Influx of Rohingya Refugees in Bangladesh

unicef

Bangladesh
Revised Response Plan
October 2017

Context and Humanitarian Needs

The influx of Rohingya refugees from northern parts of Myanmar Rakhine State into Bangladesh restarted following the attacks in the Myanmar Border Guard Police posts on 25 August 2017. As of 30th September, the Inter-Sector Coordination Group (ISCG) reported that an estimated 501,800 people have entered Bangladesh since the attacks. The situation remains highly fluid, with more than 15,000 people coming in every day. People continue to come in through different crossing points, including by marine routes in coastal areas on the Bay of Bengal, over the Naf River in Teknaf and via land crossing points in Ukhiya and Bandarban District.

SITUATION IN NUMBERS

720,000
Children affected

1,200,000
People affected

With the new Influx of 501,800 since 25 August 2017, the current total number of Rohingya people who have fled from Myanmar into Bangladesh, coupled with the affected population in the communities has reached 1.2 million[1] as estimated by the Inter-Sector Coordination Group (ISCG). It is estimated that 80 per cent of the new arrivals are children and women including newborn babies and pregnant and lactating women.

720,000 children, both from new arrivals, existing Rohingyas, contingency and vulnerable host communities, are affected and need urgent humanitarian assistance including critical life-saving interventions.

UNICEF has been providing humanitarian assistance since previous influx in October 2016. As of September 2017, UNICEF has so far reached a total of 100,000 people with WASH facilities, and deliver key message on improved hygiene practices. Over 45,000 children were screened for malnutrition of which

UNICEF Assistance Requirements

US$76 million

[1] The 1.2 million also includes 200,000 Rohingya before the new influx, 199,000 for contingency and 300,000 affected host communities. Prior to August this year, around 33,000 registered Rohingya refugees lived in two camps officially recognised by the Government located in Kutupalong and Nayapara in Ukhiya and Teknaf upazilas respectively, which have been functioning since 1992 under the care of UNHCR. In addition, more than 60,000 undocumented Rohingya resided in makeshift settlements (in Leda, Kutupalong, Shamlapur and Balukhali) and an estimated 300,000-500,000 lived scattered within the host communities through the district and across the country.

7,000 were provided with micronutrient powder and 650 were treated for severe acute malnutrition. UNICEF is also procured nutrition supplies to treat children with severe acute malnutrition; 19,000 pregnant and lactating women received infant and young child feeding counselling support; 25,000 children received psychosocial support and child protection services through Child Friendly Spaces (CFS) and Adolescent Safe Spaces; and 16,000 children are attending UNICEF supported learning centers. For prevention of diseases 133,000 children (6 months -15 years) were vaccinated against measles and rubella as well as Polio.

To deliver immediate life-saving humanitarian assistance to the affected women and children, UNICEF requires US$76 million for the next 6 months. UNICEF is responding to this emergency in partnership with other humanitarian actors (Govt. of Bangladesh, UN agencies, and NGOs) with support from donor agencies. This response plan is in line to UNICEF contribution to the inter-agency humanitarian response plan. Based on this plan, the country office will update UNICEF's Humanitarian Action for Children (HAC) appeal. The required assistance includes emergency WASH, Nutrition, Child Protection, Health including Cholera prevention and response as well as Education services to vulnerable populations, mainly women and children. This response plan will be reviewed and revised after a period of six months of its implementation.

Based on its strong existing programme in host communities and Child Protection and Education in makeshift settlements, UNICEF will aim at universal coverage of children in needs in all areas in makeshift settlements, new spontaneous settlements and host communities. UNICEF will expand its WASH, Nutrition, Community Mobilisation including through adolescent engagement and Health Programme in host communities and makeshift settlements, in particular in Kutupalong and the Balukhali extension, as well as the new spontaneous sites in host communities where other actors are not yet present. Amongst the new spontaneous settlement, UNICEF is prioritizing Unchiprang while being mindful of the government's relocation plans. All of strategies outlined below take into consideration the importance of the humanitarian-development nexus. UNICEF also aims to strengthen government systems and process to benefit the affected population; including host communities.

UNICEF Strategy

UNICEF's comparative advantage is its ability to work simultaneously with the Government, local and international NGOs and other civil society organizations, to coordinate and mobilize their support as appropriate. UNICEF is working in close coordination with all the humanitarian actors at the national and at sub-national level including government line ministries and departments, such as the Department of Public Health Engineering (DPHE) to effectively scale up WASH intervention and Civil Surgeon's Office for mass immunization campaign. UNICEF is leading the Nutrition sector and Child Protection sub-sector and co-leading WASH with ACF and Education sector with Save the Children at sub-national level.

WASH

WASH is the ***key priority for UNICEF*** given the appalling situation in the makeshift and spontaneous settlements, the immediate impact on the health of the Rohingya refugees and the *potential for a catastrophic outbreak of disease, particularly Acute Watery Diarrhoea*. The response will focus on the immediate provision of safe water, basic sanitation and community engagement around hygiene practices. *UNICEF will directly reach 50% affected population on water and sanitation and 40% on hygiene.*

Provide sufficient quantity of ***safe water*** *to the target population of the Rohingya refugees* (in compliance with Sphere standards) in the makeshift and spontaneous settlements through the most appropriate means in each respective context. This will be a combination of handpumps at tube-wells and water distribution points with storage tanks replenished by water trucks. Water trucking will be used only where no other immediate solutions are available. More durable solutions will be sought to phase out water trucking as soon as possible. This will include monitoring of **water quality** on a regular basis. In coordination with the WASH Sector, priority will be based on vulnerability and assessed disease risk.

Construct and maintain ***sanitation*** *and washing facilities for the target population of the Rohingya refugees* (including communal and shared household latrines) that are culturally appropriate, secure, sanitary, user friendly and segregated by gender. This will take into account the potential Government plan for relocation and thus subsequent appropriation of the communal latrines. Initial latrine coverage will be targeted to cover as many refugees as possible, with the aim to

progressively improve the ratio of people per latrine over the coming months in a phased way, until Sphere standards are met. Maintenance, disinfection and desludging of the latrines will also be carried out during the implementation, looking at the hygiene and environmental sustainability. The relocation and decommissioning of the latrines will also be included when needed, in the cases where the refugees will be relocated from the original settlements.

*Disseminate culturally appropriate information on **hygiene practices** to the target population of the Rohingya refugees*
Engaging with Rohingya refugee communities in a culturally appropriate way on hygiene practices including on personal hygiene, malnutrition, food hygiene and use of menstrual hygiene materials, and distribute **gender-sensitive hygiene supplies** (kits).

Ensure children's needs in ***learning centers and child friendly spaces*** are met, including provision of water, toilets, washing facilities and soap (available at all times). Toilets will be child friendly, accessible by children with disabilities, private, secure, culturally appropriate and segregated by gender.

Acute Watery Diarrhoea/Cholera preparedness and response

In the current situation in the camps with poor hygienic conditions in overcrowded places, ***UNICEF is developing a preparedness and response plan for Acute Watery Diarrhoea (AWD), in partnership*** *with WHO, ICDDRB (International Center for Diarrhoeal Disease Research Bangladesh), MSF, and other partners. The plan consists of the following elements:*

- *Scaling up WASH interventions.* This includes: (i) water supply at health centers and disinfection of latrines in the health centers and in the community for infection control; (ii) ensure water quality monitoring and disinfection / treatment at the water points; (iii) ensure that the ongoing hygiene promotion activities focus on specific safe water handling at household level and water borne diseases (AWD) prevention messages. Additionally, WHO is setting up an environmental surveillance sampling for monitoring the water supply situation.
- *Rapid information dissemination of key messages and communication engagement* strategies on prevention of AWD. Mobilization and orientation of community based volunteers, local religious leaders and Arakan youth will be undertaken in collaboration with local partners. Radio messaging will be undertaken through national and community radio partners.
- *Oral Cholera Vaccination campaign* (initial 900,000 doses of OCV allocated to Bangladesh) for all people over 1 year of age, both new arrivals, previous arrivals and host community will be organized in October. Capacity building on Treatment protocol of Acute Watery Diarrhoea includes case management, malnutrition management & infant and young child feeding (IYCF) related to AWD, waste management and infection control. A plan for *treatments points at various levels of the 'health system'* are planned for: oral rehydration solutions (ORS)/zinc distribution points in the community, standard treatment at health centers, as per national protocol developed by ICDDRB.
- Integrating mechanisms for *early detection and referral as part of the nutrition screening of children under 5*. Ensuring treatment protocols for acute malnutrition and cholera are widely available and used across all partners, to save lives. Early warning system, surveillance and Monitoring of cases will be done jointly with partners.

Nutrition

UNICEF will directly treat *at least 60 percent of the entire number of children estimated to be affected with **severe acute malnutrition (SAM)** in the coming 6 months through **community based management of acute malnutrition** (CMAM) using RUTF* which is approved by the Government only for Rohingya. UNICEF will also support treatment and recovery of children at the highest nutritional risk through inpatient care in government and partner facilities. In addition, UNICEF is establishing a pipeline of RUTF, F-75 and F-100 to ensure full coverage of children with severe acute malnutrition and support partners who will be implementing the program. In addition, UNICEF will closely partner with WFP, who will manage the distribution of supplementary food to address food insecurity and moderate malnutrition.

UNICEF will provide counselling to support ***breastfeeding*** considering the high number of lactating women in the refugee population. 84,000 women are estimated to be breastfeeding.

UNICEF will provide 70% of all children between 6-59 months, pregnant women and adolescent girls with access to health and nutrition care as well as ***micronutrient supplementation*** including Vitamin A.

Undertake close *inter-programme coordination, in particular with WASH* to ensure that safe water is available as morbidity and mortality in children are otherwise likely to increase. Water and sanitation facilities will be collocated with therapeutic sites, and families with malnourished children targeted to receive personal hygiene kits and training. Lack of availability of nutritious food combined with hampered access to adequate health and WASH services can increase the levels of acute and chronic malnutrition for women and their dependents.

Health

UNICEF will primarily *focus on* ***preventive Health services*** in close cooperation with the Government and other partners such as WHO as high number of partners are working in curative side of Health. This will focus on providing immunizations (one million vaccines have already been requested) and antenatal care services through primary health care centres in temporary structures as well as outreach sites. UNICEF will use these opportunities to raise awareness of any GBV services available in curative health services or other spaces run by other agencies, and will refer appropriately. In addition, UNICEF will work on *acute watery diarrhoea prevention and response* by supporting a coordinated effort, conducting risk assessments, mobilizing Oral acute watery diarrhoea Vaccination campaigns, where there are gaps setting up oral rehydration points and cholera treatment centres, partnering with WHO and ICDDRB to provide the necessary case management standards are practiced through training and distributing protocols in UNICEF supported primary health care (PHCs), conduct monitoring and reporting, and providing AWD kits for communities and households with the Government and WHO.

UNICEF will intervene in support for ***curative Health services*** to complement efforts of partners and ensure access to life saving interventions. Where needed and no other health provider is available, UNICEF will support the Government to set up static clinics with basic health care to provide access to essential health services with sustained coverage of high impact preventive and curative interventions to children women and adolescents including age appropriate clinical care for survivors of sexual assault.

UNICEF will *continue to* ***strengthen the health system*** in Cox's Bazar: UNICEF will strengthen the referral services for newborn, integrated management of childhood illness and skilled birth attendance through support in transport of sick children and women. UNICEF will also expand the new-born stabilisation units, Special Newborn Care Units, delivery rooms in existing health facilities to ensure access to these services for children, women, and adolescents. UNICEF will support the control room in the Civil Surgeon office in Cox's Bazar in data collection, analysis and use for action. UNICEF will also refer to the IASC GBV guidelines to ensure best practices and risk mitigation measures are implemented.

Child Protection

The child protection humanitarian response will use and strengthen the existing national child protection system to better protect and respond to the needs of the most vulnerable Rohingya children and children from host communities through the following strategies:

Identification, documentation, family tracing and reunification, and reintegration of unaccompanied and separated children, including the provision of appropriate alternative care services. As part of the case management system and in collaboration with IOM and UNHCR, the programme will set up mechanisms at entry points, camps and host communities, to identify, screen and document all cases of unaccompanied and separated children, including the provision of family tracing and reunification services to these children, and alternative care services during the process. The prevention of child separation from their families and care givers through awareness raising and sensitization of families will be promoted at all times. The institutionalization of children will be discouraged whilst durable solutions for appropriate care arrangements that include foster, kinship and supervised independent living will be supported. Lastly, UNICEF will work with Red Cross movement to establish strong family tracing mechanism for reunification including in Myanmar and other countries of the region hosting Rohinga communities.

Psychosocial support will be provided to children and caregivers to protect and promote children's wellbeing and full participation. Psychosocial support will focus on engagement of children, families and caregivers by restoring, strengthening

and mobilising family and community child protection systems, in line with IASC standards. The interventions will include: i) provision of recreational and psychosocial support to children in Child Friendly Spaces that include theatre, dance, play, art and psychological first aid - attention will be paid to engage Rohingyas youth volunteers in the centers; ii) Promotion of community and family based child protection system, by supporting parents, care-givers, community based groups, religious leaders and children's clubs; and iii) referral of the most vulnerable children to specialized care.

Strengthen the existing child protection mechanisms, including case management system. UNICEF will support the efforts of the Ministry of Children and Women Affairs (MoCWA) and the Ministry of Social Welfare (MSW) and other child protection agencies to invest in strengthening the identification and referral systems with specific refugee children risks related approach to enhance the existing capacity of the national case management practices that will then have the potential to address all child protection concerns of the Rohingya children. Government has already deployed sixty social worker on the sites and the coordination mechanism with all partners is established with UNICEF technical support. In addition, UNICEF will contribute to strengthening existing information management systems in support of case management and referrals for services while ensuring appropriate confidentiality and safety, in line with the Minimum Standards of Children Protection in Humanitarian Action. Also, the technical capacities of the social workforce, as well as teachers, at the community level, and those supporting the emergency response will be enhanced through the provision of training in child protection, including monitoring, reporting and response to child protection concerns.

Responding to Gender-Based Violence: In collaboration with other sectors, UNICEF will provide good quality, coordinated and age-appropriate health, psychosocial and safety services and systems to promote survivors' physical and psychosocial healing and recovery, to protect them from further violence. Key actions include ensuring that coordinated, multi-sectoral, survivor-centred services are available and accessible, that safe spaces are created, that dignity kits are distributed and that response/prevention of GBV is integrated across sectors including through the distribution of risk mitigation material as necessary. This outcome also aims to address barriers to accessing services by providing information about the availability and benefits of such services to women, girls and wider communities.

Special attention to adolescent and peace building: service provision for adolescents is minimal and activities to address their needs and to protect them from any impending risk of violence, abuse and exploitation arising from this situation of conflict are limited. UNICEF is setting up safe and accessible Adolescent Clubs to welcome both younger (10-14 year-old) and older (15-19 year old) adolescents, provide them with comprehensive services including life skills, recreational support, psychosocial support and early identification of risk, response and referral to appropriating services including those for Gender based Violence. Programming will specifically include the strengthening of core life skills (e.g. communication and expression, stress management, critical thinking, conflict management and problem solving) to enable adolescents to recover emotionally, build and restore healthy relationships, and engage positively in their communities. Working with adolescent and youth and key community members, UNICEF and partners will actively look for the most marginalized adolescent girls and boys that may become invisible (e.g. those confined in their homes due to social norms, safety concerns or social stigma), and for those who may disappear as a result of trafficking or because they are seeking livelihoods opportunities elsewhere.

Education

In close collaboration with Ministry of Primary and Mass Education (MoPME), UNICEF will ***provide early learning and non-formal basic education in bilingual curriculum*** *to all Rohingya children*. Lifesaving information and basic psychosocial support will be provided to all children with a particular focus on new arrivals. The Ability Based Accelerated Learning (ABAL) programme package approved by the Government and adapted to the local context. The ABAL package/curriculum is designed for out-of-school children who have missed schooling and it provides basic literacy, numeracy and life skills at the Primary education level. This package has been used for educating Rohingya in the registered camp supported by UNHCR. The package will be used along with other supplementary materials as per the needs of the communities.

Children in host communities and attention to adolescents: UNICEF will also provide support to *schools in the host communities* that are already lack and scare resources to provide quality basic education including provision of non-formal education for out of school children. UNICEF is *engaging Rohingyas as teachers and will pay attention to Rohingya adolescent and host community youth for peace building.*

Quality assurance *in service provision* will be consistently monitored including compliance of implementing partners with the inter-agency network for education in emergencies (INEE) minimum standards and child-safeguarding policies. Needs assessment and systematic feedback mechanisms for parents and communities will be introduced to ensure accountability to the affected population.

Ensuring an ***enabling policy environment for Rohingya children and humanitarian-development nexus***: UNICEF will continue leading the policy dialogue and advocacy efforts with the Government on finding medium term sustainable solutions for education of Rohingya children including certification process. Being a member of the Education Local Consultative Group, UNICEF will also advocate for linking humanitarian and development aid in education.

Communication for Development (C4D), Community Engagement & Accountability

UNICEF will work for improved access to ***life-saving information on services and household level practices; community engagement for facilitating positive behaviour development and change; as well as increased accountability to the affected population*** through mechanisms for feedback on the quality and relevance of humanitarian services. Under-pinning all interventions will be *anthropological research on the socio-behavioural context* of Rohingya refugees and factors impacting uptake of information and behavioural change. Interventions will include:

Adolescent participation and engagement: UNICEF will work with Rohingya and Bangladeshi adolescent and youth by engaging them in UNICEF supported intervention (e.g. teachers in learning centers, volunteers in Child Friendly Spaces). In addition, UNICEF will support them to develop and practice their communication skills, listen to their concerns, fears, hope and solution and reflect their feedback into UNICEF programme in order to improve our response.

Radio and local media programming and broadcasting. Through procurement and placement of radios at key locations (e.g. learning centres, child friendly spaces, information and feedback centres, health centres), communities particularly children, adolescents and women will be reached and engaged through news and entertainment education based on-air programmes in partnership with national and community radio. Working with the sectors, the focus of messaging will be on accessing services, peacebuilding, psycho-social support and promoting social cohesion among the newly and previously arrived Rohingyas, as well as the host communities.

Mobilisation and orientation of service providers and community leaders: Working in collaboration with governmental, non-governmental and other humanitarian partners, sectoral service providers such as counsellors in health centres, community based youth and women volunteers, social workers from Child Friendly Spaces and teachers from learning centres will be trained in interpersonal communication and community dialogue skills to improve service delivery. In addition, local level religious leaders and other influential people in communities (e.g. Imams, Purohits, Majhis) will be identified, engaged and oriented on a range of child and women's socio-behavioural issues. Behind these efforts will be a longer-term focus on addressing the psycho-social needs of the affected population, reducing conflict and tensions, and empowering the communities.

Community accountability mechanism: Information and Feedback Centres (IFCs) will be established to provide information on service delivery points, disseminate messages, demonstrate behaviours, conduct community consultations and meetings, and receive and respond to community feedback, grievances and complaints. The IFCs will also double up as mobile teams to conduct door-to-door visits, mobilise community volunteers and facilitate consultation meetings. Feedback received will be responded based on a standard protocol i.e. referred to relevant service provider and site management agency at the site level for first response; escalated to service provider at Cox/agency as next response; and then sector level. The outcomes and responses will be communicated back to the community, closing the feedback loop. Data will be consolidated and fed into an overall coordinated feedback system of the inter-agency Communicating with Communities (CwC) Working Group.

Humanitarian Social Protection

Life-saving social protection interventions will be integrated into all the sectoral responses outlined above in order to ensure facilitation of the transition from humanitarian responses to longer-term development interventions with the government. Emergency cash transfers have been used by UNICEF since 2010 and as an alternative or complement to the distribution of foods and goods, and have proven effective when market-monitoring systems are in place, effective delivery mechanisms exist, and capacity of implementing partners is proven. A cash-based response can as well as an instrument to strengthen the dignity and empowerment of displaced communities.

UNICEF will implement *complementary cash grants* for households to access the necessary goods and services they demand, in a joint effort with UNHCR and WFP, provided government approval and market feasibility. UNICEF' participation in a joint cash-based response is crucial to ensure a focus on positive outcomes for children, and reduces the cost of assessing and establishing parallel systems. The complementary cash grant will enhance the scale and scope of the response for families with children, and pregnant and lactating women.

The implementation strategy of this component will follow a 2-phased approach. For the initial 6-months UNICEF will work through a joint delivery mechanism with UNHCR and WFP to provide a top-up on the voucher/grants of up to 1000 BDT to all registered families with children and pregnant and lactating to cover, child protection, gender based violence or sanitation needs. This will complement as multipurpose cash-grant that is proposed by the by the Cash Working Group as an emergency response mechanism, of 4000 BDT, that does not explicitly consider these elements. After the six months, UNICEF will move to a targeted vouchers approach, which will focus on families with high dependency ratios and other vulnerabilities, such as children with disabilities. The definitive amount and delivery method of the both grants will be determined in coordination with the Cash Working Group and other agencies potentially giving voucher/grants transfers such as WFP, IFRC, among others.

In collaboration with WFP-VAM and other agencies, UNICEF will support market monitoring, market assessment and household vulnerability assessment in order to establish market capacity. Further, UNICEF will support the design of a referral to services mechanism that is triggered at the registration point and that is tied to a real time online platform that can be accessed by sectors. Currently many people are not aware of the services that are being made available in the camps, especially those that target pregnant and lactating women. Service delivery referral can be implemented and strengthened through a stronger working relationship and coordination between UNICEF, UNHCR and the government at the registration points. With an agreement with the registration authority, currently under the Ministry of Home Affairs, the registration form could include additional questions on number of children and pregnant and lactating women in the household, which could immediately trigger a referral process to special services. To enhance registration of our population of interest, UNICEF will coordinate with the government and UNHCR in order to establish biometric registration points next to/ close to the child friendly spaces, focusing on registry of all children who are attending and their household members.

Coordination

UNICEF is fully committed to its coordination mandate. UNICEF will co-lead WASH sector with Action against hunger (ACF) and Education sector with Save the Children as well as lead Nutrition and Child Protection. In particular, through Child Protection sector, UNICEF will ensure use of same system for family tracing and case management for all partners in coordination with GBV sector (led by UNFPA) under the guidance of Protection sector (led by UNHCR). Lastly, UNICEF will support IOM for its coordination for Communication with Communities (CwC).

UNICEF will make sure that use of the IASC GBV Guidelines is promoted throughout the sectors it leads, in line with global and internal commitments.

UNICEF is operating from it new field office in Cox's Bazar with technical support and guidance from the country office in Dhaka. All sub-national level sector coordinators are based in Cox's Bazar, reporting directly to the field office.

For scaling up and continues monitoring of UNICEF response, technical teams have been deployed to various settlements. These teams are led by emergency coordinator who reports to the Chief of Field Office on daily basis. These teams will be based within the UN hubs when they are opened and operational.

Monitoring and Evaluation

A separate concept/strategy note will be prepared for monitoring and evaluation based on this plan. A system is being established for humanitarian performance monitoring and an emergency Integrated Monitoring and Evaluation Plan is being developed to identity key assessments, studies, reviews and evaluative exercises, in addition to monitoring of the response results.

Results framework has been prepared to monitor progress and report against high frequency indicators based through implementing partners' weekly and month reporting. To monitor the quality of the response, in addition to implementation monitoring by the programme sections, a cross cutting field monitoring system will be established by engaging individual consultants or third party institution at the local level under the field office. Further systems and tools will be explored for real time monitoring and analysis in consultation with the regional office and Field Results Group at the HQ level.

Funding

Bangladesh L3 Response Requirements- October 2017 to March 2018

In line with the Inter-Agency Humanitarian Response Plan, UNICEF is requesting US$76 million[2] to meet immediate life-saving humanitarian needs of the affected women and children in the next six months. Without this funding, UNICEF will be unable to provide life-saving services to children, including emergency WASH, nutrition, child protection, health and education services. Provision of WASH services remains critical to responding to vulnerable population and to preventing potential cholera outbreaks. This response plan will be reviewed and revised after a period of six months of its implementation. Based on its strong existing programme in host communities and Child Protection and Education in makeshift settlements, UNICEF will aim at universal coverage of children in needs in all areas in makeshift settlements, new spontaneous settlements and host communities.

Given the complexity and fluidity of the crisis, flexible resources are essential to respond to where the needs are the greatest. UNICEF wishes to express its sincere gratitude to those donors who have provided critical support to the response such as CERF, Denmark, Japan, Sweden, the UK, the United States and various National Committees for UNICEF. Until now, US$ 7.4 million has been received for UNICEF Rohingya response

Appeal Sector	Total Requirements (USD)
Nutrition	7,721,373
Health	10,436,113
WASH	27,328,698
Child Protection	3,003,626
Education	13,406,412
Communication for development (C4D)	1,056,537
Social Policy/Social Protection	13,150,632
Total	**76,103,390**

[2] HAC Bangladesh will be revised to reflect this new funding requirement.

Sector	Expected Result	Population in need	Sector/ Cluster Target	UNICEF Target	Prioritized Activities		Funding				Monitoring Indicators
					Phase-I October-December 2017	Phase-II January- March 2018	Required amount (US$) Oct-Dec	Required amount (US$) Jan-March	Amount Available (US$)	Funding Gap	Indicators for high frequency monitoring
Nutrition	Children and women with acute malnutrition access appropriate acute malnutrition management	182,811	127,968	99,000	1. 99,000 under five children will be screened for detection of acute malnutrition. 2. Referal and treatment of 2,000 SAM children without medical complication at outpatient centre 3.Treatment of 200 SAM children with medical complication at NGO and Government inpatient health facilities	1. 99,000 under five children will be screened for detection of acute malnutrition. 2. Referal and treatment of 5,125 SAM children without medical complication at outpatient centre 3.Treatment of 175 SAM children with medical complication at NGO and Government inpatient health facilities	$ 1,250,000	$ 1,250,000	$ 450,000	$ 2,050,000	
	Support for appropriate infant and young child feeding (IYCF) is accessed by affected women and children	120,000	84,000	43,000	1. Establishment of 65 breastfeeding spaces to strengthen infant feeding 2. IYCF counseling to 23,000 pregnant and lactating women	1. IYCF counseling to 20,000 pregnant and lactating women	$ 225,000	$ 225,000	$ 230,000	$ 220,000	
	Children and women access micronutrients from fortified foods, supplements, or multiple-micronutrient preparations	564,000	466,800	335,000	1. 43,000 pregnant and lactating women Micronutrient supplementation for women will be supplemented with Iron folic acid tablet 2. 52,000 adolescents girls will be reached with Iron folic acid and deworming tablet 3.45,000 children 6-59 months will be reached with micronutrient powder (MNP) 4. 25,000 children 24-59 months will be reached with deworming	1. 43,000 pregnant and lactating women Micronutrient supplementation for women will be supplemented with Iron folic acid tablet 2. 52,000 adolescents girls will be reached with Iron folic acid and deworming tablet 3. 240,000 children 6-59 months will be supplemented with Vitamin A, 4. 44,000 children 6-59 months will be reached with micronutrient powder (MNP) 5. 24,000 children 24-59 months will be reached with deworming	$ 927,000	$ 1,007,000	$ 420,000	$ 1,514,000	Number of children 6-59 mo with SAM enrolled in TFP/community-based programmes/facilities (7,500) Number of primary caregivers of children 0-23 months reached with key IYCF messages for appropriate feeding (breastfeeding or infant formula) (43,000) Number of children 6-59 months in the affected areas receiving multi-micronutrient supplementation every month (335,000)
	Timely nutritional assessment and surveillance systems are established and/or reinforced	2		2	SMART survey	SMART survey	$ 425,000	$ 225,000	$ 86,000	$ 564,000	
	C4D Children and women access relevant information about nutrition Programme activities	1,200,000	429,308	43,000	43,000 women will have access to information about nutrition program activities	43,000 women will have access to information about nutrition program activities	$ 105,000	$ 220,000	$ 10,000	$ 315,000	
	Coordination: Effective leadership is established for nutrition cluster interagency coordination, with links to other cluster/sector coordination mechanisms on critical inter-						$ 250,050	$ 450,050	$ 125,000	$ 575,100	
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 286,385	$ 303,935	$ -	$ 590,319	
						sub-total (USD)	**$ 3,468,435**	**$ 3,680,985**	**$ 1,321,000**	**$ 5,828,419**	
						Recovery cost @ 8%	**$ 277,474.8**	**$ 294,478.8**			
						Nutrition Total (USD)	**$ 3,745,909**	**$ 3,975,463**	**$ 1,321,000**	**$ 6,400,373**	

Health	saving interventions through population-based/community-based activities e.g. campaigns and child health days: MR, OPV, Vit A campaign; Oral Cholera Vaccination campaign	U15: 250,000; >1yr :900k	U15: 250,000; >1yr : 900k	U15: 250,000; >1yr : 900k	MR, OPV, Vitamin A campaign (target 250,000 new influx); Oral Cholera Vaccination campaign (target 900k)		2,520,000		$ 462,963	$ 2,057,038	
	Children, women, and adolescents equitably access essential health services with sustained coverage of high impact preventive and curative interventions (EPI, ANC, SBA, Essential Newborn Care, Diarrhea + ARI treatment (IMCI))	U1: 44,500 U5: 348,000: Pregnant women: 42,000: Lactating Women: 72,000; newborns: 36,000:	U1: 44,500 U5: 348,000: Pregnant women: 42,000: Lactating Women: 72,000; newborns: 36,000; Adolescents: 348,000	U1: 34,700 U5: 79,800: Pregnant women: 7,350: Lactating Women: 12,600; newborns: 6,300; Adolescents: 60,900	Set up PHC clinics for EPI, ANC, SBA, PNC, Newborn care, IMCI (Diarrhea, pneumonia treatment), adolescent health services and counseling. Clinics linked to Nutrition services target: 10,000 children with PCV3 and 2000 PW with at least 1 ANC;	PHC clinics for EPI, ANC, SBA, PNC, Newborn care, IMCI (Diarrhea, pneumonia treatment), adolescent health services and counseling. Clinics linked to Nutrition services target: 20,700 fully immunized children; 4410 PW with at least 1 ANC;	1,275,000	1,875,000	$ 92,593	$ 3,057,408	
	Children, women, and adolescents equitably access referral services for newborn, IMCI and skilled birth attendance in existing health facilities (2 UHC and 1 district hospital)	U5: 348,000: Pregnant women: 42,000: Lactating Women: 72,000; newborns: 36,000:	U5: 348,000: Pregnant women: 42,000: Lactating Women: 72,000; newborns: 36,000;	U5: 348,000: Pregnant women: 42,000: Lactating Women: 72,000; newborns: 36,000;	Equip newborn stabilization units at 2 UHC and expand SCANU in district hospital: Renovate and equip delivery room in 2UHC and 1 district hospital; Ensure critical staff are available at units 24/7; Train staff in essential and sick newborn care & IMCI	Ensure critical staff are available at units 24/7; Train staff in essential and sick newborn care & IMCI; Quality improvement in all three hospitals	600,000	300,000	$ -	$ 900,000	Number of children 6mo-15y vaccinated for measles and rubella (target:250,000) Number of population vaccinated against cholera with OCV (900,000); Number of targeted children <2 yrs fully vaccinated with routine Expanded M6Programme on Immunization (target:20,700)
	Acute Watery Diarrhea Preparedness and Response: Children and women have access to information to prevent AWD and have access to AWD treatment	1,200,000	1,200,000	300,000	Preposition AWD kits; Build capacity of medical and paramedical staff in management of AWD; Distribute ORS at community level and provide IEC for Diarrhea prevention and treatment		1,321,200		$ 370,370	$ 950,830	Number of U5 children treated against ARD (target: 7,000)
	C4D Women and children access behavior change communication interventions towards improving health care and feeding practices	1,200,000	429,308	177,500	Dissemination of key lifesaving messages about nutrition services among 177,500 affected community people by using different medium and methods Capacity development of 150 frontline workers, 1500 community/religious leaders on interpersonal communication and community engagement	Continue dissemination of key lifesaving messages about nutrition services among the affected community people by using different medium and methods and capacity development of frontline workers and community/religious leaders	$ 249,000	$ 100,000		$ 349,000	
	Inter-Agency Coordination mechanisms in the health sector (e.g. cluster coordination) are supported and enhanced with links	1,200,000	1,200,000	1,200,000			$ 375,000	$ 250,000	$ -	$ 625,000	
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 570,618	$ 227,250	$ -	$ 797,868	
						sub-total (USD)	**$ 6,910,818**	**$ 2,752,250**	**$ 925,925**	**$ 8,737,143**	
						Recovery cost @ 8%	**$ 552,865.4**	**$ 220,180.0**			
						Health Total (USD)	**$ 7,463,683**	**$ 2,972,430**	**$ 925,925**	**$ 9,510,188**	

WASH	Children and women access sufficient water of appropriate quality and quantity for drinking	1,200,000	887,000	450,000	Installation of 2,625 new water points and rehabilitation of 1,050 existing dysfunctional water sources, and monitoring water quality. Maintenance and reparation of the water points, and monitoring water quality Provision of emergency water supply in the locations where safe water sources are not available (use of water treatment plants and water trucking) including jerrycans distribution	The same activities will continue to reach the rest of the target populations which are not covered in phase-I	$ 4,812,500	$ 2,062,500	$ 640,308	$ 6,234,692	
	Children and women access toilets and washing facilities that are culturally appropriate, secure, sanitary, user friendly and gender appropriate	1,200,000	950,000	450,000	Construction of 15,750 new latrines and rehabilitation of the broken ones, plus desludging and maintenance and reparation 'Construction of 2,625 bathing cubicles for women and adolescent girls, including maintenance and reparation 'Construction/Distribution of 21,000 hand washing devices 'Installation of 2,625 communal waste bins at refugee areas	The same activities will continue to reach the rest of the populations which are not covered in phase-I	$ 7,182,000	$ 3,078,000	$ 960,463	$ 9,299,537	Number of people with access to safe drinking water (450,000) Number of people provided access to cultural and gender appropriate latrines (450,000) Number of people reached with key messages on improved hygiene practices (450,000) Achievement of cluster and inter-agency coordination milestones
	Children and women receive culturally appropriate supplies to practice good hygiene, including menstrual hygiene (hygiene kits)	1,200,000	1,200,000	450,000	Procurement and distribution of 63,000 hygiene kits	Procurement and distribution of 27,000 hygiene kits	$ 3,213,000	$ 1,377,000		$ 4,590,000	
	C4D Children and women receive critical WASH related information (including personal hygiene, food hygiene and MHM), to prevent child illness, especially diarrhea	1,200,000	1,200,000	450,000	Hygiene promotion activities at community level with youth involvement, including personal hygiene, food hygiene and menstrual hygiene	Hygiene promotion activities at community level with youth involvement, including personal hygiene, food hygiene and menstrual hygiene	$ 693,000	$ 297,000		$ 990,000	
	Effective leadership is established for WASH cluster/inter-agency coordination, with links to other cluster/ sector coordination mechanisms on critical inter-sectoral issues.*	1,200,000	1,200,000	1,200,000	Effective support to the cluster and inter-agency coordination, M&E activities, communication; including links to the other cluster and sector coordination mechanisms.	Effective support to the cluster and inter-agency coordination, M&E activities, communication; including links to the other cluster and sector coordination mechanisms.	$ 250,000	$ 250,000		$ 500,000	
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 1,453,545	$ 635,805	$ -	$ 2,089,350	
						sub-total (USD)	**$ 17,604,045**	**$ 7,700,305**	**$ 1,600,771**	**$ 23,703,579**	
						Recovery cost @ 8%	**$ 1,408,323.6**	**$ 616,024.4**			
						WASH Total (USD)	**$ 19,012,369**	**$ 8,316,329**	**$ 1,600,771**	**$ 25,727,927**	

Child Protection	A. Key child protection mechanisms are strengthened in emergency-affected areas	720,000	384,000	180,000	Establish case management systems including: - 30 batches of training on case management guidelines for social workers for early identification,	Establish case management systems including: - 35 batches of training/refreshers on case management guidelines for social workers for early	$ 300,000	$ 200,000	$ 248,575	$ 251,425	
	B. Separation of children from families is prevented and addressed and family-based care is promoted.	1,597	1,597	1,200	family tracing and reunification for unaccompanied children and provision of community based care and support - 50	family tracing and reunification for unaccompanied children and provision of community based care and support - 50	$ 150,000	$ 50,000	$ -	$ 200,000	**Number of unaccompanied and separated children identified and registered (1,200).**
	C. Violence, exploitation and abuse of children and women is prevented and addressed, including GBV	144,000	144,000	36,000	Organize and facilitate life skill sessions targeting adolescent boys and girls 5000	Organize and facilitate life skill sessions targeting 10,000 adolescent boys and girls	$ 200,000	$ 100,000	$ -	$ 300,000	**Number of children received psychosocial support and other child protection services including recreational activities at Child Friendly Spaces (348,000).**
	D. Psychosocial support is provided to children and their caregivers	720,000		180,000	Establish and equip 150 Child Friendly Spaces (mobile and static) - Provide psychosocial/psychological service,	1. Establish and equip 100 Child Friendly Spaces (including functioning of 150) 2. Provide psychosocial/psychological service,	$ 900,000		$ 324,555	$ 575,445	
	C4D Violence, exploitation and abuse of children and women is prevented and addressed, including GBV	1,200,000	429,308	177,500	Dissemination of key lifesaving messages about nutrition services among 177,500 affected community people by using different medium and methods Capacity development of 150 frontline workers, 1500 community/religious leaders on interpersonal communication and community engagement	Continue dissemination of key lifesaving messages about nutrition services among the affected community people by using different medium and methods and capacity development of frontline workers and community/religious leaders	$ 109,500	$ 42,000		$ 151,500	**Number of most at risk adolescents received life skill based session and information on GBV referral services (15,000).** **Number of families with vulnerable children received support (1,000).**
	Strengthened leadership and coordination for CP sub-cluster with links to other cluster/sector coordination mechanisms with				One SBP cluster coordinator is recruited One IM Officer is recruited Three cluster coordination meetings are held	one SBP cluster coordinator and one IM Officer are in place Cluster and sector coordination meetings are held	$ 250,000	$ 250,000	$ -	$ 500,000	
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 171,855	$ 57,780	$ -	$ 229,635	
						sub-total (USD)	**$ 2,081,355**	**$ 699,780**	**$ 573,130**	**$ 2,208,005**	
						Recovery cost @ 8%	**$ 166,508.4**	**$ 55,982.4**			
						Child Protection Total (USD)	**$ 2,247,863**	**$ 755,762**	**$ 573,130**	**$ 2,430,496**	

Education	Children including preschool age children, girls, and other excluded children, access quality education opportunities**	453,000	370,000	201,765	Community mobilization Survey and identification of children of 4 to 14 years in the camp Screening and enrollment of children as per age and level Identification of schools in host community need educational support Campaign for attendance in host community schools	Formation of 1500 Center Management Committee to support identification of children, ensure attendance and monitor centers 1650 Community mobilization event per month in camps and host communities	$ 350,000	$ 350,000	$ 72,000	$ 628,000	
	Safe and secure learning environments that promote the protection and well-being of learners is established	453,000	370,000	201,765	Establishment of 1500 transitional Learning center Supply of 1500 EiE kits to the center Recruitment and deployment of 3000 teachers Training of 3000 teachers Education supplies to schools for 50000 host community children	Construction of 1500 learning centers Procurement of learning & teaching materials for 1500 LCs Training of 3000 teachers on child centered methodology and activity based learning Orientation of 500 school teachers on educational support program	$ 2,790,000	$ 6,940,000	$ 800,000	$ 8,930,000	Number of 4-14 years aged children reached by child-friendly emergency non-formal education programmes, including play and early learning for young children Target - 201765
	Psychosocial and health services for children and teachers is integrated in educational response	453,000	370,000	205,265	Orientation of 3500 teachers on psychosocial support Hygiene sessions for 201765 learners	Training of 3500 teachers on integration of psychosocial support & hygiene education in to teaching learning process Hygiene sessions for 201765 learners	$ 300,000	$ 300,000	$ 30,000	$ 570,000	Number of 4-14 years age children (disaggregated by sex) who received learning materials and supplies Target - 201765 Number of teachers are trained on EiE (Education in Emergency) and hygiene education Target 3500
	C4D Adolescents, young children and caregivers access appropriate life skills programmes ; information about the emergency; and educational options for those who have missed out on schooling, especially adolescents	1,200,000	429,308	177,500	Dissemination of key lifesaving messages about nutrition services among 177,500 affected community people by using different medium and methods Capacity development of 150 frontline workers, 1500 community/religious leaders on interpersonal communication and community engagement.	Continue dissemination of key lifesaving messages about nutrition services among the affected community people by using different medium and methods and capacity development of frontline workers and community/religious leaders	$ 64,000	$ 47,000	$ -	$ 111,000	Number of community members disaggregated by sex reached through campaign and awareness sessions on issues related to importance of education and safe hygiene practices Target 200000
	Effective leadership is established for education cluster/ inter-agency coordination (with co-lead agency), with links to other cluster/sector coordination mechanisms on critical intersectoral issues*				hiring of Sector Coordinator; 1 information management officer; meetings of the education sectors and education sector needs assessment and sector members capacity building	Sector coordination activities continue and more assessments are done	$ 250,000	$ 300,000	$ -	$ 550,000	
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 172,937	$ 549,407	$ -	$ 722,344	
						sub-total (USD)	**$ 3,926,937**	**$ 8,486,407**	**$ 902,000**	**$ 11,511,344**	
						Recovery cost @ 8%	**$ 314,155.0**	**$ 678,912.6**			
						Education Total (USD)	**$ 4,241,092**	**$ 9,165,320**	**$ 902,000**	**$ 12,504,412**	

C4D/Accountability Mechanisms	Caregivers and adolescent reached through information and feedback mechanism.	1,200,000	429,308	177,500	Establishment of 8 Information and feedback centers for 177,500 local communities to have access to the information on life-saving behaviors about nutrition and provide feedback on the quality of services	Establishment of 12 Information and feedback centers for 177,500 local communities to have access to the information on life-saving behaviors about nutrition and provide feedback on the quality of services	$ 150,000	$ 180,000	$ 30,154	$ 299,846	Number of people reached through information dissemination and community engagement efforts on life saving behaviours and available services (target: 180,000)
					Conduct socio cultural study	Rapid assessment on adaptability and resilient behavior. Field based socio and anthropological study	$ 100,000	$ 100,000	$ -	$ 200,000	Number of community leaders/religious leaders as sensitized to provide life-saving information/messages and referral (target: 3,000)
	Coordination support fo C4D/	1,200,000	429,308	177,500	Coordination with different sectors, departments and partner agencies e.g., CwC, ISCG, I&B Department	Coordination with different sectors, departments and partner agencies e.g., CwC, ISCG, I&B Department	$ 152,500	$ 215,000	$ -	$ 367,500	Number of frontline workers trained and equipped to conduct Inter Personal Communication (IPC)/ Community dialogue
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 36,225	$ 44,550	$ -		
						sub-total (USD)	**$ 438,725**	**$ 539,550**	**$ 30,154**	**$ 867,346**	
						Recovery cost @ 8%	**$ 35,098.0**	**$ 43,164.0**			
						C4D/AAP Total (USD)	**$ 473,823**	**$ 582,714**	**$ 30,154**	**$ 1,026,383**	
Social Policy	Enhanced delivery of CCCs through referral system at registration point and design of referral online real time platform for sectors	600000	600000	420000	Coordinate with Government/UNHCR/BBS establishment of service referral system at registration and establish online real time system that forwards vulnerability criteria to concerned sectors	Ensure the flow of registration-service delivery referral is functioning and ensure that sectors are using the information for planning	$ 24,000	$ 36,000	$ -	$ 60,000	Increase access to service provision
	Effective achievement of CCCs through complementary cash grants to households with children and PLW	200,000 households	200,000 households	180000	Provide voucher/grants to 180,000 households with children and PLW that can be registered at registration point or who have been identified (and not registered) in the nutrition screening or in the CFS	Provide voucher/grants to 180,000 households with children and PLW that can be registered at registration point or who have been identified (and not registered) in the nutrition screening or in the CFS	$ 5,555,556	$ 5,555,556	$ -	$ 11,111,111	number of households/families receiving voucher/grants
						Programme Support (M&E, Communication, Operations and Security) @9% of the total Programme	$ 502,160	$ 503,240	$ -	$ 1,005,400	
						sub-total (USD)	**$ 6,081,716**	**$ 6,094,796**	**$ -**	**$ 12,176,511**	
						Recovery cost @ 8%	**$ 486,537.2**	**$ 487,583.6**			
						Social Policy Total (USD)	**$ 6,568,253**	**$ 6,582,379**	**$ -**	**$ 13,150,632**	
						Response Plan Total (USD)- Phase-I and II	**$ 43,752,992**	**$ 32,350,398**	**$ 5,352,980**	**$ 70,750,410**	
						Total for 6 months	**$ 76,103,390**		**$ 5,352,980**	**$ 70,750,410**	

* It includes cluster coordination, M&E activities (including assessments, field monitoring, studies, surveys, RTEs) by the Programme and through PME section, Communication; Operations support; and Security

** the target population for includes (4-14 yrs) -225000 Rohingya children and 75000 children from host community and for UNICEF (4-14 yrs)- 151765 Rohingya children and 50000 children from host community

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