CARE **Baseline Assessment, October 2020**

Baseline Study on "Improving lives of Rohingya refugees and host community members in Bangladesh through sexual and reproductive healthcare integrated with gender-based violence prevention and response" project funded by German Federal Foreign Office

[Quantitative and Qualitative Analysis of Current Status of SRH, MHM and GBV]

Table of Contents

KEY FINDINGS

Indicator 1: %of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH and GBV prevention measures

i. 75% of respondents have a good understanding on available SRH services in the camp.
ii. Proportion of women who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. The study found that 12% women can make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.
iii. And in terms of delivery facilities, 19% female from both host community and refugee community received Anti-Natal Care (ANC) and Post Natal Care (PNC).
iv. **42% of women and girls reported feeling safe** during this baseline survey data collection.
v. 31% respondents said about violence at home and teasing/harassment
vi. 70% respondents said that they go to the leaders for seeking help when they face any form of violence both in their home and also in the outside of the home

Considering the average result of above three proxy indicators, we can say that, **35% of targeted refugee and host community reported an improved environment for women and girls on SRH and GBV prevention measures at the baseline of the project.**

Indicator 2: # of people (m/f) accessing services and information on SRH services and GBV prevention and response

As per current practice, for SRH services, 8 households are reached by each outreach team (1 paramedic, 2 HC volunteer, 5 Rohingya volunteer) a day and thus 4 outreach teams can reach 32 households a day and 640 a month. In an average 3 members of each household are reached by each visit and this way 1920 people can be reached per month by outreach workers.

Similary for GBV services, 8 households are reached per day by one outreach worker. Thus, 6 outreach workers are reaching 48 households a day and 960 households a month. In an average 3 members of the household is reached by each visit of the outreach worker and this way monthly 2880 people is reached by the outreach activity under GBV services.

Indicator 3: % of refugees and host population who report satisfaction with GBV and SRH assistance

i. 31% respondents from refugee and host community reported full satisfaction with GBV assistance 67% respondents from refugee and host community reported partial satisfaction with GBV assistance;,
ii. 89% female and 56% male from refugee and host community reported full satisfaction with SRH assistance; 6% female and 34% male from refugee and host community reported partial satisfaction with SRH assistance

Indicator 4: % of staff members with improved knowledge on SHR and GBV

80% of staff members with improved knowledge on SHR and GBV

CHAPTER 1
INTRODUCTION

1.1 Background

In response to the health and protection needs of the Rohingya refugees and the host communities in Cox´s Bazar, CARE is implementing the project "Improving lives of Rohingya refugees and host community members in Bangladesh through sexual and reproductive healthcare integrated with gender-based violence prevention and response" with funding support by German Federal Foreign Office. This is a two year project targeting Rohingya refuges of camp 11, 12, 15 and 16 and vulnerable host communities of Jaliapalong union for GBV and SRH services.
To achieve improved sexual and reproductive health, GBV survivor support and protection from GBV of Rohingya Refugees in Cox´s Bazar in Bangladesh, this project works across **three outcomes**. Firstly **general and sexual and reproductive (SRH) health services will be provided through decetralised health centers** which will rove around the target areas to provide services to people at their doorsteps**. Improved Menstrual Hygiene management (MHM)** is the second outcome of this project. There is an absence of space for washing and drying menstrual hyiene materials, leading women and girls to risk their health by drying their materials indoors. Through this project, therefore, two MHM spaces will be constructed next to CARE's existing women and girls' safe spaces (WGSS) in camps 12 and 16. The construction will be accompanied with training to ensure that the spaces are used appropriate. The third project outcome focuses on **prevention of and response to gender-based violence**. Services include psychosocial counselling, referral of GBV survivors, life-skills training, information and awareness-raising and recreational activities. These activities are complemented by community outreach activities, conducted through Rohingya volunteers, to ensure that the communities know about and can access the WGSS, and challenging harmful social norms associated with GBV. Community outreach will take place in camps 12 and 16 amongst refugee populations.

The intended impact of the project is **improved living conditions for women and girls in Rohingya refugee camps and host communities in Cox's Bazar**.

1.2 Outcome Statement:

Improved sexual and reproductive health, GBV survivor support and protection from GBV of Rohingya Refugees and host community members in Cox´s Bazar Bangladesh

1.3 Output Statement:

- ✓ SRH: General sexual and reproductive health services are provided through decentralised health centres
- ✓ MHM: Improved Menstrual Hygiene Management (MHM)
- ✓ GBV: Provision of GBV prevention actions, identification, support and referral of GBV survivors is improved through health centers and women and girls' safe spaces (WGSS)

CHAPTER 2
APPROACH AND METHODOLOGY

This was an internal baseline conducted by a team of CARE staff composed of MEAL team with the support of program team.

2.1. Purpose and scope of Baseline Study

This study indents to draw baseline value for the following project outcome indicators:

- % of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH and GBV prevention measures
- # of people (m/f) accessing services and information on SRH services and GBV prevention and response
- % of refugees and host population who report satisfaction with GBV and SRH assistance
- % of staff members with improved knowledge on SHR and GBV

Since the indicators carry quite wider sense, they were broken down by some relevant proxy indicators to understand overall prevailing situation at the baseline phase.

2.2. Data collection- method and tools:

In order to gather baseline data for key project indicators, the study applied a mixed method combining both quantitative and qualitative survey techniques to provide a more credible picture of the current status.

This baseline study methods included a household survey to collect quantitative data. This helped comprehensively measure the current status of access to different services and views of the participants to enhance the validity of interpretations and transferability of the inferences.

Based on the review of available secondary documents, the baseline study team, developed a semi-structured questionnaire for the HH survey combining key issues related to GBV and SRHR. The HH survey was conducted using KoBotoolbox with 9 enumerators (5 female and 4 male) collecting data for five days in the field.

2.3 Determining sample size

Simple random sampling method was followed to sample individuals from camps 11, 12, 15, 16 and host community (adjacent to camps) for the HH Survey with men, women, adolescent boys and adolescent girls. The baseline study ToR outlined that a sample size of 377 (189 women and girls, 188 men and boys – 50% adolescent and 50% adult), considering 95% confidence level and 5% margin of error. The sample size was equally splited between the 3 camps. The study covered the complete target area proposed by the project, considering the unique nature of each community and the homogeneity and heterogeneity of the respondents/target population.

When conducting the survey the team had enough time to increase number of respondents and finally managed to reach a sample size of 380 respondents (252 women and 128 men). While the proportion of adolescents was low compared to the number of adult men and women interviewed this was still beyond the sample size required for reliable data.

2.4 Recruitment and orientation of field enumerators

CARE recruited a total 9 field enumerators, 5 of them were female and 4 were male. After the recruitment, they were provided with a 1 day orientation on the questionnaire. The orientation schedule comprised of introduction, detailed description and explanation of questions, sampling method, clarification of questions, administrative issues and the use of tablet and Kobo software.

2.5 Data collection and data entry

The enumerator collected quantitative data from the field through face to face interviews with the sampled respondents. They interviewed a total 380 respondents in 4 camps and one union of host community. Each field enumerator was supplied with a tablet in which Kobo software was uploaded. This helped the field enumerator to ensure entry of data in the tablet was consistent and uploaded instantly.

2.6 Data cleaning and analysis

The MEAL team checked the data in the Kobo software and transferred the data into excel for further checking. Later, the team prepared separate data sheet for each specific sector and sent them to Baseline Study Coordinator who further cleaned the data.

The quantitative data analysis was done using excel. Data triangulation with the qualitative data collected in FGDs was the principal means used to ensure validity and reliability of data. The analysis also helped check the consistency with the findings of quantitative data and supported drawing a credible inference.

2.7 Limitations and challenges

There were two key challenges faced in collecting data for this baseline survey:

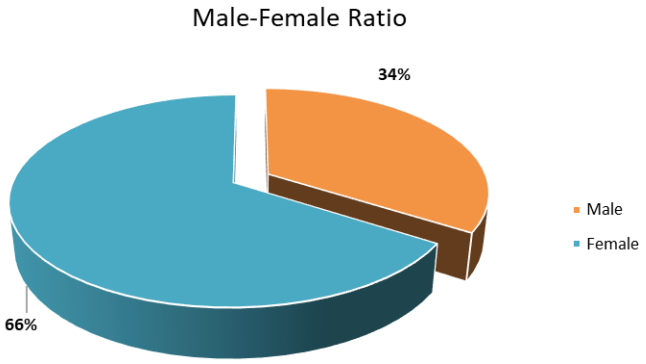
- With the limited space in the camp it is not easy to get private space to conduct confidential interviews.
- At the initial stage of taking interview, the female respondents felt shy to provide information around sexual relationships.

CHAPTER 3
DEMOGRAPHIC PROFILE

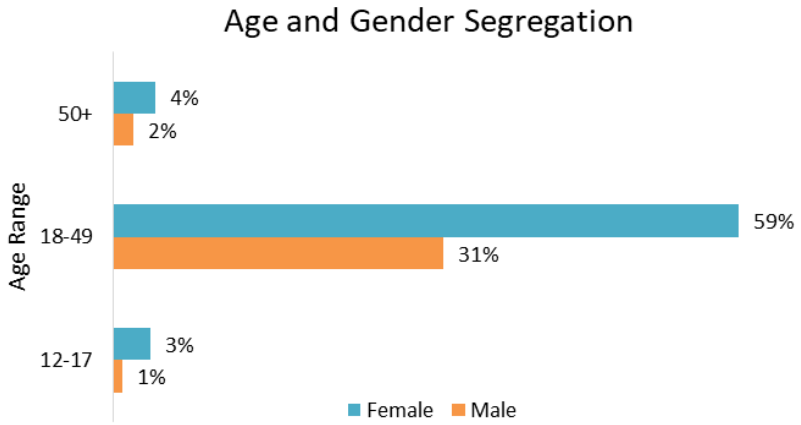
This section presents the basic profile of respondents, including the number, gender, male – female ratio, age group, age category by sex, persons with disability, pregnant and lactating women.

3.1 Age and gender of the respondents

A total 380 individual were interviewed in 4 camps and one union of host community, 66% (252) of them female and 34% (128) male.

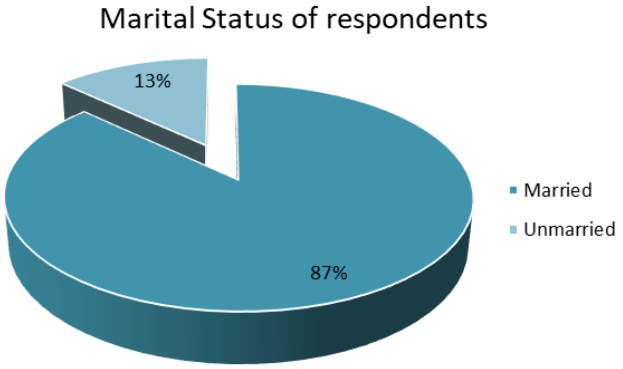


The majority of the respondents were female and male adults (aged between 18 and 49), followed by female and male adolescents (aged between 12 and 17), with a very small proportion of female and male respondents over the age of 50. Here 59% female and 31% male were within 18 – 49 age group. There were very less proportion of respondents at the age bracket of 12 – 17 and 50+.



3.2 Marital Status of Respondents

The main objective of the baseline was to assess overall environment in regard to GBV and SRH in camp and adjacent host community. Understanding marital status of respondents are thus important for the baseline. According to the survey data 87% of respondents reported they are married while 13% were unmarried.



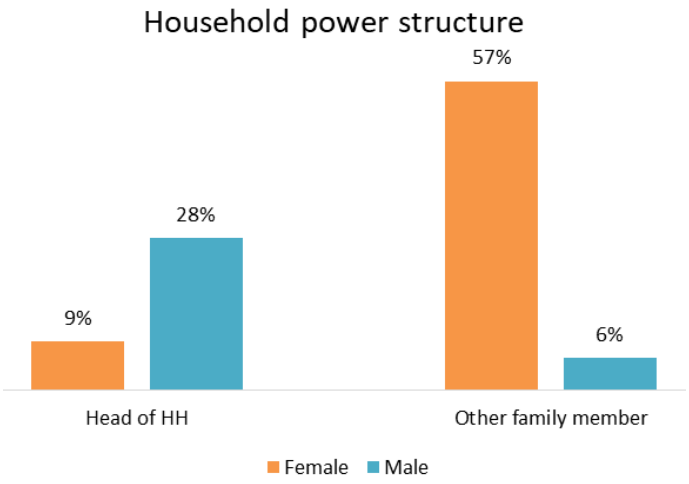
3.3 People with Disability

Among the respondents, 8% female and 2% male respondents were identified as persons with disability –in terms of having difficulty walking, difficulty hearing and difficulty using usual language or communicating.

Among the respondents with disability, 31% female 8% male reported having difficulty walking, 22% female and 6% male reported having difficulty seeing and thus they can't move freely.

3.4 Head of Household

Head of the household represents the power dynamics of the family. Among the 252 female respondents, 9% were head of household while among 128 male respondents 34% were head of HH. The rest respondents are other members of the family. It shows that, the families are predominantly dominated by male members.



CHAPTER 4
STUDY FINDINGS

4.1 Improved environment for women and girls

Indicator 1: % of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH and GBV prevention measures

In the following sections the impact of SHR and GBV prevention measures will be analysed separately.

4.1.1. Improved environment for women and girls on SHR services Sexual Reproductive Health (SRH) is an essential component of humanitarian response for Rohingya refugees. Women and girls living in humanitarian settings often face high maternal mortality and are vulnerable to unwanted pregnancy, unsafe abortion and sexual violence. To understand the improved environment for women and girls on SHR services, the baseline study explored against three proxy indicators i.e. the level of understanding of respondents on SRH services, decision making authority regarding SRH issues in the HH, and child delivery facilities in four camps and one union of host community in Ukiya Upazila of Cox's Bazar.

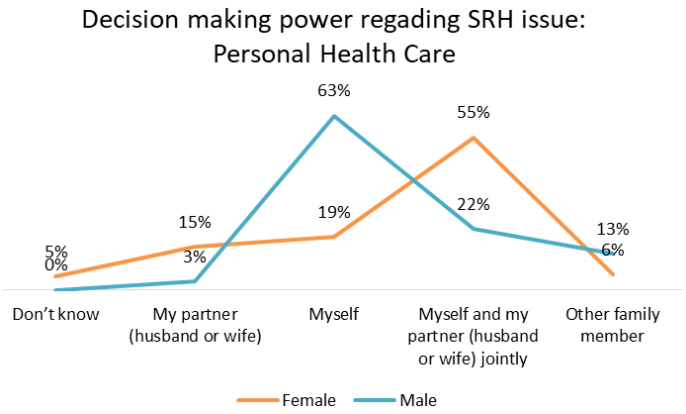
4.1.1.1 Understanding of respondents on SRH services

The respondents were asked about their level of understanding on SRH service which are offered to them and available in their camp. As per the below table, 74% and 19% of respondents respectively said that they have good and very good understanding on SRH services which are offered to them and are available in their community (both host and refugee). Among the rests, 6% responded that they have medium level and 1% responded that they have poor understanding.

Understanding level of respondents on SRH services which are offered to them and available in community	Percentage
Good	74%
Medium	6%
Poor	1%
very good	19%
Grand Total	**100.00%**

4.1.1.2. Decision making authority regarding SRH issue:

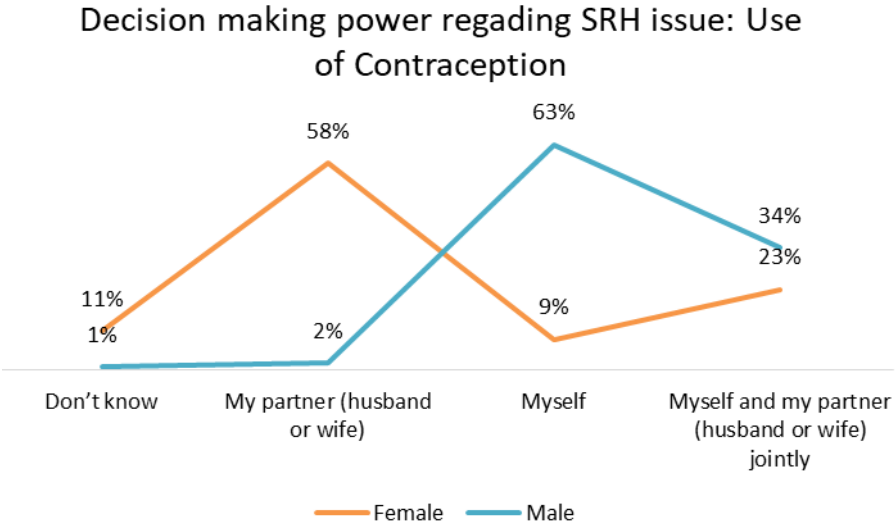
Decision Making on Personal Health Care



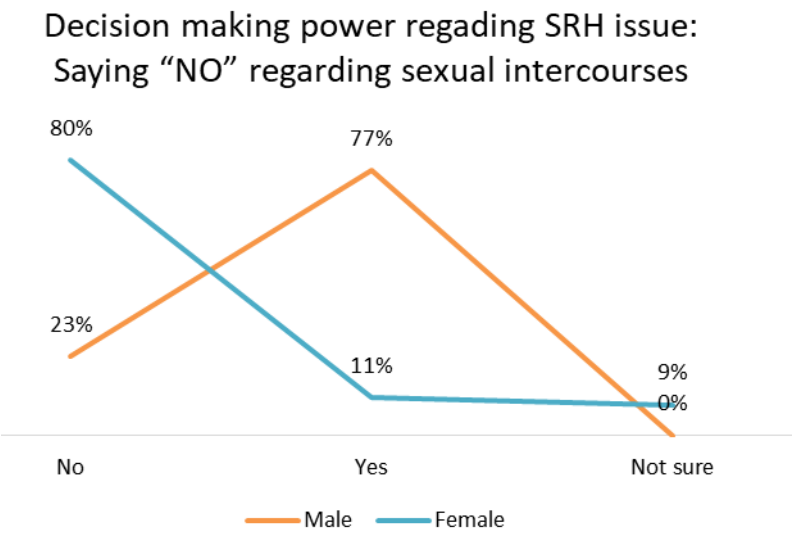
When it comes to decision-making on personal healthcare, analysis of survey data shows that among the female respondents from both host and refugee community only 19% can take decision by themselves, for 15% of female respondents' decisions are taken by their partners and for 55% female respondents decisions are taken jointly with their husband. On the other hand, among the male respondents, 63% said that they make own decision about personal healthcare. Only 3% of them depend on their partner to make decisions and 22% make joint decision with their partner (wife).

Decision Making on Use of Contraception

When it comes to decision-making on use of contraception, analysis of the results shows that 58% of female respondents depend on the decision of their partners while 9% can make their own decisions, 23% take joint-decision with their husbands and 11% of respondents reported that they don't know. For male respondents a much higher proportion take their own decision (63%) and a higher proportion report joint decision-making (34%) while only 2% said they depend on their partner's decision and 1% doesn't know. The discrepancy between male and female perceptions around joint decision-making is interesting since men appear to perceive a higher level of joint-decision making compared to women.



Decision making on Saying "NO" regarding sexual intercourses



This graph represents the power/authority to express willingness or unwillingness to have sexual intercourse with the partner. Analysis of the results shows that 80% female respondents do not believe they have the authority/ right to say "NO" to their partner on having sexual intercourse while 77% male respondents believed that they have the authority/right to say "NO" to their partner during sexual intercourse.

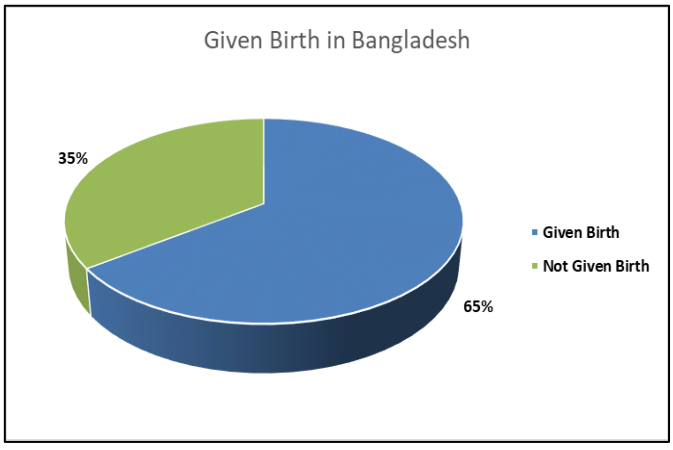
The outcome level indicator "**% of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH prevention measures**" is thuse assessed through following three questions:

- Proportion of women who make their own informed decision regarding sexual relations
- Proportion of women who make their own informed decision regarding contraceptive use and
- Proportion of women who make their own informed decision regarding reproductive health care

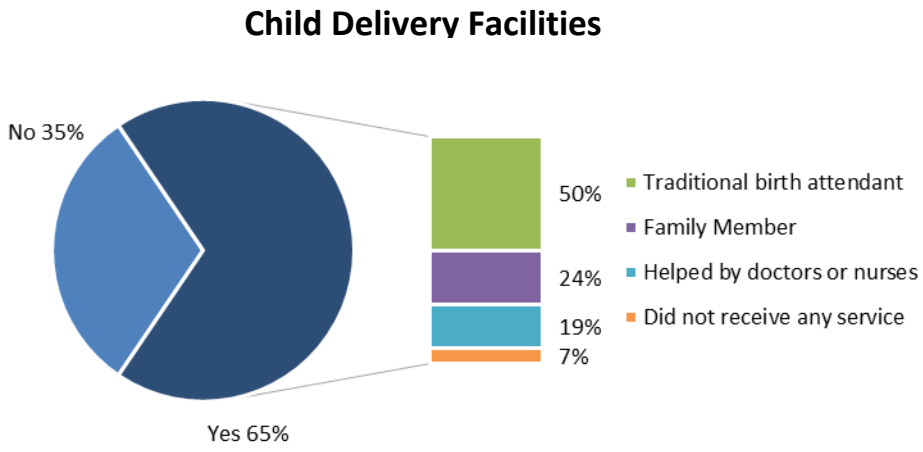
Only women who responded positively to all 3 above questions are considered as making their own informed decisions. This means that respondents must report making their own decisions on healthcare and use of contraception, and report being able to say "NO" to sexual intercourse. The results show that only 21 married female respondents among 221, answered positively to all three questions. Therefore the baseline result for this indicator is: **12% of women make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care**

4.1.1.3. Child Delivery Facilities

The married refugee female were asked if they they have given birth to any child since they arrived in Bangladesh. 65% of them responded affirmative that they have given birth since arriving in Bangladesh. Of those women, 50% gave birth with the help of traditional birth attendant, 24% gave birth with the help of family members, 19% were helped by doctors or nurses in health centers or HH visits, and the remaining 7% did not receive help during the child birth. Most common medium is traditional birth attendant. At the very beginning of influx, the situation was quite dire to provide intensive maternal health care service to the affected people.



Traditional birth attendents were the only option to get help from during that time. In the recent days, they give birth with the help of trained nurses. CARE Bangladesh is also providing training to traditional birth attendants so that they also can provide quality services.



Receiving Maternal Health Facility during last pregnancy	Percentage
No	66.67%
Yes ,post-natal care	10.95%
Yes, ante natal care	3.48%
Yes, both	18.91%
Grand Total	**100.00%**

In response to the question on whether they have received maternal health services or not during last pregnancy, majority of them (67%) responded negatively. Only 11% said they only received PNC services, 3% said only ANC services and 19% said they received both ANC and PNC services.

"%of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH prevention measures":

- 75% respondents have good understanding on available SRH service.
- Proportion of women who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. 12% of interviewed women can make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.
- 19% of interviewed female from both host community and refugee community received both Anti-natal Care (ANC) and Post Natal Care (PNC).

So, we can say that, **35%** (average of result of three proxy indicator) **of targeted refugee and host community report an improved environment for women and girls following the implementation of SRH prevention measures.**

4.1.2. Improved environment for women and girls on GBV

The improved environment for women and girls following the implementation of GBV prevention measures, was assessed though proxy indicators like feeling of safety by and most significant safety and security concern for women and girls in the community.

4.1.2.1 Women and girls reported feeling safe

People living in the camp have lost protective mechanisms such as social and economic support system and family and community structure, and are therefore more vulnerable. Some people, especially women and girls are more vulnerable to GBV than others. There are several situation at camp level where the effected people can feel safe, unsafe, very safe or very unsafe.

According to the baseline survey data, the 31% of female respondents reported feeling unsafe while going to a distribution (in-kind) point alone, whereas non of the interviewed men reported feeling unsafe to go to distribution (in-kind) point alone.

The other places female respondents also reported feeling unsafe or very unsafe include inside their home at night (15%), going to the market alone (3%) and undertaking a job outside of the household (24%).

Interestingly 11% of men reported feeling unsafe at home at night. This seems to suggest that perceived threats come from outside the home but this is not supported by the results on accessing WASH facilities at night alone – 14% of female respondents and 9% of male respondents report feeling unsafe or very unsafe – which suggest that more people feel safe outside their homes at night than feel safe inside.

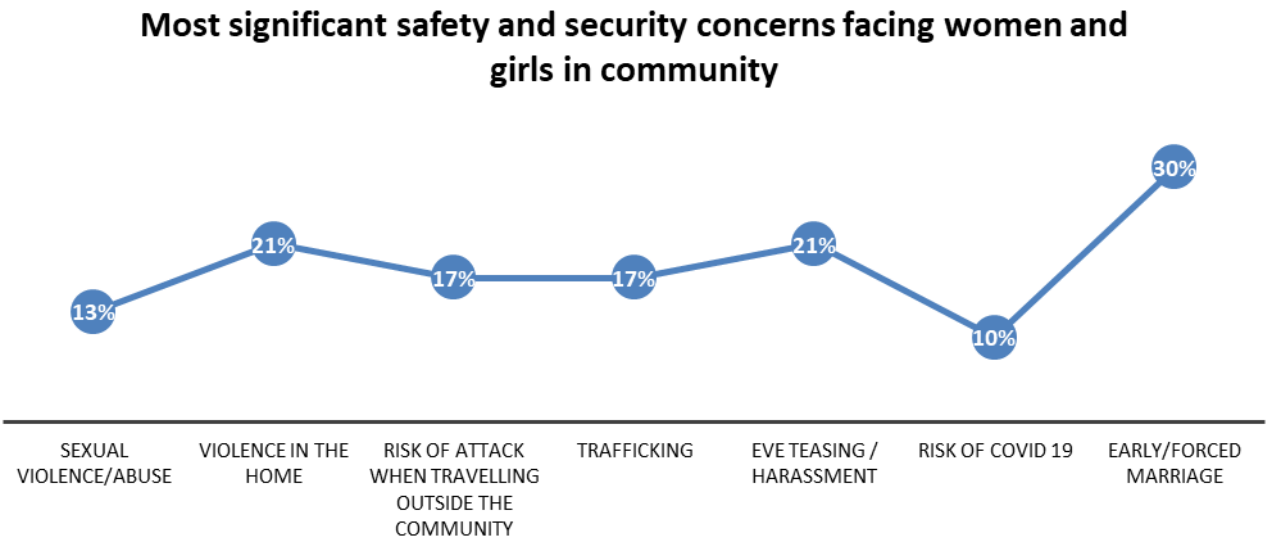
	How safe do you feel to go to the market alone?		How safe do you feel within your household?		How safe do you feel to undertake a job outside the household?		How safe do you feel to go to any distribution (in kind) alone?		How safe do you feel accessing WaSH facilities at night alone?		How safe do you feel outside your home at night?		How safe do you feel inside your home at night?	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Very safe	45%	6%	44%	11%	44%	9%	46%	6%	23%	9%	24%	7%	42%	7%
Safe	52%	49%	56%	88%	56%	67%	54%	63%	67%	74%	65%	78%	58%	91%
Unsafe	3%	3%	0%	1%	0%	24%	0%	31%	9%	14%	11%	15%	0%	2%
Very unsafe	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%
Other	0%	42%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

"% of women and girls reporting feeling safe following the implementation of GBV prevention measures" is measured through the first 3 questions around safety. This means that respondents must report feeling "safe" to all 3 scenarios i.e. going to the market, in their household and undertaking a job outside the household to count as "feeling safe". The results show that 107 female respondents among 252 female responded positively to all three questions. Therefore the baseline result for this indicator is: **42% of women and girls reporting feeling safe** [following the implementation of GBV prevention measures].

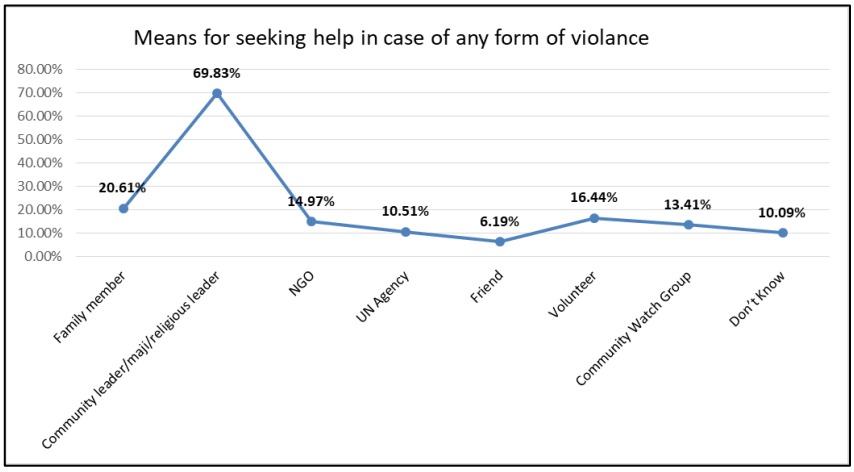
4.1.2.2. Most significant safety and security concerns for women and girls in community

The significant safety and security concerns for women and girls in the community, are early marriag (30%) violence at home (21%) and teasing (21%). Respondents mentioned that domestic violence includes both physical and psychological torture. Another security concern which was mentioned by

17% of respondents was feeling unsafe whenever moving outside in the community for any work. Sexual violence/abuse is mentioned by 13% of the respondents as their safety security concern. Most of them were not interested to discuss further about this issue.



4.1.2.3 Seeking help in any form of violence and safe space for female



About 70% of the respondents go to to their community leaders/majhi/religious leaders for seeking help whenever they face any form of violence both in their home and also outside their home. According to the baseline, most of the female respondents (52.03%) said that they feel safe in CARE's WGSS where they also can get awareness knowledge which help to improve their day-to-day life. And also in WGSS they can have some recreational activities and referrals.

Therefore, the status at the baseline of three proxy indicators are as below which will used to measure progress of the indicator "**% of targeted refugee and host community report an improved environment for women and girls following the implementation of GBV prevention" is accessed as following:**

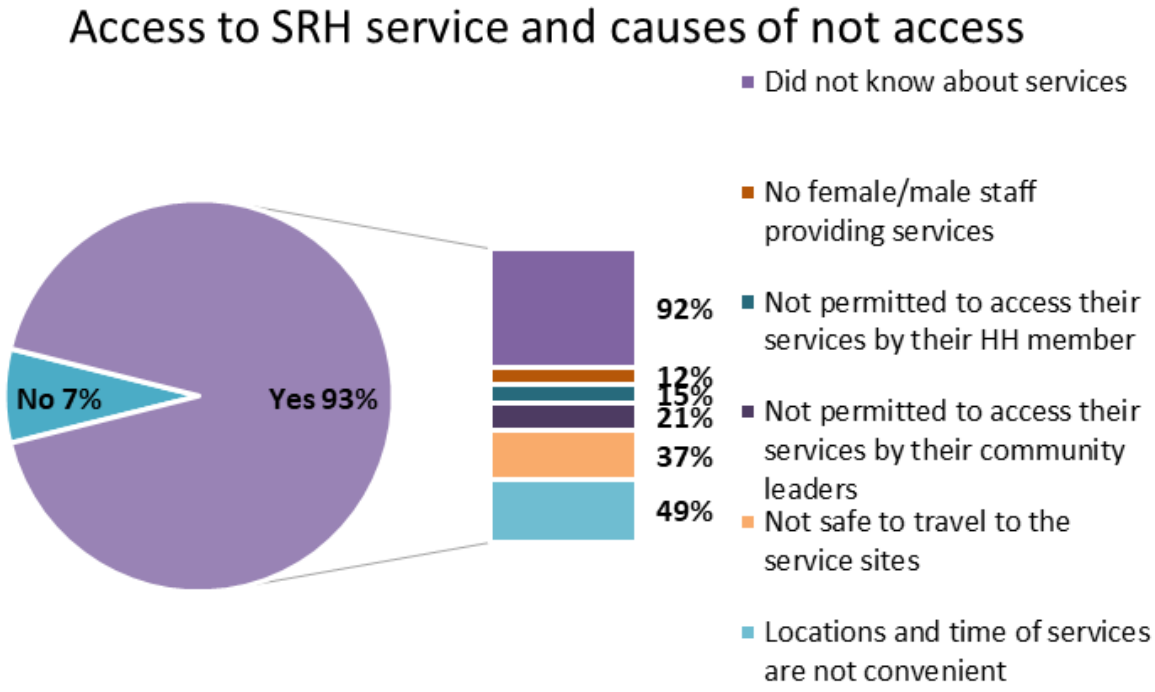
i. 42% of women and girls reporting feeling safe following the implementation of GBV prevention measures.

ii. 31% respondents said early marriage is the most significant safety and security concern, followed by violence at home (21%) and teasing/harassment (21%).

iii. 70% respondents (male 28% and female 42%) mentioned that they go to community leaders for seeking help when they face any form of violence both in their home and also outside of their home

4.2 Utilisation of SHR and GVB services

For the indicator # of people (m/f) accessing services and information on SRH services and GBV prevention and response the respondents were asked, if they have ever accessed/received any SRH service from CARE Bangladesh. 93% (353) respondents said that they have accessed the service while 7% (27) responded they have not. The respondents who responded negatively, were further asked on the reason for not accessing the service. The main reasons identified by majority of them are not knowing about the services (92%), the location and time of service provision were not convenient to them (49%) and 35% did not feel safe to visit the service center (37%). Some other reasons were also identified such as no permission from HH members (15%), barrier from community (15%), lack of female/male staff providing the service (12%).

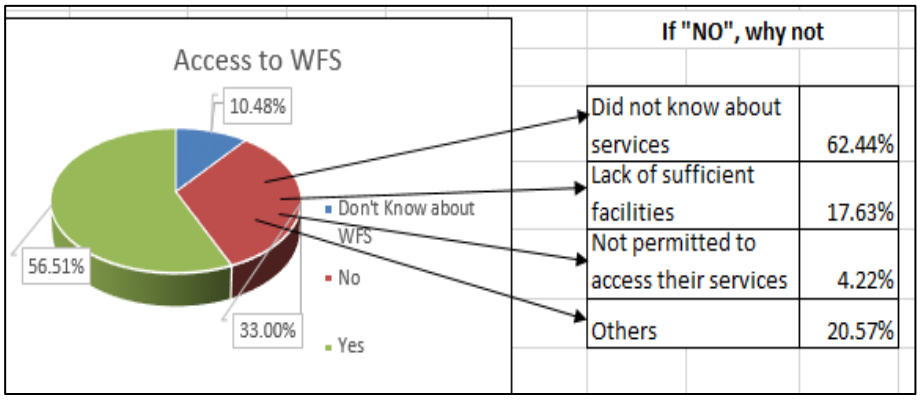


4.3. Satisfaction of population with GBV and SRH assistance

% of refugees and host population who report satisfaction with GBV and SRH assistance

To measure the satisfaction level at baseline on the GBV assistance, the resondents were asked if they have accessed WGSS.

The figure shows that, among the female respondents more than 56% female accessed CARE's WGSS and 33% of the respondents did not have access to WGSS, furthermore, more than 10% of the female respondents mentioned that they don't know about WGSS. The majority of women who didn't

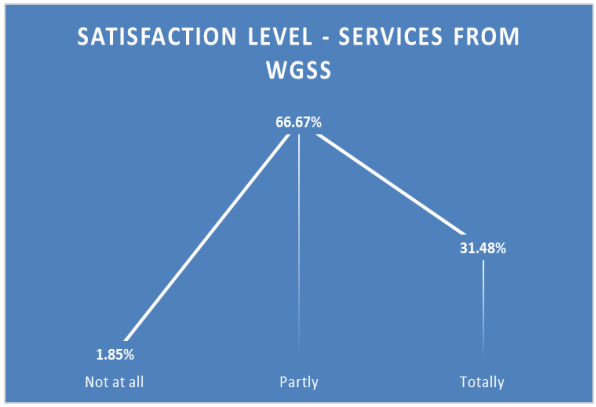


access the WGSS (62%) mentioned that they are not aware about the services provided by WGSS. Other reasons are a lack of and poor quality of sufficient facilities in WGSSS, no permission to access their services by their father/husband/other male HH member, by their mother/wife/other female HH member, not safe to travel to the service sites, and the locations and time of services are not convenient.

How safe do you feel to go to WGSS (women and Girls Safe Spaces)?	Percentage
Safe	81.09%
Unsafe	14.43%
Very safe	2.99%
Very Unsafe	1.49%
Grand Total	**100.00%**

81% of women who attend the WGSS felt safe in the WGSS, 9% felt unsafe and about 1.49% felt very unsafe due to some security concerns in camps. For example, adolescents highlighted that they face teasing in the road. That's why they are not comfortable to come to WGSS.

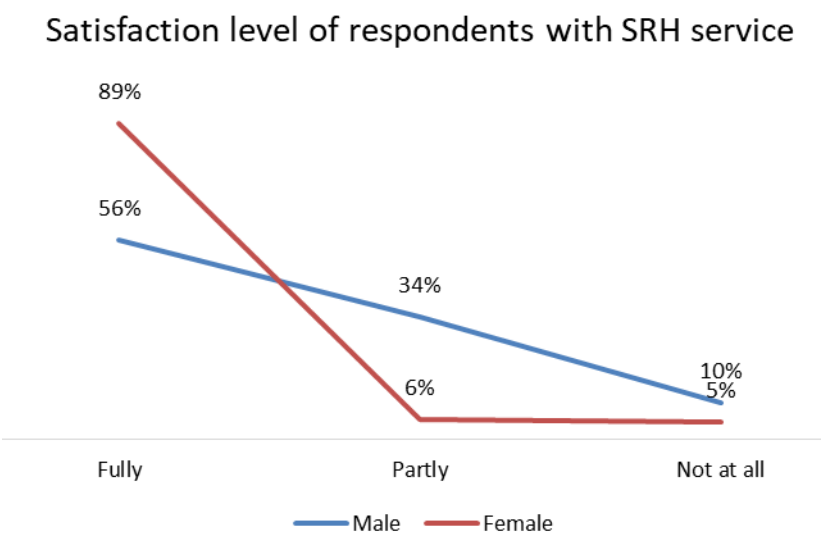
Among the female respondents, most of them were partially satisfied with the services provided from WGSS. About 67% respondents said they were partially satisfied and 31% said they were fully satisfied with the services. 2% of the respondents said they were 'not at all' satisfied. The respondents also provided some suggestions towards smooth and better service delivery. Most of the respondent suggested that need more awareness raising at household level as well as among the community leaders. Below table has further details on this:



Suggestions for Improvement	Percentage of respondents
Friendly staff behavior	5.25%
Changing the time	1.49%
More life skill materials	14.34%
More life skill trainers	17.71%
More awareness raising of HH	22.33%
Provide more information on services of WGSS	22.62%
Awareness raising of leaders	26.83%

- 67% respondents from refugee and host community reported partially satisfaction with GBV assistance
- 31% respondents from refugee and host community reported fully satisfaction with GBV assistance

Among the female respondents who used SRH services, 89% said they were fully satisfied with the service while 6% were partially and 5% were not at all satisfied. Among the male respondents, 56% said they were fully satisfied, 34% partially and 10% not at all satisfied.



- 89% female and 56% male from refugee and host community reported full satisfaction with SRH assistance. (Among them 67% female from refugee and 22% female from host community, 48% male from refugee community and 8% male from host community)
- 6% female and 34% male from refugee and host community reported partial satisfaction with SRH assistance (Here, 5% female from refugee and 1% female from host community, 29% male from refugee community and 5% male from host community)

4.4 Knowledge of staff members

80 % of staff members with improved knowledge on SHR and GBV

4.5 General sexual and reproductive health services are provided through decentralised health centres (Output 1)

Indicator 2: # of services provided by static health posts

- In an average 60 individuals per day can get services from a static health post per day. The services of static health post include sexual and reproductive health services including family planning and general health services.

Indicator 3: # of women aged 15-49 using sexual and reproductive health services

- The monthly average number of women aged 15-49 receiving SRH services from one health post is 260 and from one outreach team is 115 (the numbers are without double counting).

Indicator 4:# of long-acting reversible contraceptive (LARC) services provided

- The monthly average number of LARC services from one health post is 10.

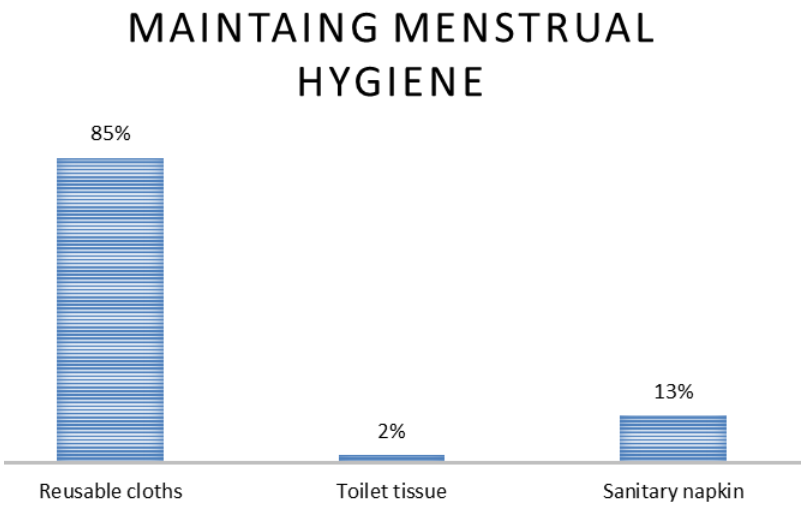
Indicator 5: # of provided different types of contraception for women aged between 15 – 49

- The monthly average number of women receiving different types of contraception from one health post and one outreach team 120 and 80 respectively.

4.6 Practice on improved MHM knowledge (Output 2)

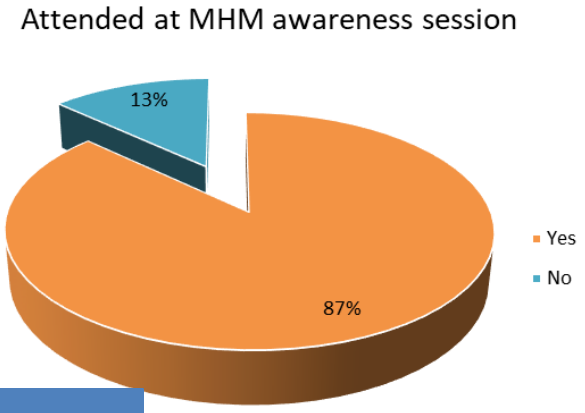
Indicator 1: # of refugee women use properly cleaned menstruation material

The vast majority (86%) of interviewed women responded that they use reusable cloths, 2% uses toilet tissue, only 13% uses sanitary napkin, because they did not receive the MHM kits at the time of the baseline survey. Further discussions showed that the respondents who use reusable cloths are facing different problems to manage the cloths such as lack of sun drying facilities, washing of cloths and storing for next use.

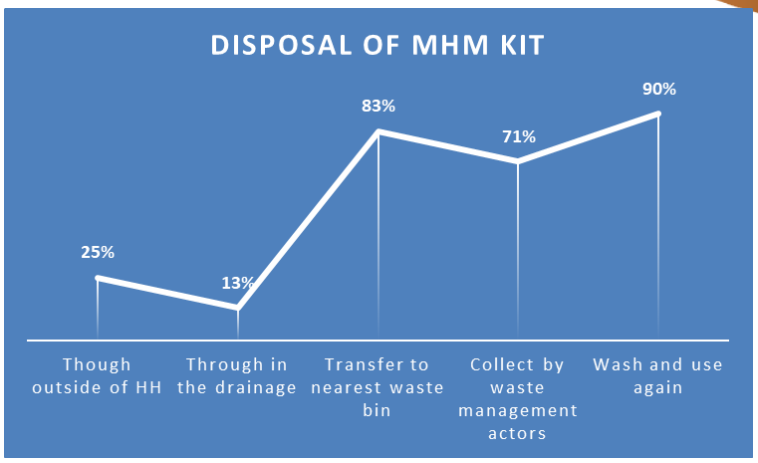


Indicator 2: # of women received and apply knowledge and information on improved MHM

The female respondents from both host community and refugee community were asked, if they have ever attended in any Menstrual Hygiene Management awareness raising session. Among them, 87% said that they joined at least one awareness raising session on MHM arranged by CARE Bangladesh. 13% of them responded that they have not joined in any session.



Respondents were also asked on the ways of disposal of menstrual hygiene kits. 90% of respondent said that they wash the cloth and use it again, 83% said they transfer to nearest waste bin, 71% said their MHM kit collected by waste management actors, 25% said they throw it outside of their house.



When they reuse the cloth most of them wash it with soap and sundry it.

- 85% of respondents use reusable cloths during their menstrual period
- 90% of respondents wash and use the cloth again

Indicator 3: # of women and adolescent girls having received MHM kit

MHM kit is a regular item for women and girls and normally it is supposed to be distributed every three months. However, at the time of baseline survey, **CARE has not distributed any MHM kits** to the women and girls of target blocks since the beginning of the year 2020.

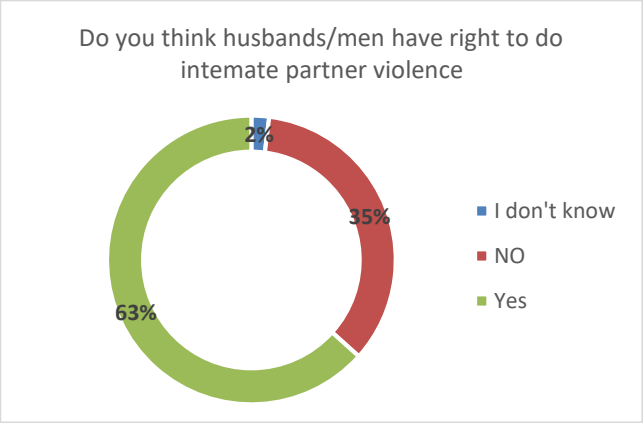
4.7 Provision of GBV prevention actions, identification, support and referral of GBV survivors is improved through health centers and women and girls' safe spaces (WGSS) (Output 3)

Indicator 1: # of women with and without disability with access to safe space

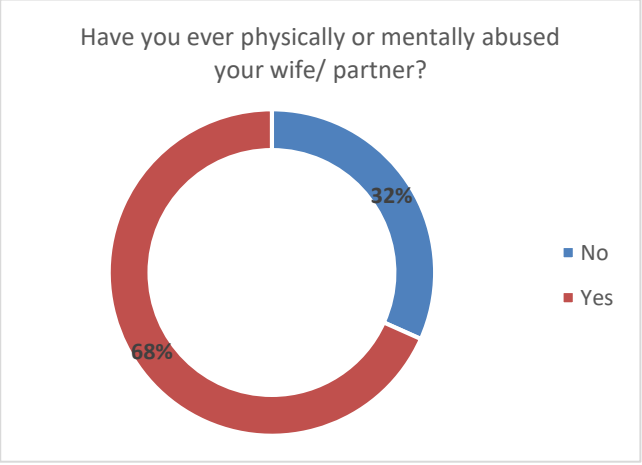
230 women with and without disability accessed one WGSS in one month (the first month after operation of the WGSS under this project).

Indicator 2: % of men and boys who report rejecting intimate partner violence and domestic violence

A questionnaire survey was conducted with only men and boys in the target refugee and host communities. The respondents were asked if husband/ men have right to commit any form of violence against their wives/ intimate partners. 35% of the respondents mentioned that they think husbands/men don't have the right to beat or do violence against their wives or intimate partners while 63% of respondents said 'yes' and rest 2% said they 'don't know'.



The respondents were also asked if they have ever committed any form of violence to their wives/ intimate partners. 32% said they have never commited any form of violence to their wives/ intimate partners.



The respondents those who said "Yes" about husbands/ men have right to beat their wives/ partners, they were asked about their perception on which situation the men can do so. Below table summarizes the responses.

	% of respondents
If wife doesn't take care of husband's parents/ siblings	38%
If children are not taken care of	28%
If wife goes outside of home	27%
If husband's clothes are not cleaned	23%
If food is not prepared on time	18%

If misunderstands	8
If doesn't obay, misbehaves and altercates	5

Indicator 3: # of women aged 15-49 receiving psychosocial support and counselling (group and individual)

- 159 women aged 15-49 received PSS and counselling from one WGSS in the first month of start of operation. Which is around 6% of the total women and girls of the mentioned age group of one target WARD.

Indicator 4: % of women aged 15-49 who used services they were referred to

- 35% women aged 15-49 used services they were referred to. During the first month of operation of WGSS, total 7 women were referred. 5 of them were referred for health services and that they received as per need. Two other women were referred for legal support which was not immediately received as it is a legnthly process.

RECOMMENDATIONS

1. Sexual Reproductive Health

1.1 There is need for intensive campaign on sexual reproductive health.

The findings suggest that the community's level of awareness is limited within only 2-3 issues such as services during pregnancy, delivery and post delivery period. Creating awareness on SRH issues like family planning issues among the adolescent girls is crucial for proper management of SRH and their development.

1.2 There is need to increase peoples knowledge about availability of SRH services

People's knowledge about availability of services for particular heath centers on particular problem is crucial for shaping their health seeking behaviors. The findings indicate that only 15% female and 12% male has awareness on SRH health services.

1.3 There is need to promote awareness of modern family planning methods.

The study reveals low level of awareness among the people on modern family planning method; it shows that Male – Female ratio of using family planning method is 32:68. So, it is needed to increase awareness within the people especially among male groups so that they can take more family planning method.

1.4 Awareness raising of female in sexual relation and increase the male engagement

The study findings suggest that taking decision of female respondents on "Taking/Not taking Contraception" mostly depends on their partners, about 58% female depends on the decision of their partners regarding taking or not taking any contraception while 9% respondents took decision

themselves for making decision on “Taking or Not taking Contraception”. In both cases, joint decision is lower than taking decision themselves or depends on the decision of partners. In this study, it showed that 27.25% female respondents have no power/capability to say “NO” to their partner during sexual intercourse while 19.66% male respondents have the capability to say “NO” to their partner during sexual intercourse.

2. Gender Based Violence

2.1 Create the provision of security inside the camp, water point and latrines.

Both in Rohingya camp and host communities there are security concerns for women and adolescent girls especially at night. The major concerns are around going to latrines and water points at night as most of the GBV incidents happen there. Through the project the structural and environmental GBV risk will be identified by safety audit and community risk mapping and action will be taken to mitigate the risk.

2.2 Increase awareness of women on GBV issues

To mitigate the GBV risk and prevent the gender based violence it is very much essential to inform the project participants and the community people about GBV messages. In this regard men and boys engagement is a crucial component to mitigate the GBV risk and to create a safe environment for women and girls.

3. Menstrual Hygiene Management

3.1 Need more awareness raising on MHM

Menstrual hygiene management is vital for women and girls to ensure better menstrual health. In Rohingya refugee crisis context, the women and girls are not much aware about proper MHM and thus there are rooms to build the awareness to uphold the SRH right for women and girls.

3.2 More supply of MHM kit

From the findings of this survey as well as other gender analysis reports, there are still gap in terms of adequate supply of MHM kits for Rohingya women and girls and as a result significant portion of women and girls still follow traditional practice during their menstrual period. Bearing that in mind, need more emphasis on providing MHM kits to the target women and girls.