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Humanitarian Emergency Fund

People fleeing Burma/Myanmar: October 2017
Response reports:

- **Christian Aid**
- **Oxfam**

Humanitarian Emergency Fund

Rohingya people fleeing Burma/Myanmar, October 2017

Emergency context

The initial movement of Rohingya people to Bangladesh dates back to 1978, however in August 2017 a massive influx of people to Cox's Bazar in Bangladesh resulted in an increasingly chaotic and unpredictable crisis.

More than 800,000 Rohingya fled to Bangladesh, arriving in urgent need of food and water, sanitation and hygiene materials, and medical treatment. Many children arrived unaccompanied, having had to flee with little or no warning. Camps previously set up by UNHCR and the Bangladeshi Government became overcrowded and unable to meet people's needs, leading to the development of huge makeshift settlements. Formation of camps at this scale is unprecedented, with over 600,000 Rohingya residing in the 'megacamp' alone. Such massive population movement led to rapid environmental degradation both in the camp and the surrounding host communities, meaning that many Rohingya continue to be highly vulnerable, living in extremely harsh and difficult conditions. Aid agencies also had to work to avert the growing threat of outbreaks of communicable and water-borne diseases.

Moreover, in such spontaneous settlements, there is little protection for children, adolescents and women who are exposed to high levels of violence, abuse and exploitation including sexual harassment, child labour, and child marriage, and at high risk of being trafficked.

Based on the Inter-Sector Coordination Group (ISCG) assessments, the Humanitarian Response Plan (HRP) identified sector-specific humanitarian response needs for immediate scale-up to save lives in both settlements and host communities:

- Shelter/Non - Food Items (NFI);
- Food Security;
- WASH;
- Health.

Achievements with HEF Support

Christian Aid and Oxfam each made maximum use of their £60,000 allocations from the HEF, collectively providing emergency support to 46,000 people in Bangladesh. The largest expenditure being on water, sanitation and hygiene (WASH), followed by shelter.

Christian Aid supported 1,480 families[1] (approximately 8,880 people), providing them with emergency shelter kits and WASH kits. Community health campaigns were also conducted to promote good hygiene practices. Furthermore, in the satellite medical camp, more than 5,000 people were treated for a range of conditions and injuries.

Oxfam installed 60 tube-wells with water-pumps and 198 latrines to serve almost 10,000 people and directed HEF funds to make a vital contribution towards the costs of the construction of a surface water-treatment plant in Unchiparang to serve more than 20,000 people.

[1] Christian Aid identified separated and unaccompanied children, pregnant women, elderly people, people with disabilities and physical injures as comprising the most vulnerable households.

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Christian Aid's response

Project Plan

The proposed intervention, implemented by Christian Aid and local partner, Christian Commission for the Development of Bangladesh (CCDB), aimed to provide shelter, water, sanitation and health (WASH) kits to 1,339 families (8,034 people) in new settlements located in Palonkhali Union, in Cox's Bazar District. In addition, an existing medical camp would be supported for fifteen days to address the main healthcare needs of displaced Rohingya people.

Project Impact

Christian Aid's response supported 1,480 Rohingya families[2] (8,880 people) in Jamtoli Camp, Palonkhali Union, in the Ukhia Upazila of Cox's Bazar District with emergency shelter support and water, sanitation and health (WASH) facilities (141 more families than the original project plan anticipated). They also supported 5,495 people with immediate life-saving health care (1,000 more people than anticipated), treating a range of conditions, including violence-related injuries.

Emergency Shelter

Christian Aid, as part of the Shelter / NFI sector, prioritised the provision of 1,480 shelter kits essential to provide security and personal safety, prevent the spread of disease, as well as protection from inclement weather. Torrential monsoon rains added swamp-like conditions to the makeshift camps which, in addition to the food and water shortages, made the experiences for already vulnerable people extremely challenging, with infants, elderly people, and people with disabilities being at even greater risk. The emergency shelter kits comprise 6x3 metre tarpaulin, 6x3 metre plastic ground sheet and 30m of rope. Those who received a kit were able to construct their own shelter with the guidance of *Majhis* (community leaders).

While the standard of the kits was basic, they were critical in protecting families from the continuing monsoon rains. The shelters also protected girls, women and children who are particularly at risk of violence and abuse while living in the open air or in overcrowded shelters.

The Shelter Sector nowneeds to mobilise Phase 2 and upgrade kits, provide technical assistance, training and IEC materials. Christian Aid is collaborating with the International Organisation for Migration to seek more support to fill the gaps.

Water, Sanitation and Health (WASH)

Christian Aid's response focused on distributing WASH kits to households, supplemented by hygiene campaigns, to promote better health and hygiene practices to 1,480 households.

WASH facilities were over-stretched with limited access to bathing facilities, especially for women, and an average of one hundred people per latrine. Given the population density, poor sanitation and hygiene conditions, any outbreak of cholera or acute watery diarrhoea, endemic in Bangladesh, could prove fatal to people living in the temporary settlements.

Each of the households received one WASH kit, comprising one 20-litre bucket, two mugs, four bathing soap bars, five laundry soap bars, 500ml disinfectant liquid (Savlon/Dettol), four 2m

[2] Average household is six members

menstrual cloths, one soap case, and ten Oral Rehydration Salts (Orsalins). Open-air dramas, performed before the camp communities, demonstrated the importance of good hygiene practices. The WASH kits and hygiene campaigns not only contributed to improving people's health in the overcrowded camps but also helped to reduce the spread of communicable disease.

Medical Services

Phase one of the Humanitarian Response Plan included essential health care provision to the Rohingya population whose needs included treatment for physical injuries, gunshot wounds, burns, prevention/treatment of communicable diseases, antenatal care, emergency obstetric care services, reproductive health and sexual/gender-based violence.

Christian Aid's partner Dhaka Ahsania Mission (DAM) established a satellite medical camp and HEF funding financed two doctors, one paramedic, and one nurse for fifteen days. In that period, they treated 5,495 people for violence-related injuries, infectious diseases (diarrhoeal, dysentery), skin diseases, malnutrition, and respiratory tract infections, among other conditions.

Oxfam's response

Project Plan

Oxfam's plan aimed to implement a flexible, mobile water, sanitation and hygiene (WASH) intervention, installing water-pumps and latrines, rehabilitating existing water-points, to provide access to clean water and sanitation facilities to at least 8,000 people living in makeshift camps, host communities and spontaneous settlements in Ukhyia and Teknaf Upazilas, Cox's Bazar District. The intervention would be supplemented by some specific technical WASH supplies provided from Oxfam's Central Emergency Warehouse in the UK as well as locally sourced materials.

Project Impact

The project response saw Oxfam lead a massive upscale in water and sanitation service provision to more than 30,000 people living in the makeshift camps and spontaneous settlements. Oxfam installed 60 water-pumps and 198 latrines serving almost 10,000 people. To maximise the impact, Oxfam allocated some of the HEF funds towards the cost of constructing a large-scale water-treatment plant to serve more than 20,000 people.

Water, Sanitation and Health (WASH)

Oxfam's response included the construction of 60 shallow tube-wells with water-pumps for 6,000 people in Kutupalong. In consultation with the targeted community, the unit price of the chosen design of the latrines cost more than had been anticipated therefore 198 were constructed instead of the planned 300, serving 3,960 instead of 6,000 people.

The third objective of the original proposal had been to repair up to 20 water points for around 2,000 people. However, as the humanitarian situation evolved during the implementation of the project, the Oxfam team decided to direct those funds towards the construction of a surface water-treatment plant to benefit of 21,639 people in Unchiparang.

The siting of water points and latrines were agreed in consultation with the families, and the different needs of women and men were considered during the discussions. The siting and

sharing arrangements for latrines were based on those families who were willing to share together. For each latrine, Oxfam formed a latrine-user group and undertook regular consultations to help each group identify their main problems, solutions that were within their control and those that required support from Oxfam. In consideration of protection risks for women and girls, Oxfam's Public Health Promotion team also ensured that, again in consultation, women were grouped with other families with whom they felt comfortable to share.

These groups were further consulted in the management of tube-wells, with several latrine-user groups sharing a water-point grouped together to form a water-user group. These groups gave feedback on how they would maintain the water-point, and how they would manage chlorination of the water-point in case of emergencies, such as outbreaks of disease.

During listening group consultations, issues with water-points, such as distance and access, were raised by women. This feedback ensured maximum numbers (250 people) were identified for each deep tube-well, and ensured maximum carrying distances of 500m horizontally and 30m vertically. As the operation progressed however, the maximum number of people per tube-well was set at 100 to take account of the available space in the extremely densely populated camp and to minimise queuing.

For Oxfam the urgency to supply such a huge refugee population at times necessitated lesser quality structures being constructed to meet immediate needs. Initial temporary structures constructed in the early days of the overall response are now being upgraded to more durable facilities, such as deep tube-wells and deeper latrines.

Many agencies have also scaled up their hygiene promotion activities to encourage actions to maintain community and individual health. In March, there was a significant shift in coordination structures that saw previous administrative sections known as zones, merge into larger scale areas now known as camps. This restructuring has supported stronger coordination of activities and minimised duplication. The focus from March onwards is shifting to preparedness, acknowledging that June and July are monsoon months for Bangladesh, and that the risk of disease epidemics is also high.

Project Methodologies of the two responses

Both Christian Aid and Oxfam had an existing presence in Bangladesh, each having many years' experience of responding to major emergencies in the country. By September 2017, they had started their own rapid response programme from their own resources: Christian Aid responding in spontaneous settlements, with food, shelter, WASH and healthcare support; Oxfam providing essential WASH, Emergency Food Security and Vulnerable Livelihoods (EFSVL), and protection assistance in Ukhia and Teknaf.

Christian Aid

Christian Aid established a team in Cox's Bazar, deploying technical experts from its Bangladesh Country Office, regional offices and UK headquarters. By implementing some of the activities directly, local partners' capacities and technical expertise have been extended while also ensuring that the response programme followed the Core Humanitarian Standards. Christian Aid also took on the responsibility of Site Management for one of the camps.

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Christian Aid's original plan had been to implement its response through local organisations. Local organisations, however, were overwhelmed by the extent of the crisis. Christian Aid therefore engaged its existing partners, Christian Commission for the Development of Bangladesh (CCDB) and Dhaka Ahsania Mission (DAM) although, initially, neither partner had a presence in the Cox's Bazar District. Nonetheless, within weeks they had taken the lead in supporting the affected people with basic lifesaving services including Health, WASH and Shelter.

DAM had to build rapport with local government, host communities and the armed forces to overcome the non-cooperation, the lack of coordination and the huge Rohingya crowds. Local volunteers were deployed, both from the host and Rohingya communities, to manage the crowds and to overcome the language barriers. In addition, DAM provided residential facilities and extra remuneration to its staff as turnover had been high due to the heavy workload, limited staff facilities and security concerns.

Oxfam

Oxfam, appointed lead for the Water Trucking and Water Sourcing Group, had established field offices in Cox Bazaar and Teknaf. Oxfam's ongoing Rohingya Response is led by the Humanitarian Programme Manager based in Cox Bazaar and supported by the Senior Management Team (SMT), responsible for oversight and to ensure strategies are followed. The office further comprises a Technical Advisory Team which provides technical inputs in design, implementation and monitoring of all interventions. This team consists of technical leads from sectors such as WASH, Emergency Food Security and Vulnerable Livelihoods (EFSVL), Protection, Partnerships, Gender, Advocacy and Monitoring Evaluation Accountability and Learning (MEAL) experts. The two geographical areas of interventions (Ukhia and Teknaf) have dedicated area managers, technical team leads and technical teams supported by the pool of technical staff in Cox's Bazar office.

Currently employing 128 staff and 600 volunteers, Oxfam is strengthening local partnerships so that in due course, more interventions will be localised and implemented by local partners. However, the need to maintain current scale of operations and provisions during the rainy season meant that interventions were implemented directly by Oxfam.

Monitoring, Evaluation, Accountability and Learning

The Christian Aid response team monitored the overall coordination and implementation. Staff and volunteers undertook the data collection for household surveys, compilation of the beneficiary lists, distribution of tokens, and distributing materials. Senior staff from Christian Aid's headquarters in Dhaka visited the project to ensure that the response was following humanitarian standards.

The response plan was shared with the local authorities (who checked the quality of materials) and the army (who monitored the distributions). Groups of *Mahjis* were engaged in beneficiary selection, distribution of materials, and that the needs of the communities were being addressed appropriately. They also gave feedback to improve the response and raise any concern or discrepancy.

Initially, Oxfam had planned to use complaints boxes and hotlines for the tracking of feedback and complaints, however neither approach was suitable. Complaints boxes were not appropriate

due to low literacy rates (approximately 71% of Rohingya self-identify as being illiterate) and new Rohingya arrivals were not entitled to enlist for registration to receive a Bangladeshi sim card, and therefore very few had access to phones.

Instead, Oxfam relied heavily on its staff and community-based volunteers to collect complaints and feedback, initially using a paper-based form, and more recently using a mobile app to record and categorise complaints. In order to better understand feedback from communities, Oxfam's Public Health Promotion team formed 'listening groups' with members of the community who typically do not have voice in other community consultations (women, elderly, adolescent boys and girls) to understand more in-depth feedback regarding WASH facilities.

Key Challenges

For both Christian Aid and Oxfam, the scale of the emergency was a major challenge, as were visas and access to work in the camps.

Initially, many international staff were working on tourist visas, however, the recommendations changed, and all international staff were encouraged to work under a minimum of a business visa, if not an NGO visa. While Oxfam had most staff on business visas, some international staff were detained when trying to access the camps. This situation was resolved by the implementation of a 'camp access pass' system which enabled international staff with the proper visas to enter the camps. Senior staff from Christian Aid's partner, DAM, had to become involved before approval was given to start their project and the DAM team then had to build rapport with the area's stakeholders to gain permission to identify an appropriate site to establish a camp.

Furthermore, although less of an issue, all funding from non-UN sources required to be declared along with a workplan for three months prior to any humanitarian activities taking place. In the rapidly changing context, it was difficult for humanitarian actors to predict the needs, even within these timescales, and this contributed to a lack of flexibility in the overall response, though this did not have implications to project work funded by the Scottish Government.

For Oxfam, the urgent need to supply such a huge refugee population led to structures of a lesser quality having to be built to meet immediate life-saving needs. These temporary structures were subsequently upgraded to more durable facilities, such as deep tube-wells and deeper latrines.

Overcoming the language barriers required the involvement of representatives from both the host and Rohingya communities who elicited information and statements as well as disseminating health and hygiene messages.

Key Lessons

Christian Aid

- Collective efforts within sectors/clusters and UN coordinating bodies is crucial to making an impact quickly;
- Recognising the challenges of liaising with local authorities and armed forces.
- Partner organisation's staff have gained practical skills and to become solution-focused;
- Primary care is linked to other service to ensure that the right care is delivered at the right time and place.

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Having undertaken 'Training the Trainer' training on hygiene promotion through UNICEF, Oxfam and the IRFC, Christian Aid's team's delivery of WASH was enhanced, resulting in greater impacts.

Oxfam

- Strong community consultation on the siting, design, operation and maintenance of facilities.
    - Formation of user groups - as opposed to committees. All members using a facility have a say in how it is operated and implement their own management structure based on what they think they can maintain. Whereas a management committee can often be difficult to maintain, is not representative and concentrates power and influence in the hands of a few members.
    - The user group was also used as a means through which to gather feedback from communities, and to pass on important information, such as information about vaccination campaigns and emergency preparedness.
- The complaints and accountability systems need to be adaptive to the unique needs of displaced populations:
    - Feedback from listening groups, due to literacy barriers or lack of mobile phones.

Finance

Bangladesh: People fleeing Myanmar			
		Christian Aid	Oxfam
SUM - A	SUPPLIES/MATERIALS	46,940	46,158
A1	WASH	**10,688**	**46,158**
A2	Health	**7,752**	**-**
A3	Shelter	**28,500**	**-**
SUM - B	LOGISTICS	6,253	1,472
B1	Transport	**6,115**	**949**
B2	Storage/security	**138**	**523**
SUM - C	PERSONNEL	6,721	12,370
C1	In-country locally engaged staff	**6,721**	**9,857**
C2	In-country expatriate staff		**2,513**
SUM - D	Personal Support	86	-
D4	Communications	**86**	**-**
E	TOTAL DIRECT COSTS	**60,000**	**60,000**

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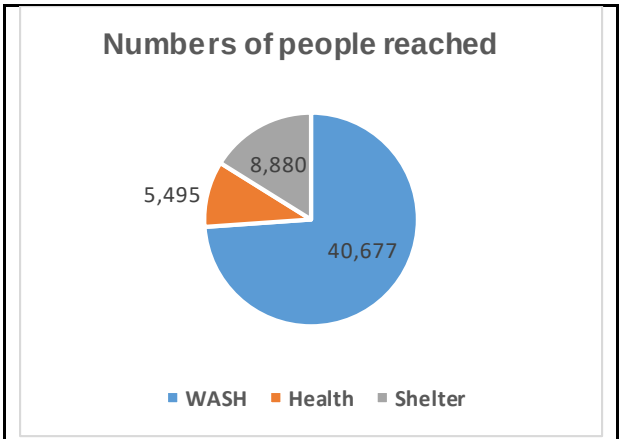
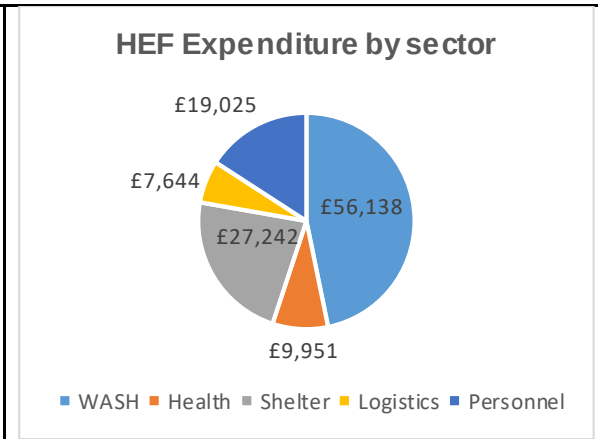


[3]



Pictures from the responses

[3] These figures are approximate and include people who have been supported through multiple interventions.

Beneficiary registration at Christian Aid — Photo credit: Christian Aid

Oxfam's Water, Sanitation and Health (WASH) response

Oxfam latrine
Photo credit: Tommy Trenchard / Oxfam

Mohammad, 8, washes with water from an Oxfam pump.
Photo credit: Kamila Stepien / Oxfam

Mohammad's mother Marium[4] said:

> *"We are happy to have the pump. We've been here for one month and the pump has been here eight days. We used to have to collect water from a well really far away. This is so much better as we can wash. We used to visit the other well three times a day but now we can use this one freely as it is near our house."*

[4] Names have been changed