygiene management in the Rohingya response and from Myanmar; and mapping of activities undertaken on MHM by different actors

[79] The Rohingya Refugee response, Gender Analysis (Aug 2018); two assessments and monitoring reports undertaken by REACH (baseline in April 2018 and the follow up monsoon assessment in Oct 2018); the investigations by UN Women and Oxfam; and the mapping by the informal MHM TWG

Sanimarts – Some Sanimarts have been supported which have workshops to make disposable sanitary pads from cotton wool. They have also provided a focus for awareness raising for women and adolescent girls on the issue of menstruation. The one visited in Camp 2, provided a positive opportunity for young women to come together for social benefit and support while making pads and to gain a small income from an allowance. But the provision of the pads was reported to be on an ad hoc basis, which did not seem like a sensible strategy, particularly in light of the previous discussion for the response to only support reusable materials. It is recommended that it would be better to consider the young women being occupied in other activities, such as making reusable pads, or in undertaking house to house advocacy and outreach to other women and girls, rather than in making the disposable pads for random distribution. However further learning would also be needed on the challenges faced by others in making and distributing reusable pads before progressing with this option.[80]

Where women and girls change their MHM protection materials

The REACH post monsoon monitoring (Oct 2018)[81] established that most women and girls change their MHM protection materials either in the household (65%) or in the household bathing facility (34%). Only 10% mentioned that they used the communal bathing facility, only 3% in a household latrine and only 1% in a communal latrine. This is very interesting and useful information and highlights how little confidence the women and girls have about managing their menstruation in the communal facilities, including latrines. This is probably due to the lack of privacy felt, the risk that men and boys may also use the facility and may also be around when coming out, and not having an easy option for disposal of the used materials. But this would be useful to discuss further with them to better understand when looking at options for going forward.

Washing, drying and disposal of materials – The same REACH post-monsoon study also identified that 40% of women report washing their menstrual hygiene materials in their shelter and 40% in their household bathing facility. Only 13% mentioned using the communal bathing facility. Likewise, 75% said they dried their materials in their shelter and 13% in the household bathing facility with only 4% mentioning the communal bathing facility. If this is the case, if bins are put into the toilet units with a discrete and sustainable disposal system, will they be used? Or would it be better to focus on a stronger household disposal system that would allow the wastes to be disposed of through this route? Trials of both would be useful along with further discussion with women and adolescent girls on the options.

The IFRC and Swedish Red Cross have also recently supported a useful study on the issue of MHM with a focus on solid waste[82], which also make a range of useful practical recommendations for moving forward on MHM. It is recommended that the sector also considers these as it establishes its way forward. In relation to disposal of materials it is noted that very little attention has been put on to this issue; and that many women and girls are waiting until dark to bury their cloths and

[80] It is understood second hand that UNHCR attempted to support such an activity and faced problems with it. However, details are not known.
[81] REACH (2018) *WASH follow-up assessment, Monsoon season – all camps in Ukhia and Teknaf Upazila (Aug - Oct 18)*, WASH sector and DPHE
[82] IFRC and Swedish Red Cross (2018) *Findings and recommendations: Review of Menstrual Hygiene Management (MHM) Actions with a Focus on Solid Waste, Population Movement Operation (Cox's Bazar, Bangladesh),* August 2018

menstrual waste, even though it is reported that some women and girls have beliefs that supernatural powers will attack them after dark if they are out at night. The study also observed that the challenges of recruiting female volunteers, limits what has be possible in the area of MHM and the turnover of staff on short contracts has lost some of the institutional memory for supporting a comprehensive response. In addition, the lack of capacity and training on such issues also relates to the fact that many frontline workers are young straight out of school volunteers hired by NGOs who have limited previous experience.

MHM training for teachers and people in charge of women friendly spaces, child friendly spaces, learning centres, staff in health centres and health workers on the provision of MHM friendly WASH and associated support – There is a need to support the training of teachers and other people in charge of these centres (both male and female) and spaces to ensure that women and girls are able to continue visiting the centres during their menstrual periods. And in addition, there is a need as well as opportunity to partner with health centres and health workers for service provision – in terms of imparting training and disseminating information as well as materials. In addition to provide support for cramps and menstrual disorders.

MHM for girls and women with disabilities – Information and support on how to manage their menstrual period has been raised by girls and women with disabilities. Disability specialists working on the response noted this as a particular area of concern that needs increased attention and support.

5.2.10 Incontinence

Incontinence is often a hidden but difficult issue to manage – Incontinence is where a person is unable to control the flow of their urine or faeces. It can be of different kinds (stress, urge, overflow and functional). It can also be of different levels of intensity, from leaking only when you cough, sneeze or laugh, to constantly releasing urine or faeces because of fistula (a tear in the lining of the bowel or bladder or associated organs). It is a highly stigmatising condition and can result in significant problems from smell, as well as the soiling of clothes and laundry. It is a significant dignity issue that requires much higher WASH needs and can limit the person or their carer's abilities to leave the house and undertake other tasks, including taking up learning opportunities, collecting water, collecting distributions, or undertaking income generating opportunities[83]. Many people will be reticent to openly talk about the issue, although it is understood that people with disabilities may talk about it more openly.

[83] Hafskjold, B. Pop-Stefanija, B. Giles-Hansen, C. Weerts, E. Flynn, E. Wilbur, J. Brogan, K. Ackom, K. Farrington, M. Peuschel, M. Klaesener-Metzner, N. Pla Cordero, R. Cavill, S. House, S. (2016, publication pending) 'Incompetent at incontinence - why are we ignoring the needs of incontinence sufferers?' *Waterlines*, volume 35, issue 3, July 2016; and Giles-Hansen, C. (2015) *Hygiene Needs of Incontinence Sufferers; How can water, sanitation and hygiene actors better address the needs of vulnerable people suffering from urine and/or faecal incontinence in low and middle-income countries*, WaterAid/SHARE

A wide range of people may be affected by incontinence

This can be young women who have given birth; people including children with disabilities; children who have been traumatised by conflict; older people; both female and male GBV survivors of rape; people who have illnesses such as diabetes, asthma, cancer or prostrate problems; and a range of others. Some individual case studies were shared:

- An old man who has incontinence calls out to his neighbours for help when his bedding gets wet, so that they can come to help and clean him and his bedding.
- *"As we were talking to a woman and her carer, a woman heard us talking about toilets and came out and wanted to talk about her husband who was injured and has a spinal injury. She said that he urinates in the bed and it is very difficult. She wanted to speak as they need help".*
- *"We came across a house which had a pathway installed to a latrine for a young man in a wheel-chair… but the latrine was tiny, and the man clearly couldn't use it alone. His father also said that he has mental disability as well, so that he doesn't actually know when he needs the toilet, and regularly soils himself. On the ground along the path to the latrine were piles of soiled clothes, which the family had dumped outside as they didn't have enough water to wash them, and couldn't keep them in the house for the smell. I've asked our team to check in with the house on a regular basis to see what else they might need (soap or larger water storage containers), but it was sad to see that whoever had done the ramp, didn't think all the way through the other implications that the family were facing".*

The bedwetting of children and difficulties of the management of child faeces in CFS's was also mentioned and it was also noted as a possible barrier for children with disabilities who would like to participate in child-friendly spaces or in learning centres.

"Functional" incontinence and implications for hygiene

HelpAge and partners also have undertaken an assessment of 1,335 older people in Cox's Bazar camps (2018, report not yet published). In this study 17% openly admitted that they have incontinence problem and 77% of them stated that they are struggling and not getting any support. 43% of older people with disabilities who have difficulty getting out of living place, also reported to have incontinence.

It was also noted that most older people have "functional" incontinence – i.e. they are not able to get to the toilet quick enough. This finding highlights the some of the implications of the gaps in the WASH sector's response in not focussing on the needs of older people and people with disabilities, but effectively leaving them until last. Not being able to go to the toilet quickly and easily contributes to people with incontinence, including functional incontinence, in not being able to manage it effectively. This can mean, in simpler terms, people ending up soiling themselves and their clothes and the indignity and shame associated with this happening because they cannot reach a toilet quick enough.

It also leads to a range of practical implications of needing more water and soap and having to do more laundry and dry clothes. Hence the need to also have access to more sets of clothes, which people may not have. It is estimated that someone with incontinence can need up to 5 times as much water and soap than someone who does not have it, to be able to wash protective materials, clothing, bedding and for bathing to keep hygienic[84]. This would be a significant challenge for any person in a low- or middle-income country. But significantly more difficult for people living in the Rohingya camps, with only access to communal toilets and bathing facilities and who needs to walk to collect water, up or down steep hills. There is also a need for a torch for older people who may need to go to the toilet several times a night.

Fistula – A discussion with Traditional Birth Attendants (TBAs) in one camp was interesting in relation to incontinence, as although in some cases they noted they had supervised thousands of births over the years, none would say that they had seen any women who had suffered with fistula or incontinence after giving birth. This was surprising as it is clear that in the Rohingya community many women are married young as girls of ages 13 to 20, with some women or around 20 years of age being reported to have arrived from Myanmar, already with between 2 to 4 children[85]. Fistula is known to be a particular issue for girls who give birth young and hence who easily tear. It is known the incontinence has a high level of stigma attached to it and it can be difficult for people to come forward to ask for help. The TBAs also noted that they don't tend to manage the most difficult cases, as they would refer them to hospital, so it is also possible that some cases where fistula occurs, they have been managed at hospital rather than at home. But it is also possible that it might be felt that admitting that a woman or girl you have supported to give birth has ended up with incontinence or fistula, would be seen as a failure on part of the TBAs. Hence this may also lead to a reticence to admit that it happens. Further investigation on this issue led to discussions with the team from the Hope Foundation Hospital which is the fistula hospital in CXB and with UNFPA and UNICEF Health teams, who both provide support for the same hospital. See the box which follows.

[84] Source: Informal global email group on incontinence in low and middle-income contexts
[85] UN Women (2018) *Gender Brief on Rohingya Refugee Crisis Response in Bangladesh,* http://asiapacific.unwomen.org/en/digital-library/publications/2017/10/gender-brief-on-rohingya-refugee-crisis#view

Fistula in CXB and Hope Foundation Hospital in Ramu, CXB[86]

There are about 2,000 known new cases of Fistula in Bangladesh per year, although it is expected that the cases are likely to be much higher. 77 of the fistula operations undertaken during the last year in the Hope Foundation Hospital in CXB were on women from the Rohingya camps. 75% of the patients in Bangladesh are from the 25-29 age group. 90-95% of women in the host communities and camps deliver at home, which adds to the challenge of fistula.

Obstetric fistula often occurs when the babies' head pushes on the soft tissue between the baby's head the mother's pelvis and cuts off the blood flow to the tissue causing the cells to die. Most women who have fistula lose their baby (92%).

Many women who have fistula suffer very badly in their home situation – for some their husbands leave them and divorce them and for some their parents disown them, due to the smell and embarrassment. It is very difficult to maintain hygiene and severely restricts their access to services.

The Hope Foundation Hospital is training midwives and is also encouraging women who have had fistula operations and have recovered to be ambassadors to reach out to other women and girls in the communities to come to the hospital for care. It is very difficult for some women to engage in health care and so these fistula survivors are an important link and influencers to encourage women to trust the hospital to have the operation and change their lives. The hospital also provides some employment for women who have had the operation and livelihood training.

Responses to support people with incontinence – In the Rohingya response some bed pans and urine containers have been given out by the disability and older people specialist organisations (HI and HelpAge and partners). HelpAge and partners have provided commode chairs and HI and CBM and partners and some other organisations have supported adaptations to some WASH facilities to enable people with disabilities to access them easier. See **Section 5.1.1** for more details. One HP Core Facilitation Team (HP CFT) member gave an example of how they realised an older woman had this problem, and so they built a toilet in her house.

However, it is obvious that not much other support has been provided and not at the scale needed. A range of useful items are available globally and also in some other low-income contexts that could potentially be very useful to people with incontinence and their carers' in this response. These include items such as waterproof mattress protectors, reusable incontinence underwear and plastic pants, as well as the urine containers, bed pans, commode chairs and additional water containers and supplies of soap. It is also very important that anyone who is met who has incontinence, will be referred to a disability or health professional, particularly if they are immobile, as this combination can lead to very serious consequences including bed sores, urinary infections

[86] Akter, F (2019) *Incontinence in Female Genital Tract,* Hope Foundation Hospital, Ramu, Cox's Bazar, Bangladesh; Akter, F (2019) Fistula Activities in Hope Hospital, Hope Foundation Hospital, Ramu, Cox's Bazar, Bangladesh

and even death. Some people with incontinence may also benefit from using catheters, which would need to be provided with training by a health professional, occupational therapist, or a disability specialist.

Possibility of supporting urine containers or commode chairs and buckets with lids for women and girls – It would also be worth considering whether providing urine containers or commode chairs with supporting buckets and lids (maybe of different colours to the water buckets), could also be a positive strategy for women and girls. This is in particular for those who are currently urinating or even possibly defecating in their shelters to help them manage their urination and defecation with more dignity, including at night. Even in European countries within the last century, people who had outside toilets, such as in the back yard of their homes, would tend to use what were known as 'chamber pots', which would then be emptied in the morning into the outside toilet. These containers would need to be emptied into a latrine and also kept clean, so this adds another step to the process, but it might be worth discussing with women and girls. This should not however, take away the priority for ensuring appropriate support to be given to older people and people with disabilities, who have been mostly overlooked as part of the response.

The informal "MHM and incontinence" working group and market research – Very positively, the informal MHM working group has expressed an interest in learning more about incontinence and how to support people with it and has expanded its title from "MHM" to "MHM and incontinence". Many of the components that need to be considered for MHM are similar for incontinence, as both involve the management of liquids or solids coming from the body and both need private and accessible WASH facilities, which are user-friendly to manage them. With incontinence, however the volume of liquids or solids can be much higher and it can affect some people every day of their life, rather than just for a few days each month. It also has a much higher level of stigma associated with it and so it can be harder for people to talk about it. There is also less experience within the humanitarian community in how to support it. A half day training / workshop session was held with members of this group and other interested parties in Jan 2019 and a discussion was held on the different roles of different sectors, as well as a review of possible NFIs that could be supported as part of the response. The box which follows highlights a summary of the key responsibilities proposed during this workshop of three sectoral areas in relation to incontinence. These discussions need to be continued and will contribute to learning in the CXB response and globally.

Table 5 - Suggestions for responsibilities for incontinence as noted during Jan 2019 workshop

Health	WASH	Gender, GBV
1. Ask repeated questions in different ways to try and identify people who have a problem with this very stigmatising issue. 2. Provide technical advice for catheterisation, provide medication, provide NFIs and refer people to specialist centres (such as the Hope Foundation Hospital for surgery). 3. Provide training to the caregiver and counsel / do awareness raising with family members and religious leaders. 4. Follow up with the patient, ensure safe deliveries and provide psychosocial care.	1. Undertake consultations to identify if people have additional WASH needs from incontinence. 2. Respond on a case-by-case basis. 3. Do capacity building of WASH actors to be able to recognise these needs. 4. Coordinate with the health sector for referrals. 5. Consider the distance to water facilities, the volume and quantity of water people need including the storage capacity they have and need. 6. Consider the distance to the toilet and bathing facilities and access to communal or household facilities and drainage and solid waste management. 7. Distribution of NFIs / additional soap. 8. Communicate to break down stigma and raise awareness.	1. Create awareness around the issue to prevent isolation and GBV – promote dignity. 2. Ensure timely access to support for sexual violence survivors. 3. Optimise safe spaces for women and adolescent girls to increase knowledge and provide services related to sexual and reproductive health. 4. Build capacity of health workers and frontline staff across sectors. 5. Strengthen referral systems. 6. Engage husbands and family members and assist providing care and rehabilitation.

5.3 Hygiene promotion, community engagement, consultations and feedback

Key learning from this section:

1. What has been understood by "Consultations" and the quality of consultations has varied. To undertake effective consultations, including with particular attention on issues such as gender, GBV and inclusion, requires skill and experience. Whereas many frontline workers are young and with limited experience in development or humanitarian situations. The gaps in the consultation processes are likely to have been major contributors to the gaps seen in the WASH response related to gender, GBV and inclusion. Significant attention is needed on capacity building in this area.
2. There is a need to significantly increase attention on ensuring that the people who may struggle more with accessing and practicing their WASH are identified and consulted. This includes older people, people with disabilities, adolescent girls and women, including those who stay in their shelters, as well as men and boys.
3. There is a need to consult on the different options for improving the existing set up of WASH facilities and offering options, including screening or reallocation of facilities to make them more gender- and GBV-sensitive, as well as accessible. Capacity will however be needed as to the options and how to undertake these discussions and gain consensus between different groups.
4. The earlier stages of the response had limited attention on hygiene promotion. Efforts have been increasing and capacity is now being built, including through the formation of a Core Facilitation Team (CFT).
5. Some people find it difficult to access distribution points and it is not clear whether there are support systems in place to assist them. More investigation and efforts are needed in this area.
6. Attention is required when developing BCC / IEC materials to ensure that people of different ages and people with disabilities are integrated throughout all images as they are in society, so they do not continue to be invisible. Likewise, more attention is needed on making sure that BCC / IEC materials do not build on stereotypes and help to contribute to greater gender equality.
7. A range of feedback mechanisms have been set up across the camps, which appear to be functioning to some degree. It is not clear, however, whether records are being kept of when the issues raised have been resolved, or if any feedback is being given to the people who raised the issues. This is a gap that needs attention.

5.3.1 Hygiene promotion and community engagement

Lack of attention on hygiene promotion - It is reported that hygiene promotion (HP) was mostly ignored for the early stages of the response, except for the provision of non-food items (NFIs). But there has been increased attention on hygiene promotion and community engagement as time has progressed. The gap in hygiene promotion expertise in all three of the WASH Area Focal Agencies (AFAs) has been obvious at different stages, but with some increased attention over time, with initial HP staff employed in UNICEF at CXB level, a staff member with responsibility identified in

IOM and more recently a dedicated staff member employed by UNHCR. UNICEF also supported a WASH sector Hygiene Promotion Coordinator, which is understood to have helped to increase attention on this issue. However, a delay in renewing her contract over a number of months, has posed difficulties for the sector and keeping hygiene promotion and community engagement as high up the agenda as it needs to be.

HP Core Facilitation Team – A HP Core Facilitation Team (HP CFT) has been established to try and influence the harmonisation of approaches across agencies and camps and build capacity of key actors in hygiene promotion and community engagement. This team includes partner representatives working with all three AFAs and currently has approximately 61 members, both female and male. The aim is for the membership to grow to 110 members with 20 to be identified as field leaders to help supervise the work of the others.

Community volunteers - There has also been an increase in the use of community volunteers, both male and female from the Rohingya and host communities. They have varying roles, including those focussing on hygiene promotion, community mobilisation, cleaning of WASH facilities, desludging latrines, collection of solid waste and water operators (presumably of piped water supplies). This has increased opportunities for household visits to reach women and girls and people who are less mobile and also to involve more women and men from the communities in the programmes and service provision, whilst also providing a small income through an allowance. As previously indicated in **Section 5.1.3**, female HP and volunteers can speak with both women and men, but men do not have the same level of access to talk with women and girls.

Behaviour change communication (BCC) and information, education and communication (IEC) materials – Not many BCC and IEC materials were seen during the audit, except for a selection shared by the UNICEF C4D team[87] and a few sector-based materials on hand-washing, Acute Watery Diarrhoea (AWD), water, food hygiene and sanitation[88]. Of the examples from the UNICEF C4D team viewed, there were a few examples which had considered the need to not reinforce gender stereotypes and roles, such as the one below with the man taking responsibility for chlorinating the drinking water and another with both mother and father taking a child to the health facility as part of the acute watery diarrhoea outbreak preparedness materials. But most others were based on more traditional gender roles and stereotypes. For the WASH sector HP materials, both men and boys as well as women and girls were represented collecting water, although more traditional roles were included in other places, such as women being the ones cleaning containers and men being the shop keepers.

Although only a few were observed, none were seen across either set, which integrated people with disabilities into the general images. It is recommended that moving forward that attention should be placed by WASH and other sector actors, to try and ensure that the images reflect the wide range of people within society, including people with disabilities and older people, as well as trying to not stick too much to traditional gender stereotypes.

[87] UNICEF Communicating for Development (C4D) (2018) WASH related IEC material samples, most for AWD preparedness; and
[88] WASH Sector, Cox's Bazar and DPHE (accessed 2019) HP IEC materials

	
IEC material on making drinking water safe, which includes both a man and woman involved in the process	**IEC materials that mostly sticks to traditional gender roles of the woman being the carer and cooking, although it does include men or boys washing their hands.**

In addition, in safe spaces and Child Protection and Learning Centres the materials are often in English and depicting western symbols. The Learning Centres are restricted by the Government of Bangladesh on the languages that can be used to teach (English or Burmese), which as probably also influence the language of the posters, but this is likely to pose some barriers to understanding the information.

'Clean Camp Campaign' - There has been a plan for a 'Clean Camp Campaign', which it is understood will be facilitated adapting some of the approaches from the Community Led Total Sanitation (CLTS) approach.

WASH Committees - Occasional mention has been made of the establishment and use of some form of WASH Committees, but on questioning it was not easy to identify where these currently exist. A relatively new proposal from Terre de Hommes (TdH) for funding by UNICEF, includes a structure of WASH Committees that will be supported to strengthen the opportunities for feedback and complaints and also for increased engagement of different groups in the management of the facilities. A particularly interesting feature of this model is that they are proposing to establish a number of 'base committees' covering 3 to 5 blocks from different groups of people – Women Committee; Youth Committee and Elderly Committee, and that they will make pro-active efforts to also involve people with disabilities. The idea is that each will meet and feed in separately to the main WASH Committee, which will then link to the *Mahji* with the support of TdH. Feedback will also be given back to the base committees on a regular basis. The purpose of the separate committees is to respond to some of the challenges of specific groups of people not being able to move far or speak freely in front of others, or being overlooked in consultations. This seems like a very positive option to start to use and then to learn from how well it works for modification in the future if needed.

Engaging with different groups from the community – A priority for the sector for going forward has to be on ensuring that different groups within the community have an equal chance to be consulted and be involved in discussions on their needs and decisions on the way forward. The TdH example above is a positive example of trying to strengthen in this area. There are probably other agencies who are also making improvements in their programming processes, but considering the major gaps in the programme to-date, disaggregating involvement of different groups to make sure they are not overlooked, will need to be kept high on the agenda in sector discussions and plans. This particularly relates to ensuring the inclusion of older people and people with disabilities, but also with consultations with women and engagement of youth, particularly adolescent girls, and making sure that children are also consulted.

5.3.2 "Consultations"

Have people been consulted? - One recurring theme and cause of concern for people who have been trying to promote change in the areas of gender and GBV in the response, has been how limited or non-existent the consultations with women and girls have been. Discussions with various actors also led to confirmation that multiple organisations have not been strong in this area. They also confirmed that men and boys, have also not been consulted much and in particular that they had not consulted with people with disabilities or older people.

However, the Rohingya Refugee Response, Gender Analysis[89] study published in August 2018, indicated that between 55 to 70% of Rohingya respondents *had felt they had been consulted before the water point, latrine or bathing facility construction*. This was contradictory information to that which was being expressed by sector actors, including those admitting weaknesses of their own organisations. The fact that many people felt like they had been consulted over bathing facilities, but over 50% of all women are reported to be using their own makeshift facilities in their shelters, could possibly indicate that the effectiveness of the consultation process was questionable. It could mean that they were not really consulted in the real meaning of the word, or they were consulted, but the people who asked the questions did not respond positively to their feedback or requests. Hence, they have stopped using facilities and found their own more appropriate solutions.

One stakeholder noted *"This is a real issue in humanitarian settings, where due to all of the complexities of the situation, such qualitative information is not given priority".*

What does "consultation" mean? - The audit team tried to investigate further where this difference in concept or experience may have come from. The team focussed on trying to understand what the term "consultation" means to different people and as part of this who was consulted, what was asked, and what was done about what was said?

Some women in the communities who were met, said they were consulted, but only if they wanted a toilet or bathing facility, not about its design or siting. In this case, it should also be asked if they had turned around and said *"no we don't want a toilet or bathing facility",* whether the WASH

[89] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*

sector would have allowed them to not have one? It is doubtful, and so in this case, this could be argued to not be real consultation, but only ticking a box to note that consultation has been done?

Potential issues were also raised with quantitative surveys. They can be very useful for providing an overview of the situation and changes within it, but they should also be interpreted with caution. For example:

1. There are language issues, in that the language being used is Chittagong which has some differences to Rohingya. Hence, there may be some areas of misunderstanding.
2. The Rohingya people have also for a long time been repressed as a society and so are not used to being asked their opinions.
3. They may also lack the confidence to say no, or give negative responses for fear that services may be withdrawn, or they may face serious consequences, such as being repatriated.

Consultations and gender considerations related to the "army latrines" – Eleven thousand five hundred "army latrines", in two phases, plus five thousand associated bathing facilities and 2,000 latrines decommissioned, under UNICEF funding. The construction was undertaken by contractors, who were supervised for the construction by the army, most of whom were not technical. They in turn were monitored and supported by the EIMS engineering consultancy team.

It was explained that some consultations had been undertaken which involved mixed groups of males and females and also involving the army, the EIMS engineers and *Majhis* (but who in most cases would have all been male). A number of features were also included in these latrines to try and consider gender issues, such as the direction the doors opened, a split between male and female and a solid wall in between the male and female parts. See the box below.

Interestingly also a female engineer noted that when women were consulted at these earlier stages, that some women said they *"would not be able to come out of their shelters during the day anyway and they can't restrain men from using the facilities they like, so it was not so important that the facilities were gender-segregated".*

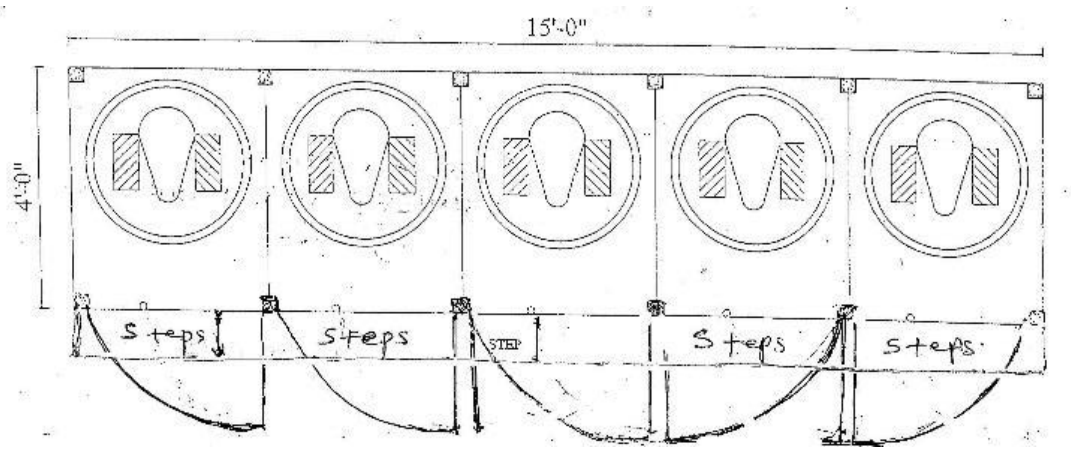
Who undertakes the consultations and the language they use, can also make a difference, including to influence if they can reach women and adolescent girls. The people doing the consultations also may not have known how to ask questions and what to record and may have lacked training in how to conduct these particular consultations.

Gender considerations incorporated into the “army latrines”

The design considerations that made for the “army latrines” related to gender included:

- Each block would have 3 units for women and children and 2 for men
- A solid wall would be constructed in between the male and female portions
- The doors would open in opposite directions to act as a kind of screen when they were open

13	Safety / Privacy wall, that will be constructed from flat GSI, fixed between male and female toilet (as Gable) to keep privacy of female. (**Attention:** From one blocks of 5 latrines, 3 of them are dedicated for Female). **Attention:** The safety walll will be fixed @ the right side wall of the third toilet



Undertaking consultations effectively takes experience and skill - This example, and the fact that many women and girls are not using the facilities during the day, or in some cases at all; along with the understanding that in most cases no considerations have been made to consult with and respond to the needs of people with disabilities and older people, offer a number of lessons and considerations for moving forward. These include:

1. Knowing how to undertake consultations well, including to know who it is important to involve and consult with, asking the correct questions and then responding to what the respondents say, is not as simple as it may first seem. It requires skill.
2. The facilitation process that needs to be undertaken is quite complicated, as there is not likely to be one simple answer in each specific context – but for and against angles for each option. Also, a number of different people need to be involved in the discussions from the

affected community side to ensure that people who face the most difficulty in accessing and using WASH facilities will be able to do so.

3. Even if adaptations are made to the communal WASH facilities as they exist at present, or if new communal or shared facilities are constructed that consider some of the improved features to try and respond to gender, GBV and inclusion related concerns; it is still possible that they will not be fully used by all people. It may be that for some people household toilets and bathing facilities will be considered as the only suitable option.
4. In the Rohingya response, people who are working at field level and engaging directly with the affected communities may have limited experience of undertaking such consultations, particularly ones that have a range of considerations associated with them.
5. There are clearly still gaps in capacity and confidence in undertaking such consultations at present and responding to the findings. Hence, this should be a priority focus area for capacity building interventions.

To expand on this a little further, the set of three tables which follow, identify some of the observations / lessons on the possible complexities of solutions. These have been highlighted through a number of sources. This includes through the discussions through the 'Women's Social Architecture Project (Pt 1)', discussions the audit team had with Rohingya and host community volunteers (female and male), discussions with a number of active members of the HP CFT, and discussions with specific experts in the sector.

A small block has been placed in this bathing facility in Camp 6. One suggestion mad was that it may have been designed for washing menstrual cloths, but is not clear. Another suggestion made is that I could have also possibly been to aid squatting.

If blocks are to be put into bathing facilities for future designs, the blocks should be higher to form a seat for people who find it difficult to squat with accompanying handrail for rope or handle, and also higher if to be used for laundry, to reduce the amount the person doing the laundry has to bend over when undertaking it. Women and older people and people who find it difficult to squat must be consulted when developing standard designs for improving the facilities.

Table 6 - Examples of considerations for improvement of current WASH facility arrangements (table 1 of 3)

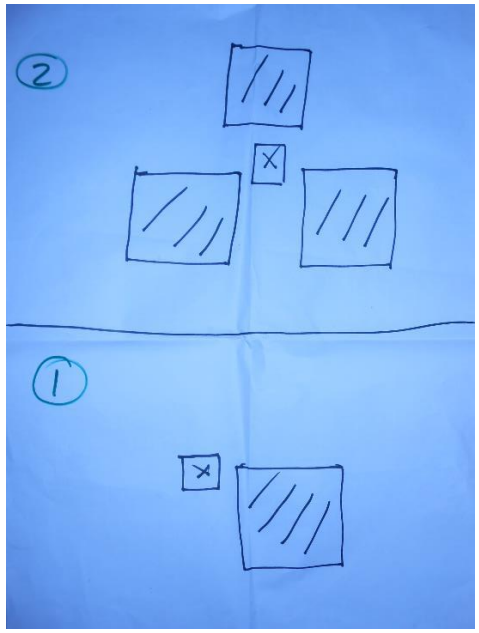
	Images used during discussions to debate on particular options	Possible positive features	Challenges / possible negative features
1	 This image just represents the principle of: 1) having one toilet or bathing facility per household; or 2) having the same but shared between three households. The facilities may also be inside the house or attached to a house.	• Having one toilet and one bathing facility for each household is seen as the best option. It benefits women and girls, children, people with disabilities, older people and people from minority groups. • Less distance to reach facilities • The household can be responsible for cleaning and minor maintenance	• This would require more space than is possible in some of the camps (restricted by space and geographical conditions) • It would require more resources and skills for construction and materials • More pits would require emptying and hence need access (although they would fill up slower)
2		• Having one toilet and bathroom shared by three households, is seen as the second-best option • It is believed that having three families sharing facilities would be accepted, but once it goes above this then sharing becomes more challenging • Less distance to reach facilities • The households can be responsible for cleaning and minor maintenance	• This would require more space than is possible in some of the camps (restricted by space and geographical conditions) • It would require more resources and skills for construction materials and construction • More pits would require emptying and hence need access (although they would fill up slower) • This arrangement would still require a level of collaboration for cleaning and use between families

Table 7 - Examples of considerations for improvement of current WASH facility arrangements (table 2 of 3)

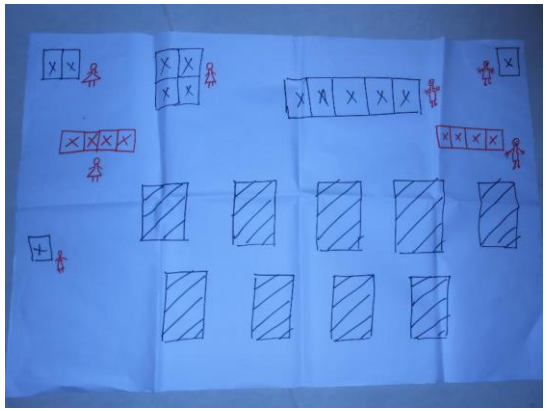
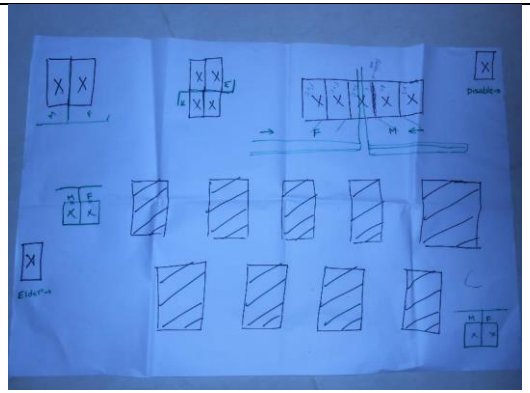
	Images used during discussions to debate on particular options	Possible positive features	Challenges / possible negative features
3		• Re-allocating the existing units to make whole blocks either male or female, or constructing new only male or female blocks in different locations could partly respond to the requests for gender-segregation of the facilities • Specific or single units could also be adapted and allocated for men or women who face mobility difficulties / older people	• Separating the blocks so that women and men have to go to separate locations for using the toilet and bathing facilities, would mean they would have to walk longer distances to reach the facilities • When they walk to the facilities, they would still have to pass people of the opposite sex which could still make some women and girls uncomfortable • If the units adapted for people who face mobility challenges are far from their shelters, this could also pose difficulties
4	 This image represents the use of screens. The actual arrangement for the screens and how far they cover the entrance and building would require thought and discussion in each location	• Splitting existing blocks into both male and female units, but adding some form of screen to ensure that the entrances are separated and to allow males and females to be separate when queuing, could help some women and girls feel more secure	• When they walk to the facilities, they would still have to pass people of the opposite sex on the way to reach the facilities, which could still make some women and girls uncomfortable • The screens would need to be of a solid material and placed in such a way that it increases the feelings of safety for women and girls. Care must be taken to ensure that adding screens does not end up enclosing both males and females behind the same screen, which could add to the feelings of insecurity

Table 8 - Examples of considerations for improvement of current WASH facility arrangements (table 3 of 3)

	Possible adaptations	Possible positive features	Challenges / possible negative features
5	**Adaptations for accessibility:** • In all bathing facilities add a raised platform that can be used as a seat and add either a handrail near to the seat or a rope with handle for people to hold on to when sitting or standing • Ensure that toilet units have enough space to allow a commode chair to be moved on and off of the unit • Ensure that there is a water supply within the squat hole • For specific individuals – consider other adaptations in response to their particular impairment – such as adding a permanent seat; handrails to access, rough paths or curbs for cues for people with sight impairments, ramps etc	• Adaptations to improve accessibility could be useful for older people, people with disabilities or who have injuries and for some heavily pregnant women • If facilities are designed for specific users this is even better, as they can be designed to respond to the individual's specific impairment	• For communal facilities, there will need to be consideration of both people who have impairments and others • A rope would need to be fixed securely • Care would be needed that a person with an impairment will not need to walk too far to the facility • Some accessibility features can be built incorrectly – for example globally there are many examples of ramps that have been built that are too steep which can be dangerous
6	**Other adaptations to help improve the privacy, security and usability of the toilets and bathing facilities:** • Check the internal locks are functioning • Check the walls and doors are solid and there are no gaps • Add hooks (or a rail) and a shelf for clothes and items such as soap or menstrual products when manipulating clothes • Add a medium length mirror in bathing facilities for dignity and to enable female users to check for menstrual stains • Add a clothing line inside the bathing space • Make the units pleasant to use through paintings or plants	• These are minor adaptations that can make the facilities more user-friendly and offer dignity and increased feelings of security • Making the units pleasant to use through painting murals or plants can also lift spirits and contribute to well-being	• No negative aspects – all costs are minor, except for making walls and doors solid (but this has already been incorporated into the unified designs) _____ (note that the IFRC have a partnership with "Artolution" and have already started supporting communities with murals on latrine blocks)

Specific consultations undertaken to-date and shared with the sector – The following are also three examples of some of the specific consultations that have been undertaken:

- 'Women's Social Architecture Project (Pt 1)[90] – Discussions organised by OXFAM with the engagement of female architecture students who facilitated 38 women to discuss options for possible designs for communal facilities, as well as options for upgrading the existing arrangements. They also discussed innovative solutions such as the use of Tiger Worms for sanitation, the use of and urine-powered lighting. This process and document have provided a range of useful ideas for building on and utilising in the start of other consultations across the camps.
- UNHCR Protection, Shelter and WASH[91] –
    - Consultations were held on the arrangements for possible household and toilet facilities if space permits. This process involved both a household survey (449 respondents in 3 camps) and FGDs (2 for women, 2 for men). This included whether they should be within the shelters, attached to them or stand-alone, and whether the entrance doors to each should come from inside the shelters or outside. The findings of the household survey indicated that the overall preference (92.5%) was for facilities to either be (A) in the shelter, or (B) attached to the shelter, but only the shower entrance to come from inside the shelter. The majority of women (72%) preferred the option B.
    - One UNHCR respondent noted that later the discussions were continued and that people were more open to also having the toilet opening into the shelter, as long as it didn't take away space from inside the shelter. It was also shared that with the decongestion processes being planned over the coming few years, that UNHCR intends to only support household toilet and bathing facilities. The process is likely to last a number of years. The decongestion process aims to increase the number of access ways / roads through the camps and to move people from the more congested areas (such as the East of the Ukhia camp) to the lesser congested areas (such as the West of the Ukhia camp).
- Consultations by the GBV Sub-sector (CARE, PULSE & PIN)[92] – Consultations were held on preferences of women and girls regarding bathing facilities. This was undertaken with participants from 5 camps and three host communities, through 5 FGDs with adolescent girls and women of different ages:
    - They initially concluded that women and girls preferred communal bathing spaces and that sex segregated latrines should be further from each other, with the distance from home being a less critical issue than sex segregation. They also noted that it was requested that a separate water point or water tanks should be provided for women to enable them to practice *Purdah*.

[90] Farrington, M (2018) *Women's Social Architecture Project: Phase 1 Final Report, OXFAM Rohingya Response, Cox's Bazaar,* September 2018
[91] UNHCR (2018) *Refugee Preference for Location of Bathing Spaces and Toilets*, UNHCR Protection, Shelter, WASH Cox's Bazar, October 2018
[92] Consultations by the GBV Sub-sector (CARE, PULSE & PIN) – on preferences of women and girls regarding bathing facilities, October 2018

- Later it was reported that the team revisited the women and re-discussed the preference for communal bathing facilities. At this time, the women said that they had only asked for communal facilities previously, because they did not think that household ones would be possible. But if there was an option, they would prefer household facilities.

A number of guidance materials have also been prepared that include information on good practice (checklists, minimum standards etc). See **Section 6.2** for more information.

The figure below provides an overview of the recommended changes to the toilets and bathing facilities to respond to:

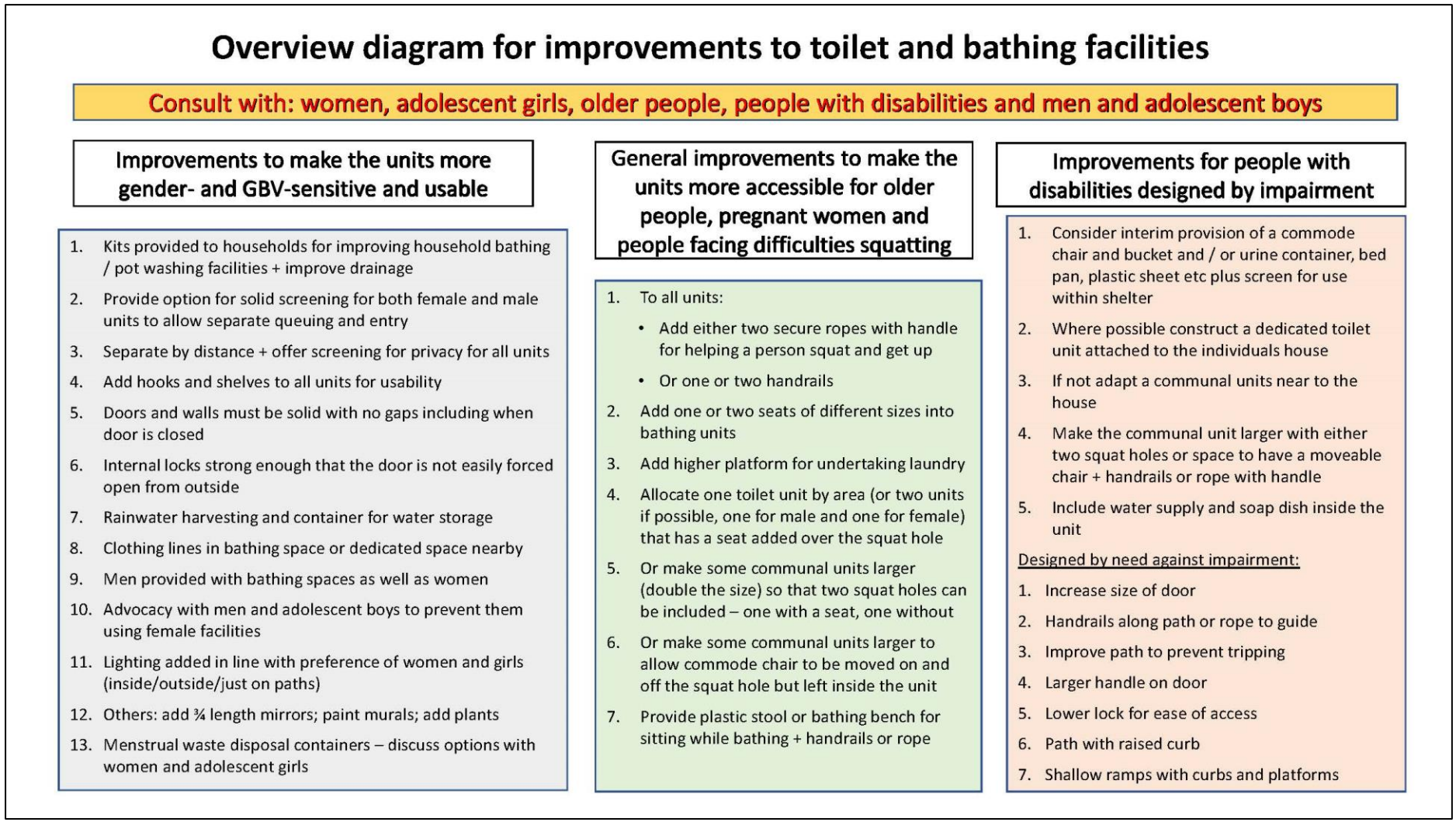
- Improvements to make the units more gender- and GBV-sensitive and usable
- General improvements to make the units more accessible for older people, pregnant women and people facing difficulties squatting
- Improvements for people with disabilities designed by impairment.

5.3.3 Cleaning and maintenance

Most cleaning of communal WASH facilities is being undertaken by teams of community volunteers paid small allowances for their work. This is a sensible solution for the cleaning and minor maintenance of communal WASH facilities; as global experience is that communal facilities have always proven difficult to manage if left to households to manage on their own. However, some actors have noted that some community members have already been repairing some of their facilities, including handpumps, and there have been some requests for tools to be distributed to facilitate this process. But their ability to take on such tasks will probably depend on skills within particular community groups and the level of community cohesion of the users of the different facilities.

One of the big benefits of having household facilities, or facilities used by a maximum of three families, is that they can more easily be cleaned and maintained by the households themselves, which will be easier to manage over the longer term. The exception to this will be the desludging, which is likely to still require support from outside actors, as well as issues such as major repairs or strengthening against landslides. The proposal for three families maximum to share facilities, came up from three different sources: the Social Architecture study, some UNHCR consultations and some consultations undertaken under this audit process.

Fig 3 - Overview of suggested improvements for the toilets and bathing facilities



5.3.4 Feedback

Routes for feedback - Various routes have already been established for people to provide their feedback or complaints. These include through:

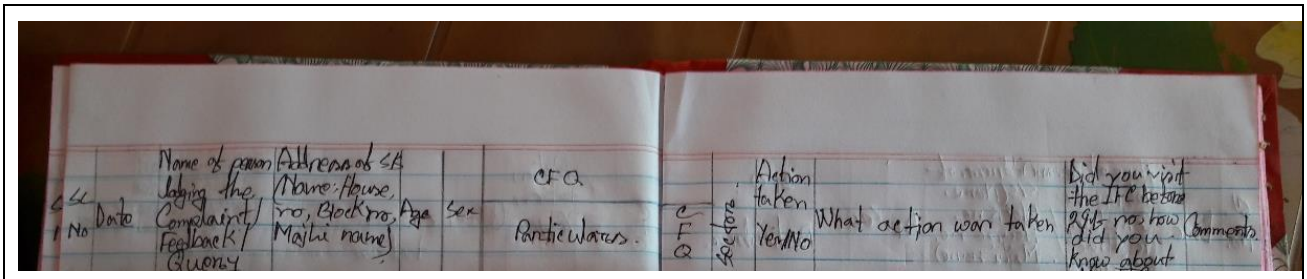
- Site management volunteers
- Information centres (multiple – across agencies)
- Community mobilisation volunteers (female + male)
- The *Majhi* system (mostly male)
- HP volunteers (female + male)

A camp WASH focal agency representative, explained how they are receiving feedback from various of the channels above, and the audit team saw both men and women (together, probably related) visiting information centres. It is clear that different people are likely to have different levels of confidence to feedback and have information on how to do so, and some would probably need pro-active consultation / encouragement to do so. An open consultation by BBC media action[93] highlighted the lack of knowledge of some of the people affected by the emergency as to where to go to feedback.

Feedback record keeping and information on good and bad practices - An example of a feedback record book used in an information centre is shown below, along with a poster from another agency highlighting feedback mechanisms and good and bad practices for distributions. The feedback book has a column for actions taken, but this relates to the information having been passed on to someone else to act, rather than the issue having been resolved. However, the fact that the information centre and feedback book exist and WASH related complaints were seen to be clearly included in them, are very positive steps.

Through discussion with a few implementing agencies, it is clear that not all WASH agencies seem to be keeping records of the complaints given to them. Some have records, but no record of when the complaint or request has been resolved. One agency met did not seem to keep any record of the complaints made. This is an area that needs improvement and the resulting actions should be monitored. Also, the computer system that records all of the feedback from the UNICEF C4D supported feedback centres, had been down for some weeks with the back-up also damaged, which indicates how vulnerable the information is. A process is underway to retrieve the information.

[93] BBC Media Action (2018) *What Matters? Humanitarian Feedback Bulletin on Rohingya Response*, Issue 12, Weds, Oct 03, 2018



Above:

This is an example of a feedback record keeping document in an information centre managed by The Bangladesh Institute of Theatre Arts (BITA) with support of UNICEF. It includes a column on action taken, but this would tend to stop at the information being passed on, rather than the action necessarily having been resolved.

To the left:

This is an example of a poster from Save the Children, put up next to a distribution centre in Camp 11. It provides a contact number and some images and text on acceptable and unacceptable practices.

6. Findings and discussion – capacities, coordination, strategic, institutions

6.1 Capacities, commitment, confidence, leadership and pride

Key learning from this section:

1. Whilst there has been progress in some areas and the WASH situation has continued to improve over time, the clear gaps in the consideration of the needs of various different people in this response, highlight a significant need for building capacity, confidence, commitment, leadership and accountability systems at all levels to respond to gender, GBV and inclusion.
2. Many reasons have been given as to the inaction to-date in considering gender, GBV and inclusion, which has resulted in many of the most vulnerable people within the affected communities struggling with managing their WASH needs.
3. See the table (in **Section 6.1.2**) which provides an overview of the different levels of understanding, commitment and leadership on gender, GBV and inclusion issues – which is applicable globally and also the range also seen in this response.
4. There is a need to build capacity, confidence, commitment, leadership and pride in WASH sector actors across all agencies and across all levels. This includes from the senior level in the sector to the people working on the front line directly with the communities.
5. Capacities of staff in both international and local organisations need to be built, with priorities focussing on people who will be in position for longer periods of time.
6. There are particular opportunities for capacity building of the DPHE teams across all offices including the many engineers, and also the 22 engineers currently under recruitment to work with the RRRC.
7. Capacities need to be built at scale on issues such as why considering these issues are very important, how to do effective consultations and on how to design gender- GBV and accessible WASH facilities.
8. Capacity building needs to be varied – with priorities on participatory activities to provide the "ah ha" or "lightbulb" moments; the development of standard operating procedures; reviewing the existing tools; updating the unified designs; development of simplified guidelines and tools; workshops and on-the job trainings; and strengthening the M&E framework.
9. Funding from the Swiss Development Cooperation (SDC) could be a useful opportunity to build capacity at sectoral level and to provide on-going leadership support in these areas.
10. Capacity building needs to be in the main language of the trainees and repeated over time to respond to the turnover of staff.

6.1.1 Building the enabling environment and pride

Whilst there has been some progress in some areas and the WASH situation has continued to improve over time, the clear gaps in the consideration of the needs of various different people in this response, highlight a significant need for capacity building at all levels. But it is not just capacity building. It is also a need for building leadership and commitment and confidence in being able to respond effectively to these issues. There needs to be a move to encouraging a sense of pride when the WASH sector actors effectively respond to the needs of all groups within the affected communities; including in particular those with less opportunity to express their needs and who face greater difficulty in accessing WASH facilities and managing their WASH needs. And conversely to encourage an environment where it becomes unacceptable (and shameful) for WASH professionals to continue to ignore the needs of some of the most vulnerable people within the affected communities. This section and those which follow, identify and discuss issues that will affect this process going forward.

6.1.2 Commitment

Various people met expressed concern at the general lack of attention on the areas of gender, GBV and inclusion. A few examples of what was said to explain these gaps are included below.

Concern over the lack of attention on gender, GBV and inclusion

"The sector is not taking it seriously – they are being really dismissive and not being challenged"

"During a UNICEF retreat for staff, I recommended that one of each block of toilets should be accessible – it was not taken up"

"No-one is consulting with people with disabilities or including them in FGDs or obtaining feedback"

"Not much has been considered on the issue of vulnerability"

"Much is said at the table… but not much is done in the field"

"Knowledge and capacity is missing from high to lower levels"

See the table which follows, which provides an overview of the different levels of understanding, commitment and leadership related to gender, GBV and inclusion issues. There are clearly a few individuals within the sector who have provided leadership in the sector and are highly committed to improving in these areas and in particular to make sure that the facilities better meet the needs of women and girls (at level 6). This effort has mostly led by actors working from the Hygiene Promotion sub-sector and with support of actors from the Protection and GBV Sectors. During the audit process, a few people were also seen in the 3, 4 and 5 levels, but from the significant gaps in the response, it appears that many people were still at the 1 or 2 levels. By the second trip, it was clear that change was happening and a few others are coming forward as leaders (so moving at least into the level 5) with clearer increased commitment from both the sanitation and water sub-sectors.

Table 9 - Scale for understanding, commitment and leadership – on gender, GBV and inclusion issues

Scale for understanding, commitment and leadership - on gender, GBV and inclusion issues

1	2	3	4	5	6
No commitment	**No commitment**	**Some but limited commitment**	**Committed but unsure how to act**	**Commitment and increasing leadership and action**	**Strong commitment, leadership and action**
• Not aware of issues	• Aware of some of the issues • Not really interested • Doesn't feel the issues are important • Does not believe the issues are their own responsibility • Finds it irritating when others try to discuss issues • Defensive when others try to discuss on gaps or areas needing to improve	• Aware of some of the issues • Know that they are expected to act by organisational or donor requirements (policies, strategies, accountability frameworks, etc) • Supports some activities but tends to do the minimum needed to get the gender actors and line managers off their backs • Does not prioritise over other issues / deprioritises attention on these issues easily – leading to actions on these issues dropping to the bottom of the pile • Susceptible to being defensive when others try to discuss on gaps or areas needing to improve	• Becoming more aware of the issues • Starting to have compassion and empathy for the people affected • More aware of organisational commitments to respond (policies, strategies, accountability framework) • Wants to act but not sure how to • Interested to build their own capacity • Open to discussions on gaps in programmes and to find ways forward • Happy to work with gender, GBV, inclusion specialists and to learn from them how to improve	• Increasingly aware of the issues • Has compassion and empathy for the people affected • Tries to act and improve within their own sphere of work • Interested to build own capacity and to support opportunities for colleagues to also learn and build their capacities • Open to discussions on gaps in programmes and activities and keen to find ways forward, at least at small scale at first • Happy to work with gender, GBV, inclusion specialists and to learn from them how to improve • Aware of and agree with accountability requirements of organisations to respond to these issues • Not yet fully confident as to how to deal with negative backlash or attitudes that are often faced when providing leadership in these areas	• Understands in detail the implications for some of the poorest and most vulnerable people • Has compassion and empathy for their situation and understands our role in improving the situation • Determined to make positive change happen, including at scale • Makes pro-active efforts to increase capacity, awareness, action and encourage change • Prepared to deal with negative backlash or attitudes to encourage change at scale • Encourages others to act • For some people this is core to their ToRs (for example Gender, GBV and / or Inclusion Advisors)

Multiple reasons were also given (or excuses depending on your perspective) as to why gender, GBV and inclusion have not widely been effectively considered in this response. See the box which follows.

Reasons given for inaction on considering gender, GBV and inclusion

- *"It was a massive influx so was overwhelming";*
- *"There has been no time to do this as we are too busy";*
- *"We need to support the majority first";*
- *"We will only do it when we have time";*
- *"It's too expensive";*
- *"The people self-settled and there is not enough space";*
- *"We have to use the unified designs which do not consider these aspects";*
- *"Our organisation has too difficult bureaucratic processes, so it feels too difficult to revise proposals and it takes time to get partner on board";*
- *"We don't have the technical knowledge";*
- *"If the donors insist then it will get done" [and hence by implication if they don't, we won't do it].*

From the positive reactions of most people who engaged in the CXB level focussed activities during the second trip, it is also expected that more people from these groups have now started to move up the scale, particularly from the 1 or 2 levels to the 3 or 4 levels and maybe a few to the 5 or 6 levels. It is also possible however, that some will have remained at their previous level of understanding, commitment and leadership.

6.1.3 WASH sector leadership and coordination

Leadership – It is clear that along the way a number of efforts have been made to integrate strategies to respond to gender, GBV and inclusion. This can be seen from the consultations attempted in relation to the 'army latrines', the existing WASH sector strategy (March - Dec 2018) and the development of the latrine and bathing checklists and minimum standards. However, a clear gap can be seen in the commitment and leadership from the WASH sector at senior levels to make sure that these issues are kept on the agenda and integrated into all response efforts. This is evidenced by sectoral discussions where these issues only seem to be mentioned when specific champions raise them; and sector presentations, documents and plans that still only consider these issues, as a 'tack on' the end or a single sentence mentioning the words "community consultation".

Responding to these issues is not difficult when they are integral to all actions and considered as part of each stage of the process, as required under the global "5 Minimum Commitments". It is more about mindset, about caring about people including people who face more difficulties than others; and prioritising to ensure that all people are treated as equal human beings with a right to

be able to access and practice WASH with dignity and in safety. It is also about understanding that people are not a homogenous group and have different needs, vulnerabilities and strengths.

The sector leadership needs to move from considering that this is someone else's job, such as a few leading hygiene promotion experts, to taking ownership, to also raising the issues themselves and challenging their teams and partners working across the three sub-sectors, when the issues are not being discussed and dealt with. The issues need to be on the agenda as a standard item with requests for updates requested on a regular basis.

Co-ordination - The following table provides initial observations on the different levels of engagement of the three sub TWGs in the WASH sector in the issues of gender, GBV and inclusion.

Table 10 - WASH sector technical working groups at CXB level

TWG	Initial observations on engagement in gender, GBV and inclusion issues
Water TWG	The audit team did not attend a meeting of the water TWG or engage directly with the leadership of this group during the initial visit to CXB. But from observing a draft of the water master plan, from information from various sector actors, and hearing reports at the WASH sector coordination meeting level, this seemed initially to be the TWG that seemed to be the furthest behind in terms of taking ownership of these issues. However, discussions and engagement with the Water TWG leadership and members during the second visit, indicated that there was increasing interest and commitment to respond to these issues, which was very positive. Critical issues include those related to accessibility, drainage, and gender, age, disability related issues around usage and safety at water points. As has been discussed elsewhere in the report, these are critical issues, particularly at the time of master planning and must not be left to last at the end of the process. A positive community consultation process has been developed as part of the Master Planning process. It has some clear strengths, but could also be strengthened further in a few areas and will need to be implemented in all areas with budget availability to be effective (see **Section 5.2.5**).
Sanitation TWG	There have also been gaps observed in discussions at TWG level and a presentation related to the sanitation master planning also just had 'community consultation' as a last mention at the end. However, the existing strategy has a number of positive recommendations related to sanitation and there have also been a number of presentations that have been given in this TWG over the past few months that have focussed on gender, GBV or inclusion related issues. There is also an increased focus by the leadership at coordination level and a move to more pro-actively integrate these issues into the sanitation component of the sector strategy currently under development. The first draft of the WASH facilities section of the new strategy /

	roadmap may end up making this sub-sector the strongest of the three going forward. This is very positive.
Hygiene TWG	The hygiene promotion TWG had taken most of the leadership on trying to get gender and in particular the needs of women and girls considered in the response. A number of initiatives have come from this TWG with the support of its leadership and other key actors. These include: the formation of an informal cross-sectoral working group on MHM; the formation of the HP CFT which has started to build capacity and share ideas on how to strengthen HP and community engagement; and the leadership on the 'Women's Social Architecture Project (Pt 1)'. The HP section of the existing WASH sector strategy, was also the strongest in this regard. However, until relatively recently issues related to inclusion, were also not high on the agenda of the HP TWG; although like the sanitation TWG, this issue is now being given more attention which is very positive. One of the risks for the HP TWG members at all levels is that other actors, including in particular those responsible for construction, will not themselves internalise the issues, but see the consideration of gender, GBV and inclusion as only the responsibility of the HP actors. Gender, GBV and inclusion seem to have been commonly seen as 'HP issues' - this needs to change.

Building capacity of the DPHE team at all levels and the RRRC – Building capacity of the DPHE technical teams at all levels and the key RRRC representatives who make decisions on WASH sector actions, would also be positive for facilitating a sector wide change. It is understood that the DPHE technical teams at different levels have not previously had the opportunity to be trained on these issues, but that some have been learning on the job and picking up things as they go along. There are 8 sub-district teams, each with an engineer and also 5-6 other staff. It is understood that there would be some interest in having the opportunity for such capacity building.

RRRC approvals through the "List of prioritised items and services to include as emergency relief (FD-7/6) – This list is drawn up periodically and is used as the basis for approvals for the work of NGOs in the Rohingya response. It will be very important to get the modifications to the existing WASH facilities, integrated into this list, if the NGO partners are to be given approval for undertaking this work in the response.

Swiss Development Corporation (SDC) supported technical unit – The SDC are supporting the DPHE with a technical unit to help respond to technical gaps in the response. It is possible that they may be able to consider providing technical support in terms of advice on gender, GBV or inclusion related issues, if the type of support is clearly identified as a need and agreed by the DPHE. This could include trainings or other form of support.

6.1.4 Building capacities and confidence

Capacity and confidence to act - Part of the reason for a lack of commitment and action is related to people's knowledge, capacity and confidence to act. There is a significant need for capacity, commitment, confidence and pride building at all levels. As is also common within the WASH sector, capacity building is also needed at senior levels, as well as at mid and field levels. It is sometimes assumed that just because staff have been around for some years that they will automatically know about these issues and how to translate the principles into action. But it is often not the case, particularly if they have not had, or made their own opportunities to learn, including by doing, in the past. This capacity and confidence gap at senior level has a knock-on effect across the whole response. Hence senior staff are encouraged to also be honest as possible about the areas they need support on, and where they need to build their own capacities.

The table which follows provides a summary of what are considered the priority areas for capacity building support for different actors.

Table 11 - Priorities for capacity building for different stakeholders

	Stakeholder	Priority areas for focus of capacity building
1	**Sector leadership: WASH sector coordinators; DPHE; RRRC; AFA WASH leads; Water, Sanitation and HP TWG coordinators; CiCs; Camp WASH Focal Points; Donors**	To build confidence, commitment and accountability, including to leading the sector to keep these issues at the forefront and core to all work. Without strong leadership at this level to keep these issues central to the agenda, nothing will change. How to also strengthen requirements from sector partners and methods of enforcement and encouragement to ensure these issues are considered and all are acting accountably to the people who face more vulnerabilities in the communities. To institutionalise these commitments.
2	**Technical specialists from AFAs, NGOs at CXB level and leads from DPHE sub-offices: Water, Sanitation and HP; the EIMS team; as well as site planners, protection, health, education and camp management specialists**	To build confidence and commitment and technical knowledge, as this is the group of professionals designing programme interventions and establishing budgets, supporting capacity building for the professionals working at field level and monitoring interventions. Building the capacity of the DPHE team at all levels will be particularly important and will offer secondary longer-term benefits, considering that many are based in CXB and work for the Government of Bangladesh for the longer term. Plus training on MHM and how to do rapid appraisals or action research for quick assessments of the situation and analysis of people's needs. To institutionalise these commitments.

3	**Senior leadership in AFAs outside of WASH (such as emergency programme managers, programme directors)**	To build knowledge and commitment to be able to recognise gender / gender equality, GBV and inclusion issues - making sure that they provide appropriate leadership to the staff they manage and they also pro-actively require action on these areas.
4	**Field engineers, community development and HP specialists including the HP CFT members, army professionals**	To build capacity, confidence and pride of this group of actors, as these are the people who will be leading the actions at camp and community levels. They will be supervising the community volunteers and engaging with the community to undertake consultations and decide on changes to facilities and services. Plus training on MHM and how to do rapid appraisals or action research for quick assessments of the situation and analysis of people's needs.
5	**Contractors, site management teams, hygiene promotion volunteers and cleaning volunteers**	To build capacity and confidence in how to engage with and consult with different groups of people within the community, including people with disabilities and older people, and how to be respectful and encourage them to provide feedback and request support. To build the capacities of contractors to be able to build accessible WASH facilities.
6	***Majhis*, imams, *Hafes*[94], traditional birth attendants and other female leaders within communities**	To build their capacity to consider the needs of different people within the communities and how to support them to provide feedback and request support.
7	**For all**	How to identify gender, GBV or inclusion issues, so they will act in a sensitive manner. To ensure that all are aware of appropriate behaviours when engaging with community members and with other professionals and actors; the code of conduct; the prevention of GBV, PSEA and the basics of GBV referral systems.

The major challenges in relation to capacity building are:

1. The scale of the response
2. The wide range of organisations and individuals working on the response at a range of different levels

[94] Men and women who have completely memorised the Qur'an

3. The complexity of the supervisory structure and multiple lead agencies at different levels
4. The turnover of professionals
5. The need to be able to use best judgement on some issues and to be flexible – as it's not always possible to always just replicate the same standard actions
6. The need to build capacity across sectors on issues that are influenced or linked to different sectors work (such as protection, GBV and gender equality)
7. Due to the cross-sectoral nature of the issues, there can also be the risk that people think / assume these issues are someone else's responsibility, particularly when line managers are not emphasising that these issues are everyone's responsibility and requiring action

Capacity of local and international organisations – There are clearly different strengths of national and international organisations working on the response. A weakness of the international organisations and staff is often the turnover of key international staff, who tend to be in management or leadership positions and the time it takes new staff to get up to speed with understanding the context. There is a degree of 're-inventing the wheel' each time new international or national staff arrive to work on the response. Also, in some cases, international organisations have been seen to not bring in international or even national expertise to support their teams in CXB. Staff engaged in CXB may also have limited broader humanitarian experience and technical weaknesses. National organisations tend to be stronger in some aspects due to their knowledge of the working, cultural and language context in the area and Bangladesh, but may have additional capacity building needs, particularly if most of their staff are new to working in the humanitarian context, or are newly graduated students with no hands-on experience or previous knowledge of development or emergency work.

BRAC, as the world's largest NGO and a significant leader in Bangladesh, has clearly engaged at scale in a wide range of roles in this response and has contributed a significant amount to the lives of the Rohingya people and services being provided. But various actors have also highlighted some significant gaps in their capacity, which has impacted on the quality of some responses (although other reports note that they are relatively better than others). Because of the value of their contributions, not just to this response, but also to future humanitarian responses in Bangladesh and the scale of their responses, it is recommended that particular resources are dedicated to providing them with solid capacity building support in these areas. This is in addition to the general capacity building support provided to all actors.

Approaches for capacity building - Discussions with sector stakeholders on what they felt would be useful and from the audit team's own experience and observations, it is suggested that the approaches for capacity building will need to be varied, comprehensive and sustained over time. This will be needed if the principles are to become institutionalised and the turnover of staff effectively responded to. It is also recommended that capacity building should provide tangible,

practical guidance in simple language, all of which will be particularly important for the engineering and associated technical staff.

The following approaches are proposed in order of priority as a starting point for capacity building efforts:

1. Participatory activities and training activities to provide the “ah ha” or “lightbulb” moment. This is where professionals start to recognise the importance of considering these issues and the implications of not doing so and hence build commitment for action. This includes through direct engagement with people who face more difficulty in managing their WASH.
2. Development of standard operating procedures (SOPs) for undertaking specific tasks – such as consultations with varied community groups and establishing practical solutions.
3. Review the bathing and toilet facility checklists to update them to include inclusion and check they align with the new SOPs.
4. Updating of the unified toilet and bathing facility designs and prepare additional ones to support water point consultation and design and laundry and pot washing facilities. These should incorporate gender, GBV and accessibility considerations. Associated government directives would also need to be issued to support their effective roll-out at scale.
5. Development of simple guidelines including in pictures.
6. Practical exercises such as accessibility and safety audits; peer to peer experience sharing; and mentoring.
7. Workshop and on-the job trainings.
8. Building capacity on how to do rapid appraisals or action research for quick assessments of the situation and analysis of people’s needs.
9. Development of checklists (including specifically highlighting the different practical solutions which can respond to each of the gender, GBV and inclusion related issues).
10. Development of a clear accountability framework, sex, age and disability monitoring indicators and an M&E framework with clear gender, GBV and inclusion related indicators.

6.2 Sector strategies, guidance, assessments, studies, monitoring & learning

Key lessons from this section:

1. Gender and GBV had already been integrated into some WASH sector strategies, guidance and tools reviewed at the time of the initial audit, but the guidance was not generally being followed. Inclusion of people with disabilities and older people were generally overlooked. There appears to be increased attention on these issues, particularly inclusion and accessibility in some of the strategies and roadmaps currently being written (Feb 2019).
2. There has been an increase in attention on gender and GBV related issues in various studies, in recent months following the one-year-on mark. Attention on people with disabilities and older people and people facing other additional vulnerabilities has still been lacking.
3. Sector-wide on-going monitoring by the REACH team has been improving over time from the perspective of gender and GBV, with increased disaggregation of information and useful consideration of issues such as feelings of safety when using the facilities. Consideration of the opinions and needs of people with disabilities and older people are still gaps.
4. There is an increase of requirement from the GiHA group to strengthen the focus on gender- and age-segregated data. The attention on strengthening the information on people with disabilities is still lacking.
5. There has been a number of learning activities across the sector and cross-sectorally that relate particularly to gender and GBV. This includes in particular the 'Women's Social Architecture' project study; studies by UNHCR and others related to household or communal facilities; and a few studies by UNICEF and Save the Children related to children.
6. Within the WASH sector there had been very little learning undertaken in relation to people with disabilities and older people, but HelpAge and Handicap International have undertaken broader studies that include WASH components. More recently there has been a bit of increased attention on the needs to improve in the area of accessibility, with some accessibility audits (such as by the Centre for Disability and Development / CBM and OXFAM) and some action learning (such as by the British Red Cross).
7. There is a need to reflect on the monitoring indicators at each level, to check how well they consider gender, GBV and inclusion related issues.

6.2.1 Sector strategies and guidance

Some efforts have been put into trying to in particular integrate gender and GBV into sector strategic documents, sometimes with the support and guidance of specialists across sectors, and in particular, from GBV and gender specialists. A few examples exist where considerations have been integrated related to inclusion and accessibility in a meaningful way, but these are less. Examples of where considerations have been made in key documents are included in the table which follows.

As can be seen from the table, there are a number of examples of good efforts, in some cases very good efforts, to integrate some of these issues into these strategic and guidance documents. But there is less evidence that these are being used or followed by agencies working on the response. A more detailed analysis of these same sectoral documents can also be found in **Annex VI**.

The current opportunity where the sector strategy is being updated to strengthen in a number of components, combined by a concerted capacity building effort at different levels are very positive for improving the situation moving forward.

Table 12 - Mentions of gender, GBV and inclusion in key strategic / guidance documents

	Strategy or guidance document	Observation / comment
1	**Government of the People's Republic of Bangladesh, Ministry of Local Government Rural Development & Cooperatives, DPHE and Department of Disaster Management (2017)** ***Operational Guidelines for WASH in Emergencies – Bangladesh, Second edition, 2017*****, WASH Cluster**	Includes guidance on consultation with different groups. Includes guidance including images on simple improvements for accessibility and also considers the needs of different groups of people, including people with disabilities and people who are chronically ill. Includes some recommendations related to MHM and also some forward-thinking ones related to incontinence, including for male survivors of GBV.
2	**Strategic Executive Group and partners (2018)** ***Joint Response Plan (JRP) for the Rohingya Humanitarian Crisis, March–December 2018***	Includes some observations on the challenges related to WASH facilities for different groups of people. It includes a couple of small mentions on inclusion / accessibility, but pays a bit more attention to the needs of women and girls and issues around gender segregation, privacy and safety. States the WASH sector partners need to reaffirm their commitment to implement the global '5 Minimum Commitments for Dignity and Safety'.
3	**Government of the People's Republic of Bangladesh, Office of Refugee Relief and Repatriation Commissioner (RRRC) Cox's Bazar (2018)** ***Unified/standard design for latrines in Rohingya settlements - BofQs***	Includes some improvements to previous designs with solid walls and doors, more space, no gaps, a solid roof and a solid sub-structure. These are positive, but the improvements miss other usability features, such as options that may improve privacy, such as screening and also accessibility features.
4	**WASH Sector Cox's Bazar (2018)** ***WASH Sector Strategy for Rohingyas Influx, March to December 2018***	This sector strategy covers a range of key issues, particularly in the HP and sanitation sections, with the water supply section only having a minor mention. Includes a commitment to increased community consultation, a focus on the disposal of

		children's faeces and on MHM. It specifies a need to identify people with disabilities. It also discusses support for household facilities or facilities shared only by three families as priorities.
5	**WASH Sector Cox's Bazar (2018)** ***Minimum requirement for Rohingya response,*** **April 2018**	This document is strong in most areas - focussing on: the global '5 Minimum Commitments'; dialogue with the community; gender and age sensitive post-distribution monitoring; child faeces; water points designed for different people; the need to consult with women and girls; and the need to identify specific needs including for people confined to bed or using a wheelchair.
6	**WASH Sector (June 2018)** ***Bathing facility checklist to ensure minimum level of privacy and safety*** **WASH Sector (June 2018)** ***Latrine checklist to ensure minimum level of privacy and safety***	These are well constructed and simple documents with simple actions summaries in one page each. They are strong on consultation with women and girls and on possible design options related to privacy, dignity and safety for women and girls. They are however weak on issues related to inclusion and accessibility and could be more direct about the need to involve men and boys as well to encourage them to not use the facilities for women and girls.
7	**UNICEF Bangladesh Cox's Bazaar (2018)** ***UNICEF WASH Gender and GBV Integration Strategy, July – December 2018***	This is an example of a Gender and GBV strategy for one AFA – UNICEF. This was developed through collaboration between WASH and Gender Based Violence in Emergencies (GBViE) specialists. It is a strong document with practical actions identified to strengthen GBV and gender in the work of UNICEF and partners. It is weaker on issues related to inclusion. The team have progressed with a number of the actions identified, including this audit and capacity development assessment.
8	**ISCG (2018)** ***WASH Sector + Site Management Sector + Protection Sector + Shelter/NFI Sector – Joint Response Plan (JRP) – Project Portfolios, Guidance Note for Gender and Protection Mainstreaming***	These are simple one-page guidance notes prepared for each sector by the ISCG GenCap Advisor, the GiHA WG and Protection Sector teams. They focus on the 4 key elements of protection mainstreaming and focus on issues such as consultation, prioritising safety and dignity, doing no harm, feedback and complaints and participation and empowerment.

6.2.2 Assessments and studies

Gender and GBV focussed studies - As the Rohingya response has progressed, an increasing number of assessments and studies have focussed on issues related to gender and GBV, and in particular on the needs of women and girls. Two significant gender studies were published around the one-year mark of the onset of the displacement of the Rohingya people from Myanmar. One an overview gender analysis of the response, which was undertaken by Action Against Hunger, Save the Children and OXFAM[95] and the other by OXFAM[96]. Both have been referenced within this audit and include a wide range of useful information on gender issues and GBV, including a range that specifically relate to WASH. In particular the Gender Analysis one has asked some detailed questions on feelings of safety when using WASH facilities and the reasons for their responses. This information could potentially be very useful, but the way it has been presented sadly limits it's use as the findings are not clear. This has already been discussed in **Section 5.1.3**.

Specific assessments and studies looking at WASH that have considered gender and GBV related issues – Likewise there have been some WASH specific studies that have included a range of gender or GBV related information. These include the sector wide REACH baseline and monitoring and mapping studies supported by UNICEF[97], a KAP also supported by UNICEF[98] that is underway at present and some assessments, such as one undertaken by CARE in 2017 in the *Balukhali* makeshift camps[99]. What has been particularly impressive with the REACH monitoring reports and their on-going mapping data, is the way that safety issues have been integrated and that also you can visibly see the questions being asked improving between the baseline and the later monitoring reports. For example, in the baseline in April 2018, most of the data was not disaggregated, whereas more effort was made to disaggregate the findings between male and female for the follow-up monitoring report in October 2018. There are still areas for improvement, but the REACH team are clearly very thoughtful and open to feedback and improvement in these areas. This is also without any level of defensiveness, which has probably contributed to why they have been able to improve on the information they have gathered over time.

The 'Women's Social Architecture Project (Pt 1)' that is commonly mentioned within the sector whenever you ask about consultations with women and girls, has also been well documented and widely shared which has contributed to its potential use and impact. As mentioned in **Section 5.2.9**, there are also various studies now being undertaken focussing on menstrual hygiene.

Assessments and studies focussing on inclusion and the WASH needs of people with disabilities, older people and children – One big gap in the assessments and studies in the WASH sector,

[95] Action Against Hunger, Save the Children and OXFAM (2018) *Rohingya Refugee Response, Gender Analysis; Recognising and responding to gender inequalities, August 2018*
[96] Sang, D (2018) *One Year On: Time to put women and girls at the heart of the Rohingya response, OXFAM*
[97] REACH (2018) *WASH follow-up assessment, Monsoon season – all camps in Ukhia and Teknaf Upazila (Aug - Oct 18)*, WASH sector and DPHE; and WASH Sector Cox's Bazar & REACH (2018) *Water, Sanitation and Hygiene Baseline Assessment, Cox's Bazar, Rohingya Refugee Response*, April 2018
[98] Swiss Centre for International Health (2018) *Protocol (Inception Report); Baseline survey to determine the current status of knowledge, attitude, behaviours and practice (KABP) relating to water supply, sanitation services and hygiene amongst Rohingya refugees in Ukhiya and Teknaf upazilas Cox's Bazar district,* UNICEF (plus interview grids and associated documents)
[99] CARE Bangladesh (2017) *Myanmar refugee influx crisis from August 2017, Rapid gender analysis report, CARE Bangladesh, Balukhali Makeshift Camp, Ukhiya, CXB, Bangladesh*, 18 Oct 2017 (version 3)

however continues to be a lack of focus on the experiences and needs of people with disabilities and older people. Some as of yet unpublished studies by HelpAge and HI include some learning related to WASH issues. A few other studies or publications have touched on the additional challenges that people with disabilities or older people are facing. But mention is limited and is a clear area where much more attention is needed. People with disabilities and older people need to be pro-actively sought out during assessments, consultations and feedback processes and as is clearly spelled out in the global '5 Minimum Commitments' (see **Section 4.2**). It would also be positive for more studies to be undertaken with children of different ages and including adolescents. There are more ethical considerations to being able to consult with children and hence it is suggested that detailed studies to learn from children would be best done with appropriate support from child protection specialists and agencies.

Involving people who are often overlooked in assessments and feedback – There is a need to increase attention on and seek out people who are often overlooked in assessments and consultations. This includes people with disabilities, older people and women and girls who are not able to leave their homes.

6.2.3 Monitoring, reviews and learning

WASH sector monitoring – The WASH sector monitoring processes include the use of the 4Ws and also includes the REACH supported mapping of facilities and coverage. This has been discussed elsewhere in the report and is seen as very positive, as it has attempted to integrate considerations related to safety when monitoring the toilets and bathing facilities. The huge numbers of facilities and their evolving status, also leads to a huge challenge in keeping track of the facilities and their maintenance status and hence the quality of the services.

Sex, age and disability related data – The GiHA cross-sectoral working group has been encouraging the increase in use of sex and age disaggregated data (which has been shortened to SADD). However, whilst a positive move, this also overlooks the issue of disability, which also reflects the general lack of focus on the needs of people with disabilities across the response. The focus should change to try to improve on 'sex, age and disability related disaggregated data'. There is a need to reflect on the current indicators being used at sector level and agency level to see if improvements can be made in these areas.

Collecting data on disability is however quite complex, as the standard 'Washington City Group Questions' (WGQs) that were developed for use in national census' but are increasingly being promoted for use in the WASH sector (whether or not they are appropriate for the level of use of the data), are quite complicated. The 'short version' has six core questions on people's functioning and then multiple levels of possible response to each depending on severity. If data other than WGQs on disability is to be routinely collected, then it is suggested that a simplified form of questioning should be adopted for general use; and the short set of WGQs (6 questions on functioning with various levels of severity) only be considered to be asked when the data is going to be directly used in a specific response for that individual person.

The 'Gender & Age Marker'[100] – The GiHA and the WASH Sector is also encouraging sector actors to complete the global 'Gender & Age Marker'. It is not clear how far this has been done, who will collate the information and how it will be used, but this is worth further investigation. Just asking organisations to self-report on data, may help to bring the issues back into their consciousness for some, but may not be particularly useful if there is no verification or comparison between agencies or sectors. There is a comment in the JRP (2018) that *"All projects have been gender marked in three tiers (self-marking, peer review marking and gender advisor marking"* to ensure integration of gender across the board. But it is not clear what projects these refer to?

Learning – As noted above, including in **Section 5.3.2** – a number of learning exercises have been undertaken that relate to gender and GBV and others probably exist. UNICEF and Save the Children are known to have undertaken some general learning on the situation of children, including some that relates to WASH. But not so much has been undertaken in the WASH sector to learn about inclusion or the needs of people with disabilities and older people, although some as studies (not yet published) by HelpAge and HI have identified significant WASH challenges that older people and people with disabilities are facing. See **Section 5.1.1**.

But even with some of these very useful learning activities, some efforts to develop sector-wide tools (see **Section 6.3.2**) and some efforts to turn the findings into action by individual agencies, it is not clear that all agencies are taking these issues seriously, or working to use the lessons. Part of this may be due to capacity, but it may also relate to commitment, so both need attention. See **Section 6.1** for further discussion.

[100] (https://iascgenderwithagemarker.com/en/home/)

6.3 Cross-sectoral linkages related to gender, GBV and inclusion

Key learning from this section:

1. A range of cross-sectoral collaboration has already been undertaken, with some of the increased focus on gender, GBV, because of engagement between the WASH, protection, site management, gender and GBV actors.
2. There has been some increased engagement between individual agencies working on WASH and some disability specialist organisations, for small numbers of WASH organisations.
3. The programmes of the disability and older person specialist organisations are currently small in scale. The two international disability organisations do not have WASH programmes. HelpAge has a focus on WASH, but does not have dedicated staff working in this area. If the WASH sector is to benefit from their expertise, they will need to establish a way to add to the staff numbers of HelpAge and the disability organisations and to link to them at sectoral level.
4. One of the big challenges for cross-sectoral coordination is the wide range of different sectors that the WASH sector needs to collaborate and communicate with to be able to respond effectively to the needs of people who are currently overlooked, including older people, people with disabilities, women and girls and people with additional specific vulnerabilities. See **Fig. 4** below.
5. Coordination with Site Planning has been a particular frustration for some in the WASH Sector, as the communications does not appear to have been successful around the amount of space that is needed for effective WASH facilities and the management of those facilities, including for faecal sludge management.

A range of cross-sectoral collaboration has already been undertaken, with some of the increased focus on gender, GBV and inclusion being because of engagement between the WASH, protection, site management, gender and GBV actors. Examples of this, have been mentioned in various places throughout the report. There has also been some increased engagement between individual agencies working on WASH and some disability specialist organisations. This cross-sectoral engagement needs to be continued and expanded, to help build the capacity of the WASH sector to better respond to gender, GBV and inclusion related issues in the sector's work.

There is a need to continue and strengthen the encouragement of joint working, consultations, capacity building and planning wherever possible, establishing formal linkages and inviting advice and engagement in sector activities.

Collaboration with colleagues from the protection sector and GBV specialists seems most prominent so far, with examples of protection specialists from UNHCR and OXFAM contributing to assessments of the priorities and needs of women and girls. There has also been support from two GBViE specialists from UNICEF Head Office, who have provided support for: the development of the

WASH Sector Minimum Standards; and the latrine bathing and toilet checklists; the UNICEF WASH team to develop their gender and GBViE strategy; and presentations at various sector meetings.

Particular opportunities exist for cross-sectoral collaboration with:

- **Site planning, camp management, energy** – Space, lighting, drainage etc
- **Protection, child protection, GBV, gender** – Consultations with particularly excluded or vulnerable community members (including orphans, widows, survivors of GBV and SGM); women and child-friendly spaces; training on PSEA and code of conduct etc
- **Disability and older people** – Consultation with and WASH for people with disabilities & older people; MHM and incontinence for people with disabilities and older people
- **Education** – WASH facilities and activities for children; children with disabilities; children with incontinence; WASH in CFS and learning centres; adolescent groups.
- **Health & Nutrition** – Hygiene promotion, maternal and neonatal hygiene; MHM, GBV, incontinence, health facilities – community volunteers and traditional birth attendants (TBAs); nutrition for small children (stunting etc).
- **Communicating with communities (and C4D)** – Mutually supportive activities engaging with communities and feedback systems, including improving them for confirmation of resolution of complaints and reaching people less likely to use the formal systems.

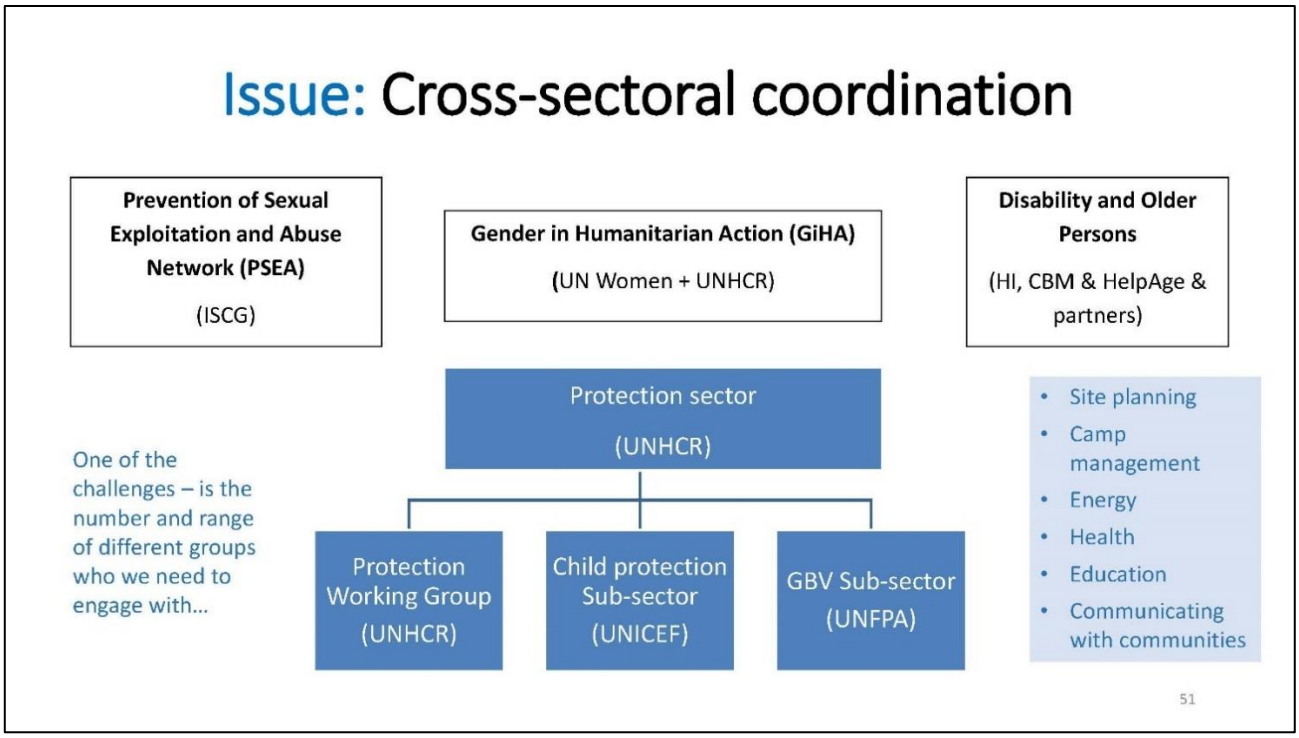
Support has also been noted from gender specialists from within various organisations and several partners have stated a commitment to also strengthen their own team's capacities in these areas, through supporting specialists (gender or GBV) to work with their teams, including WASH.

Protection, GBV and gender sector coordination structures - The figure which follows provides an overview of the key coordination structures for the protection, GBV and gender actors. The structure is quite complex arrangement for a general sector providing services such as WASH; as there are potential multiple professionals who should ideally be linked in to. Most WASH organisations seem to have formed links with the component which fits their own organisational remit the best.

Coordination with disability and aging actors – As discussed in **Section 5.1.1**, the disability and ageing specialist actors are few and their teams of small size. In addition, the two key international disability organisations do not have WASH programmes and the key international aging programme has a WASH focus, but no dedicated staff working on the programme. They also need to coordinate with multiple sectors. Hence whilst they are very committed, it will be very difficult to engage with all 50 of the WASH agencies and to join in the multiple coordination meetings in the WASH sector and at camp levels. It is suggested that the WASH sector should consider funding additional staff such as in HelpAge and / or additional technical training capacity in the disability organisations, to be able to provide the required capacity building support to build the capacity and confidence of the WASH sector and bring in more of their expertise.

Co-ordination between WASH and site planning – Several actors mentioned the challenges that there have been between for coordination between the WASH sector and the site planning teams in IOM and UNHCR. This is in particular in relation to the WASH sector trying to get minimum

Fig 4 - Coordination structure for the protection, GBV and gender actors



amounts of space for the access, construction and management of WASH facilities, including faecal sludge management facilities.

It will also be particularly important for the site planning and WASH sectors to work together during the process of de-concentration of the sites, where it is being planned to move people from the more concentrated areas to the areas that are less dense (if it happens). As part of this process the IOM and UNHCR shelter teams are planning for 100,000 new shelters which will be prefabricated concrete structures. It is understood from the UNHCR side that the plan is that all WASH facilities will be at household level. The period of time for this to happen is not known, but it could take years. However, other actors have stated that deconcentration is unlikely due to the Government of Bangladesh stated geographical limits on camps and the possibility of new arrivals.

6.4 Donors including AFAs, partner agreements, budgets and enforcement

Key learning from this section:

1. There is a need for donors, including the AFAs, to increase requirements for the organisations they fund to consider and respond to gender, GBV and inclusion in all of their work.
2. There is an essential need for the donors, including the AFAs, to include budgets that enable flexibility in their designs and activities, to be able to respond to the needs of different people, including people who struggle the most to access and manage their WASH.
3. It would also be positive for scheduling to enable a learning period at the beginning of new contracts to undertake detailed consultations with people who may struggle most to access their WASH and to make plans as to how to respond.
4. Analysis of existing UNICEF partner agreements (most of which are in the process of coming to an end) is that some considerations have been noted related to gender, GBV and inclusion within them, but that the content and substance was limited and some of what was included was wishful thinking and not implemented. However, increased attention is now going into these areas in the programme agreements currently under development.
5. Staff managing the development of the partner proposals for the AFAs also need to build their own capacities to better support their partners.
6. There is a need to establish guidance on minimum standards for project agreements and for monitoring and enforcement in relation to the work of partners related to these areas.

The role of donors including the WASH AFAs in leadership and promoting change – The donors, including the three WASH Area Focal Agencies (AFAs), have significant power in promoting change in relation to gender, GBV and inclusion. If they require action in these areas and make it mandatory, the partners are much more likely to act and focus on these areas, particularly if they will also be monitored on the same and if the likelihood of future funding also depends on success in these areas. However, the converse is also the case. This is if the partners see that the donors including the AFAs are not taking the issues seriously, then they may also place less attention on these issues. This is unless the partners have specific individuals who are champions on these issues, or particularly strong organisational values and focus in these areas.

Budgets – It will also be critical that the AFAs enable their partners to incorporate budgets that allow for flexibility in their designs and solutions to respond to the needs of different groups within the communities; that funding and outputs are allocated for improvement of existing WASH facilities from a gender, GBV and inclusion perspective; as well as adequate budgets for supporting accessible WASH; and capacity building across a range of areas. Significant budgets should also be included for quality monitoring and where feasible, evaluation. This is often underfunded and contributes to the weak monitoring and evaluation in humanitarian contexts.

Learning periods – A suggestion was made that it would help the partners to learn from the communities, if they are required to have a lead in time at the beginning of new agreements. For example this may be one month, where they would be expected to start consultations and plan responses before starting construction. If they are also required to report on these consultations and the findings and changes to be made to the programme and designs in response, this could be beneficial to influence in action.

Analysis of existing partner agreements – An analysis was undertaken of existing programme agreements for most of the UNICEF partners (soon to be coming to an end)[101]. Some considerations related to gender, GBV and inclusion were noted within them, but the content and substance was limited. It was also clear that some points included in the documents were probably more wishful thinking than expected they would happen. Discussions with specific partners, indicated that some of what was included had not actually happened yet (such as the development and use of gender sensitive distribution guidance, the segregation of male and female facilities for privacy and the construction of screened facilities). However, discussions with partners also indicated an interest and commitment to improve in these areas in the new programmes. Some positive and interesting efforts have also been noted, including some examples of accessible WASH facilities that have been supported (such as by NGO Forum).

Guidance on minimum standards for project agreements and monitoring and enforcement mechanisms – A particular point of stress point for the current WASH team in UNICEF is how to integrate gender, GBV and inclusion into the new programme agreements and simple bullet point checklists are being requested for guidance. It was felt positive to develop these, which will hopefully be useful across all three AFAs, if they do not already have them. These should also include some ideas for possible mechanisms for enforcement or encouragement if the partners are found to have or have not taken these issues seriously. For example, for the best performing partners to include additional budgets in subsequent proposals to enable innovative gender, GBV and inclusion related research, or to be able to mentor and organise capacity building opportunities for other partners. Drafts have been submitted as an output of this contract for further development.

It should however also be emphasised that team members supporting the development of the programme agreements, also need to build their own capacity and knowledge and take initiative to make sure that programmes are strengthened in these areas. It is not just a matter of copying bullet points into an agreement, or expecting that Gender, GBV and Inclusion colleagues should be the ones to integrate these elements. It is also about all staff building their own capacities to be able to support increased capacity of the partners to be able to act.

[101] Whilst this audit and capacity development assessment process is focussing on the wider WASH sector and not on UNICEF, the audit team had easier access to documentation from within UNICEF and hence this is what has been focussed on here and in other parts of the report. However, most of the UNICEF partners are also partnered with the other two AFAs and hence it is expected that the issues and strengths and gaps will be similar.

6.5 Codes of conduct, PSEA and referral systems

Key learning from this section:

1. Some WASH sector organisations stated that they have codes of conduct and have provided some training on the prevention of sexual exploitation and abuse (PSEA), including for front-line workers; although it was not possible to see any of the training materials for this level of staff to confirm this.
2. The PSEA network noted that there are some general training materials for the humanitarian actors, but that it is not yet in Bangla (as of Nov 2019). The materials were not seen.
3. It is not clear that many frontline workers, including HP promoters, technicians, the army and contractors have been trained in codes of conduct, PSEA and referral systems. These are the people who have the most direct contact with the affected populations, many of whom are in very vulnerable positions, due to limited access to resources, making them potentially vulnerable to sexual exploitation and abuse.
4. There are established GBV referral pathways, although these have been noted as not adequate for the need. They face their own challenges, including that they are not so suitable for GBV incidents related to children and there are limitations in opportunities for legal redress for survivors. But work is continuing by the GBV sub-sector to strengthen them.
5. Capacity needs to be built on how to identify, gender, GBV and inclusion issues and on appropriate behaviours when engaging with community members and with other actors. It includes on the code of conduct, the prevention of GBV and PSEA and the GBV referral systems.

Codes of conduct and training on the prevention of sexual exploitation and abuse (PSEA) - Some WASH sector organisations have stated they have codes of conduct and have provided some training on PSEA, including for a few, to the level of frontline workers. For example, CARE and OXFAM have stated they are providing training to all levels. But others are not clear that they have codes of conduct, or they do not train at all levels, although some train on specific issues such as on child safeguarding. It is however understood that all response implementing partners are meant to have codes of conduct.

The audit team requested examples of the training on code of conduct and PSEA for humanitarian workers on the Rohingya response, in particular for frontline workers from a number of organisations, but as of yet none have shared these documents. Whether this is because the organisations are reticent to share what they are training people on, or just busy and this was an oversight, or the trainings do not exist, is not clear.

It is reported that the PSEA network has some training materials for the response, but these are not yet in Bangla, and with around 2,000 humanitarian workers across the response and with the constant turnover of staff, the training needs are significant. It seems that for some, training of some kind, such as on GBV, may have happened on an ad hoc basis as and when there was a staff

member present with the particular mandate for this area. But the trainings probably have not been repeated to keep up with turnover.

Training for frontline workers – It is not clear that many frontline workers, including HP promoters, technicians, the army and contractors have been trained in codes of conduct, PSEA and referral systems. But these are the people who have the most direct contact with the affected populations, many of whom are in very vulnerable positions, due to limited access to resources and hence some may feel they have to take desperate measures. A report by UN Women recognises that some women may feel they have to resort to transactional sex to be able to survive[102].

Child labour – There should also be a clear line about not using child labour, including by contractors. However, it is understood that some contractors may still be involving children.

GBV referral pathways – There are established GBV referral pathways for the Rohingya response. There are 29 referral paths in different locations, but these are noted as not adequate for the need. These referral pathways face their own challenges, including that they are not so suitable for GBV incidents related to children and there are limitations in opportunities for legal redress for survivors. But the GBV sector actors are continuing to work on and strengthen them. There are also mobile protection teams (supported by UNHCR) and Protection Focal Points in each camp.

The guidance on these pathways[103] also notes specific roles and responsibilities of frontline workers and specifies some do's and don'ts in line with protection ethics (such as not interviewing survivors themselves, seeking consent and keeping information confidential). It is reported that these guidelines have been circulated to all partners. However, it is not clear that most WASH sector actors are aware of referral systems for GBV, or would know what to do if they witness and incident of GBV or are approached by a survivor. For general background guidance on good practice on this issue that has been prepared for WASH practitioner's globally, the cross-organisational 'Violence, Gender and WASH, Practitioner's Toolkit'[104], Briefing Note 4 on 'Understanding the Protection Sector', can be a useful starting point. But response specific GBV experts, should be sought to help contextualise and explain the good practice for the referral system in the Rohingya response.

Core set of training materials on code of conduct, PSEA and referral systems - It is suggested that the sector needs to put effort into developing a core set of training materials for its' frontline workers. This should be rolled out to all frontline workers as a minimum, but could also be added to by specific organisations when felt appropriate. To do this, it is suggested to first try and get hold of examples of training materials and codes of conduct and guidance from the protection and GBV sectors and then adapt this to come up with a set of standard materials for the sector's use. As this will be quite a significant task, the sector may want to recruit a GBViE specialist with some expertise or experience of working with the WASH sector, to spend dedicated time to work on this with the sector.

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[102] UN Women (2018) *Gender Brief on Rohingya Refugee Crisis Response in Bangladesh*

[103] No author (2018) *Gender-based Violence Referral Pathways, PPT presentation* (provided by Chair of CP WG / UNICEF CP)

[104] House, S. Ferron, S, Sommer, M, and Cavill, S. (2014) *Violence, Gender & WASH: A Practitioner's Toolkit - Making water, sanitation and hygiene safer through improved programming and services*. London, UK: WaterAid/SHARE (co-published by 27 organisations) http://violence-WASH.lboro.ac.uk

6.6 Human resources, staff and female-friendly work environments

Key learning from this section:

1. Increasing efforts have been made to recruit female as well as male volunteers. There are also reports that there tends to be a high turnover of female volunteers because of the pressure from their husbands and families.
2. Engineers tend to be paid more than Hygiene Promoters (HPs) and are often male, while more females are HPs. The engineers also tend to be the managers and hence if they don't agree with the importance of considering and responding to these issues, then the HPs are restricted from acting. There is an essential need to build the understanding, commitment and capacity of engineers working on the response on these issues, as well as those working on the community engagement and HP activities.
3. Whilst efforts should continue to be made to also encourage more women with engineering and associated technical skills to work in this response, it is also important to note that male engineers and technicians can also be very positive champions, if given opportunity to learn.
4. All new staff recruited for the WASH sector in the AFAs, DPHE, NGOs and associated actors should have the requirement for integrating gender, GBV and inclusion into their work as a core component of their job descriptions and terms of reference. Organisations should also monitor commitment and adherence to these issues in staff progress reviews.
5. There is a need to increase efforts to employ more female staff at all levels, aiming for gender balance where possible and also encouraging employment of people with disabilities as part of teams.
6. There is a need to undertake a review in particular with female working in the sector and across organisations, but also with male staff, to check their working environments and on issues related to workplace harassment and ensuring a supportive environment.

Female HP / volunteers – Increasing efforts have been made to recruit female as well as male volunteers, but there are also reports that there tends to be a high turnover of female volunteers because of the pressure from their husbands and families. It will be important to consult with female community volunteers from both the Rohingya and host communities to review their experiences of engagement and ways that the programmes could better support and retain them in their roles (such as working in pairs at all times and adequate allowances). And associated with this, it would be important to try to improve practices and share examples of good practice across agencies. Review HR and volunteer policies – to check the are female-friendly and friendly to people with disabilities (such as related to breastfeeding, child care, maternity/paternity leave, support for assistant etc).

Mostly male engineers – As is common in much of the WASH sector around the world, the majority of engineers and technicians are male in this response, although some examples also exist of female engineers also engaged in the response. This includes for example, those working in the DPHE teams, some members of the sanitation TWG and those in the EIMS consultancy team supervising the army supervisors of construction teams. The box which follows highlights specific concerns that were raised during the audit related to the predominance of males and engineers in the decision-making structures in the WASH sector.

Engineers – tend to be male, be in higher positions and have more decision-making power

A practical concern was raised during the audit from the Hygiene Promoters (HP) perspective is that engineers tend to have more power than the HPs in this response. They tend to be paid more than HPs and are often male, while more females are HPs. The engineers also tend to be the managers and hence if they don't agree with the importance of considering and responding to these issues, then the HPs can't act. Hence, it is critical that awareness raising and commitment building is done with the engineers as well as the people working more on the hygiene or community engagement sides of the work.

Whilst efforts should continue to be made to also encourage more women with these skills to work in this response, it is also important to note that male engineers and technicians can also be very positive champions, if given opportunity to learn. For example, it was noted that the DPHE engineers at different levels have not been trained on these issues, but are picking things up as they go along and there would be interest for such training to be given. CARE noted that they have 50% female and 50% male staff, but all female staff are working on software side.

Integrating gender, GBV and inclusion into job descriptions (JDs) and terms of reference (ToRs) - All new staff recruited for the WASH sector in the AFAs, DPHE, NGOs and associated actors should have the requirement for integrating gender, GBV and inclusion into their work as a core component of their JDs and ToR. Organisations should also monitor commitment and adherence to these issues in staff progress reviews.

Recruitment of male and female staff, people with disabilities – There is a need to increase efforts to employ more female staff at all levels, aiming for gender balance where possible and also encouraging employment of people with disabilities as part of teams. There is also a need to undertake a review in particular with female working in the sector and across organisations, but also with male staff, to check the situation of their working environments and on issues related to workplace harassment and ensuring a supportive environment.

7. Conclusions and recommendations

7.1 Conclusions – WASH, gender, GBV and inclusion audit

7.1.1 Positive efforts made to respond to gender, GBV and inclusion

The Gender, GBV and Inclusion audit of the work of the WASH sector identified that some progress has been made in considering / improving the situation from the perspective of different groups of people with different needs within the affected communities. Examples include:

1. The response has been huge with many facilities having been constructed in complex topographical & political context. The response has saved many lives.
2. Most toilets and bathing facilities have locks of some kind, even if some are only wire ties.
3. The lighting of the camps is increasing, particularly on the main accessways and more is planned.
4. The data collection related to the toilets and bathing facilities, has included considerations related to safety, with improvement seen over time (for example in the work by REACH).
5. Over 50 percent of households have reported that they have constructed their own bathing facilities inside their homes – so people are finding their own solutions.
6. There is evidence that the WASH facilities have been improving over time, with the unified designs including some improvements to the previous designs, particularly with respect to having more solid super-structures for increased privacy.
7. There has been increased analysis of gender and GBV issues related to WASH in assessments, particularly after the one-year mark of the response.
8. Hygiene promotion efforts are being strengthened with the establishment of a Hygiene Promotion Core Facilitator's Team and an informal cross-sectoral MHM working group.
9. Some examples exist of accessible toilet facilities (although few against the needs).
10. The "Women's Social Architecture Project (Pt 1)" and sector latrine and bathing checklists that have been developed have the potential to be very useful if used. These included some great cross-sectoral collaboration, reflection, discussions and action planning.
11. Some good efforts have been made to integrate gender and GBV into sector strategies and tools, such as the WASH strategy and the WASH sector minimum requirements for the Rohingya response.
12. There are a number of functioning feedback systems (although the efficiency is not clear).
13. There are some positive examples of WASH in the child friendly spaces, age friendly spaces etc (although this is not consistent across all spaces).

14. There are opportunities for improvement of the facilities with the decommissioning of old facilities and the construction of new ones.
15. There has been some positive feedback on the use of reusable pads for menstrual hygiene.

7.1.2 Gaps in efforts to respond to gender, GBV and inclusion

But significant gaps and challenges have also been identified:

1. A large number of women & girls are not using WASH facilities except at night.
2. Facilities for men and women have generally been constructed without gender-segregation in the same area with no screening or distance separating them, leading to males and females having to queue in the same place.
3. There has been limited engagement with men and boys, with bathing facilities mostly constructed for women and girls. Men and boys are bathing at water points, which also poses challenges for women and girls.
4. Inclusion and accessibility and older people and people with disabilities have been mostly overlooked. These issues have mostly been relegated to *"when we have time".* Even the efforts to increase attention on sex and age disaggregated data misses disability.
5. Gender & GBV issues generally seem to be seen as the responsibility of the hygiene promoters and a *"tack on"* the end of considerations, rather than central to all work (although this was changing by the second visit).
6. The quality of *"community consultation"* is questionable. It needs to be unpacked. Just saying *"we will do community consultation"* will not resolve these issues if not done well, does not reach the people who are most excluded, and what is raised is not responded to.
7. Gender, GBV and inclusion are cross-cutting issues, with opportunities for support from across sectors. However, some of these opportunities have either been missed or not made the most of to-date, such as engagement with the health sector.
8. There has been limited success with the management of child faeces.
9. The responsibilities for maintaining the drainage systems are not clear and seem to have been deprioritised, resulting in stagnant water mixed with solid waste.

It is also important to highlight that "gender" issues are not equal to GBV issues or MHM issues alone. They are broader and consider the different gender-based norms, relationships and power differences that perpetuate issues such as GBV and lack of control over resources or ability to make your own decisions, or in this case for women and girls to feel they are able to leave their shelters. It is important that the WASH sector realises this whilst also strengthening the areas of inclusion and ensuring that people with disabilities and older people are considered and involved; it must also pay much more attention to understanding the different issues influenced by gender.

7.1.3 Barriers and challenges faced by specific groups of people

The following table summarises the barriers and challenges that have been understood to have been faced in the Rohingya response by different groups of people[105].

Table 13 - Summary of barriers and challenges being faced by specific groups of people

		Barriers and challenges that may be faced in managing their WASH
1	**Women including those practicing *Purdah***	• May feel uncomfortable having to queue next to men and boys when using communal WASH facilities. • Do not feel able to access communal WASH facilities during the day, only using them at night, potentially increasing risks to GBV. • Harassment and other forms of violence including GBV on the way to / from and when using the WASH facilities, NFI distributions etc. • Bathing, urinating (and some also defecating) in their shelters, sometimes next to the cooking area. • May reduce eating or drinking to reduce how often they need to go to the toilet. • May be unable to go to the distribution centres to collect hygiene items, including those related to menstrual hygiene. • Limited opportunity to engage in community discussions and decisions related to the design and siting of WASH facilities. • Unable to access WASH information shared in public forums. • May be finding it difficult to manage their menstrual hygiene, including accessing adequate amounts of materials and finding appropriate locations to wash, dry and dispose of materials.
2	**Adolescent girls including those practicing *Purdah***	• Similar to women, but have less power to contribute to discussions and decisions related to their WASH needs. • Have less power to decide to leave their shelters to access WASH facilities. • Particularly uncomfortable to collect water when males are bathing at water points. • Girls may face menstruation-related bullying, shaming or other negative experiences by peers, school administrators and / or teachers.[106] • May have limited information on menstruation and how to manage it.

[105] Except for a few instances where the expectations of challenges have been identified from the global context. These have been indicated.
[106] From global knowledge.

3	**Men and adolescent boys**	• May not have been involved in discussions about good hygiene practices and the impact of men and boys using WASH facilities allocated for use by women and girls and bathing at water points. • May not have been provided with bathing facilities. • May have limited information on menstruation and hence do not know how to support their wives, daughters and sisters.
4	**People with disabilities and their carers**	• May not be able to access or use a standard squat latrine – either because of distance, or because they find it difficult to squat. This may result in them having to sit on a contaminated toilet slab, or to have to urinate in their shelters and to balance on a water bucket to defecate. • May have additional water and soap needs, including to manage incontinence (where a person is unable to control their urine or faeces) and having to wash clothes and bedding on a much more regular basis. • Water collection may be very difficult for the carer, where they do not have other family members to support collection. • It may be difficult to go to distribution centres to collect hygiene items. • May be less able to leave their shelters and not pro-actively consulted on their needs or for giving feedback on WASH interventions. • Less likely to have the opportunity or confidence to request support.
5	**Older people including older people living alone**	• For some older people – the same as above for people with disabilities. • They may find it very difficult to queue to use toilet facilities and may soil their clothes due to functional incontinence, as they are not able to hold in their urine or faeces as long as others. • They may find it very difficult to collect water, particularly when the water point is up or down a hill from their shelter, or when they are living alone and particularly during the rainy season.
6	**Children**	• The carers of small children (usually women and young girls) may not have the tools or knowledge to manage their faeces safely (no scoop, no potty, no cloth or plastic pants). • Children may be frightened to use communal WASH facilities. • Children may be vulnerable to harassment and GBV when using WASH facilities, including violence at water points when there are queues.

		• Young girls in schools or madrassas may have to use toilet facilities in secluded areas in the same space as male teachers and boys, including with open urinals present. • Girls may find it difficult to manage their menstrual period when in school or child-friendly spaces or learning centres, if the WASH facilities are not menstrual hygiene friendly and the teachers not knowledgeable on how to support them.
7	**Single headed households – widow, orphan, or other female or male**	• They may find it more difficult to leave children to undertake WASH tasks, such as collecting water or accessing communal toilets or bathing facilities. • They may find it more difficult to access distributions for hygiene items. • Orphans, particularly those not living with a family, may be particularly vulnerable to harassment and abuse with no adult to provide support. • Orphans may have limited confidence to express their needs and demand support.
8	**Sexual and gender minorities (SGM)[107]**	• May face harassment, abuse and violence in their daily lives, including when accessing WASH facilities. • May face harassment when using male/female segregated toilet facilities. • Can be made more vulnerable if they are identified to provide support. Hence it is critical that any engagement with SGM is undertaken only by Protection professionals and not the WASH sector.
9	**Minorities and other people marginalised within society[108]**	• People may be marginalised due to being minorities by religion, ethnic group, or engagement in activities not approved of by the wider society (such as undertaking transactional sex). • Less opportunity to engage in community discussions and decision-making. • They may face harassment or abuse when using WASH facilities. [109]

[107] The examples for sexual and gender minorities has been taken from global learning and not the CXB specific context.
[108] The examples have been taken from global learning and not the CXB specific context.
[109] In a workshop a participant shared that there are minority ethnic groups within the camps, who are in some cases facing exclusion from using the WASH facilities> but further details were not shared.

7.1.4 Discussion on the gaps and their implications

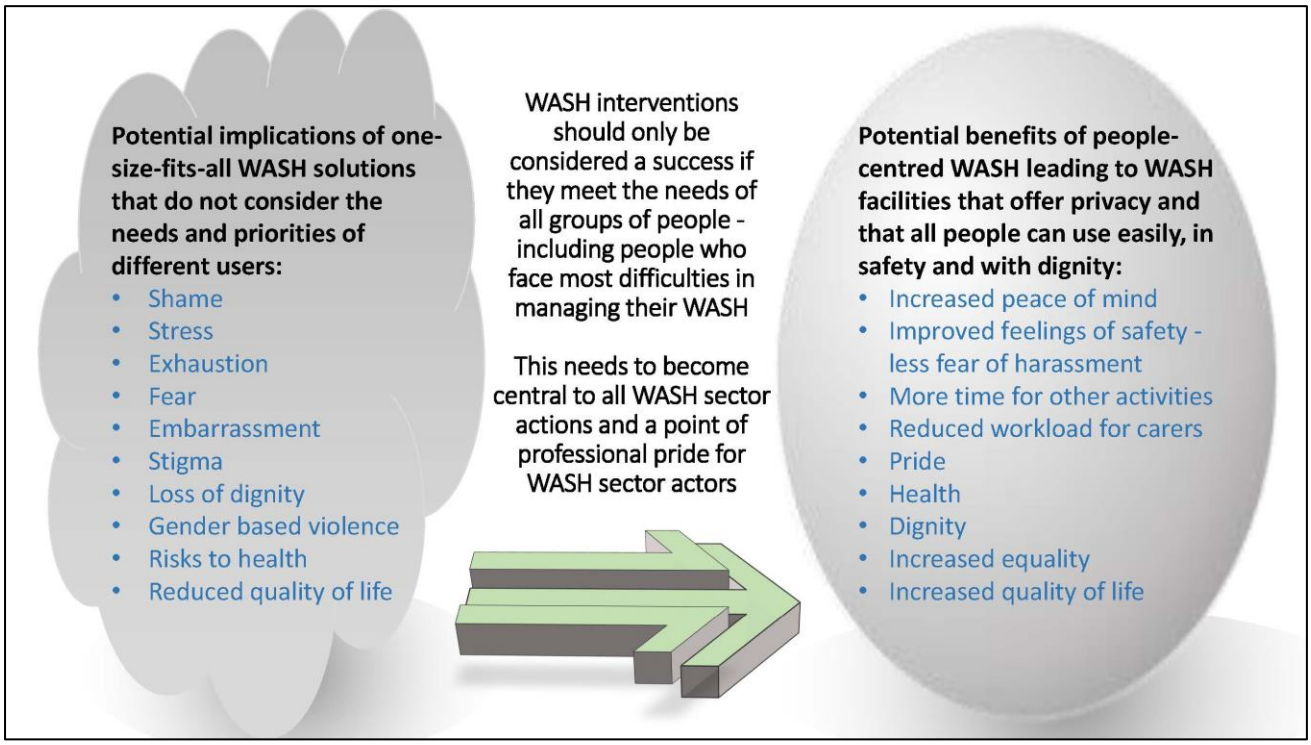
Whilst WASH sector actors have faced multiple challenges to respond to the WASH needs of the affected populations, due to the self-settlement of the people arriving from Myanmar and the complex topographical and political context; these are not a good enough reason to not consider issues related to gender, GBV and inclusion, throughout the process.

The implications of this lack of action by the WASH sector can potentially be severe and may include:

- Women and girls reducing their eating and drinking.
- Some women and girls only using the WASH facilities under the cover of darkness, hence potentially risking increasing their vulnerability to GBV and the wide range of serious implications that this could in turn lead to, particularly if a serious assault or rape has occurred.
- Adolescent girls are fearful of using the WASH facilities, including water points where men are bathing; or not able to go to places where men are present, because they have to observe strict *Purdah*.
- Older people and people with disabilities, facing increased levels of 'functional' incontinence, where they are not able to hold in their urine or faeces in time to reach the facilities; and hence soiling their clothes or bedding. This leads to embarrassment, shame and a loss of dignity, as well as increased need for water and soap.
- People who are caring for children and family members who have impairments of various kinds face significant difficulties in supporting the WASH needs of all family members, leading to stress and exhaustion.
- Increased contamination of the environment through the poor management of child faeces, or from faeces being washed into open drainage from household bathing areas, if people are using these for defecation as well as urination and bathing.
- Increased embarrassment, stress, exhaustion, fear, loss of dignity, risks to health and quality of life.

See the figure below which provides an overview of the implications of WASH that is not people-centred.

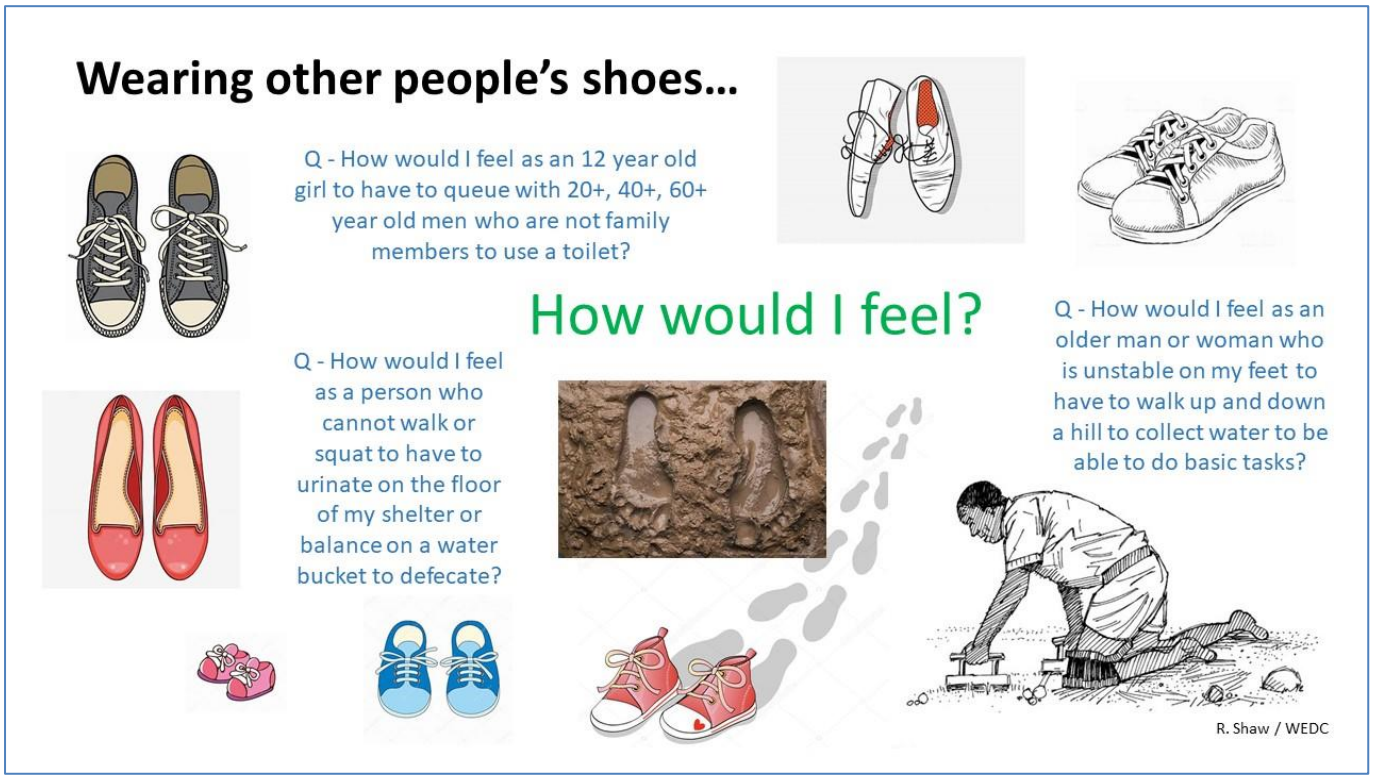
Fig 5 - Implications of WASH in the Rohingya response that is not people-centred



It is clear that for many professionals in the sector, they had not yet spent much time considering these issues and responding to them in their work. This was confirmed by multiple people who were met during the audit. However, a number, noted that they are starting to look more at these issues and stated a commitment to improve in these areas, which is very positive.

It is proposed that it can be helpful to encourage increased understanding and empathy for the WASH sector actors if we all start putting ourselves in other people's shoes and ask the question "How would I feel?" if I was in this situation?

Fig 6 - Putting ourselves in other's shoes



See the box which follows.

"Putting ourselves in other's shoes"

During an exercise at the Water TWG workshop in Feb 2019, an exercise was held to identify how three different people may feel with the difficulties that they face in accessing the water services. The three people considered were: a 6-year old female child; a woman who practices Purdah and is pregnant; and a 70-year old man.

The types of feelings that the participants imagined the people may feel included: *Insecurity; anxious; fearful; lonely and isolated; stressed; not understanding why they have to do adult tasks; angry; overwhelmed; neglected; confused; being uncomfortable; helpless and depressed; sad, lonely and useless; may feel like they want to die because they don't know who will take on their responsibilities; they may feel like a burden to their family; loss of dignity; concern over placing demands on their neighbours leading to negative relationships.*

7.2 Conclusions – Capacity assessment of skills in gender, GBV and inclusion

Some of the key observations related to capacity include:

1. It isn't just capacity building that is needed, but the building of leadership, commitment, confidence and pride in the work of the WASH sector that meets the needs of different groups of people, including those who face the most difficulties meeting their needs.
2. There have been many reasons (or excuses depending on your perspective) given by sector actors as to why these issues have not been responded to. Some have a degree of validity, but much of the gap in action is due to a gap in mindset and recognition that this is a critical issue that should be central to the sector's work and which can have significant negative impacts, if not responded to well.
3. Capacity and confidence building are needed at all levels, including from senior levels to frontline workers, across agencies and also in both international and national organisations.
4. The DPHE teams at different levels have not previously had the opportunity to be trained on these issues, but have been picking things up as they have been working on the job; and would be interested to receive capacity building on these issues.
5. There is a need to develop a basic minimum package of training (or locate and identify and adapt existing materials) for frontline workers on issues related to code of conduct, PSEA and GBV referral systems, which should be rolled out across the sector as a basic minimum. This includes for HP and community mobilisers, the army and construction workers, including contractors.
6. Capacity building approaches will need to be varied and sustained, including engagement with people who may face most barriers for managing their WASH, the development of SOPs, reviewing existing tools, updating the unified designs, practical exercises, peer mentoring and workshops and on-the-job trainings.
7. Capacity building that is provided also needs to be in the language that the participants are most comfortable with wherever possible. Any training for people working at field level should either be in Bangla or Chittagong/Rohingya.
8. There are already some good examples of how gender, GBV and inclusion have been integrated into sector strategies and tools. Some need updating, including to strengthen elements such as inclusion, and also to disseminate, encourage and monitor their use more significantly than at present.
9. There have been some good examples of cross-sectoral collaboration and support, particularly with the protection, GBV and gender actors. This should be continued and built upon as part of the process of capacity development.

10. Donors including the AFAs, have an important role in promoting action on these issues. Efforts should be made to provide additional guidance on minimum requirements and ideas for monitoring and encouragement / enforcement that donors, including AFAs, can use.
11. Attention should also be put into increasing the numbers of female staff, people with disabilities and people from minority groups into the sector, as well as strengthening requirements for issues related to gender, GBV and inclusion, to be covered in staff job descriptions.
12. Capacity building will need to be planned for repetition over time to respond to the turnover of staff. Hopefully though, as these issues are further integrated as core into the sector's work, then it will be possible to reduce the scale and focus of capacity building efforts as more learning will be possible through learning by doing.

7.3 Conclusions - Challenges and barriers going forward

Key challenges and barriers going forward include:

1. Understanding and commitment of sector leaders / managers as to why this is critically important and hence not keeping it on the agenda. The issues have tended to only be mentioned when a few interested individuals raise the issues, rather than being accepted as core aspects of all of the sectors work.
2. Some sector leaders seem to now have increased awareness on some of the issues (Feb 2019) but there is a risk that the responses will be small-scale rather than at the large scale needed.
3. Complexity of needs and priorities of women and adolescent girls (and men and boys), alongside the space limitations & topography. For some it is possible that only household facilities will be acceptable.
4. Huge number of toilets (over 47,000), bathing facilities and water points, which would need discussion and possible modification.
5. Huge numbers of humanitarian actors with high turnover of staff, meaning that capacity building would be needed on a significant scale for response wide improvement.
6. The difficulty of coordinating large numbers of sector actors to change approaches.
7. The unified designs, whilst being an improvement from earlier versions, do not in particular adequately incorporate modifications to respond to gender and inclusion issues. It is expected that will be updated but the risks are how well and how fast.
8. Lack of confidence of general WASH actors in supporting accessible WASH.
9. Language barriers for the Rohingya people with communication in Chittagong and for Bangla speakers working in English at sector level.
10. Relationship building needed between the WASH and disability sector, including to agree on procedures to identify people with disabilities, so that the WASH sector can support their WASH needs at scale.

7.4 Recommendations – roadmap and concluding remarks

7.4.1 Overview of the proposed roadmap for the way forward

The proposed roadmap is based on a foundation of the following 5 principles:

1. **Principle 1** – Put gender equality, GBV and inclusion at the centre of the WASH sector's work
2. **Principle 2** – Recognise different barriers that different people face – and also their equal human rights to live in safety and with dignity
3. **Principle 3** – Prioritise those who face most difficulty in practicing their WASH needs
4. **Principle 4** - Involve people in their own solutions – *"Nothing about us without us!"*
5. **Principle 5** – Improve effectiveness through building capacity, commitment, confidence, pride and accountability mechanisms

It has been structured around 6 core strategies:

1. Building capacity
2. Integration
3. Cross-sectoral collaboration
4. Pro-actively engaging with people who face greater barriers
5. Modifying the existing facilities and programmes
6. Strengthening enforcement, monitoring and feedback

Suggested actions have been provided for:

1. Quick wins (progress within 3 months)
2. Interim (progress within 3 months to 1 year)
3. Longer term goals

The specific recommendations through the proposed strategies and actions, are not being noted in this report, as they can be seen in the recommendations for the roadmap itself.

Efforts have been made when writing the roadmap, to use simple language and terms that non-gender, GBV and inclusion specialists will be able to understand. This will hopefully enable increased understanding and make the importance of the issues clearer.

See the separate document for the recommendations for principles, strategies and actions:

"Recommendations for the WASH Sector Roadmap. The way forward to ensure that all girls, women, boys and men, including small children, older people, people with disabilities and people facing additional vulnerabilities, can access WASH facilities and practice their WASH needs easily, in safety and with dignity"

7.4.2 Concluding remarks

In conclusion it is important to reflect on the question:

"How well have we really succeeded if half the population does not feel comfortable or safe using our facilities and people who have impairments are being treated as second class citizens…with their needs and dignity left to last… until… or if… we have time?"

Bringing humanity in humanitarian action to the forefront of our work

"As we walked through the camp to reach the Age Friendly Space (AFS) in Camp 18 as part of the audit process, an older man came up to a male HelpAge staff member and gave him the hugest heartfelt hug"

Older men talked of:

How they had easy access to WASH facilities in the AFS that they do not have outside – where they struggle with distances to water points, queues, lack of accessible facilities…

How the staff (RIC and HelpAge) treat them with kindness and give them dignity and respect…

How they felt happier in the AFS than in their own homes

What these teams have clearly done is to bring the **humanity** in their humanitarian action to the forefront and to the centre of their work – this is what also needs to happen in the WASH sector.

It isn't difficult or "rocket science" to consider the needs of different groups or people, particularly those who may struggle the most to access and practice their WASH. It is more about mindset, looking at the situation through eyes that see differences and different needs and barriers that people are facing. It is about caring that if as professionals we do not effectively consult and respond to the needs of different groups of people, that they are likely to struggle to meet their WASH needs, with potential negative impacts on their health, dignity, safety and quality of life.

It is also essential to recognise that to succeed, that this is going to take consistent and sustained effort at all levels and across sectors. It is not going to be resolved by a single or multiple gender and GBV reports on their own, or a few pages of roadmap as something to show that 'we have done gender'.

The 'Women's Social Architecture Project (Pt 1)' and the latrine and bathing facility checklists were (Nov 2018) also commonly stated when asking people about what is being done in the WASH sector to consider and respond to issues related to gender, GBV and inclusion. Both of these are very positive and great interventions, contributing to overall progress of the sector in relation to gender and GBV. But they are only two interventions and have to be acted upon to be useful.

It is also important to recognise that there will also be no one single simple solution to repair gaps in existing facilities as set up. Success will come from commitment, effort and site by site dialogue, to listen to different groups of people and the flexibility to adapt.

We should also expect some efforts to not work – this is also normal - and to recognise that the most effective and useful learning is practical and iterative and when done in parallel by different actors.

We should build on the successes, but also accept our limitations and gaps, using them as opportunities for learning. We should not just sit and wait for a single trial or the perfect solution - as there isn't likely to be one. There are too many challenges on too big a scale to just wait….

47,000 latrines! 1.3 million people!

The WASH sector with support of other sectors, needs to bring the focus

on the **humanity** of the humanitarian response to the forefront

and as one actor said

"We need to remember that there are real people behind the numbers".

Good luck to the sector with taking this forward.