BANGLADESH

Age and Disability Inclusion Needs Assessment

Rohingya Refugee Response

May 2021

PROTECTION SECTOR
COX'S BAZAR

REACH Informing more effective humanitarian action

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About REACH

Helvetas Swiss Intercooperation is a Swiss INGO, registered in Bangladesh, with livelihood, WASH, governance and emergency projects in the country. REACH Initiative operates under the umbrella of Helvetas as a technical implementing partner. REACH facilitates the development of information tools and products that enhance the capacity of aid actors to make evidence-based decisions in emergency, recovery and development contexts. The methodologies used by REACH include primary data collection and in-depth analysis, and all activities are conducted through inter-agency aid coordination mechanisms. REACH is a joint initiative of IMPACT Initiatives, ACTED and the United Nations Institute for Training and Research - Operational Satellite Applications Programme (UNITAR-UNOSAT). For more information please visit our website: www.reach-initiative.org. You can contact us directly at: geneva@reach-initiative.org and follow us on Twitter @REACH_info.

SUMMARY

Over the past four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Since August 2017, an estimated 715,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas. In response to this refugee influx, national and international organisations alongside the government of Bangladesh have been delivering humanitarian assistance.

Within this context, a core component of the 2019 Joint Response Plan (JRP) was to ensure the meaningful and dignified inclusion of all at-risk groups, including persons with disabilities. Building upon these priorities, protection mainstreaming, including the equitable consideration and inclusion of individuals across all age groups and persons with disabilities, was incorporated into the 2020 JRP as a cross-cutting issue. While the heightened risk of persons with disabilities and older persons is generally recognized by affected populations and humanitarian actors alike, there remains a lack of data on disability prevalence across camps as well as on the needs, barriers and preferences of older persons and persons with disabilities; hindering effective evidence-based inclusive programming.

Against this background, REACH, with support from the Age and Disability Working Group (ADWG), conducted an Age and Disability Inclusion Needs Assessment across Rohingya refugee populations. The assessment aimed to support key actors working in Cox's Bazar, including coordination bodies and technical agencies and actors, to consider the nuanced and specific requirements, access to services and assistance, and involvement of persons with disabilities across all age groups, and older persons living in Rohingya camps, within the response programming.

The assessment was coordinated through the ADWG, and implemented with technical contributions from the Age and Disability Task Team (ADTT). The ADTT consisted of representatives from the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), the Water, Sanitation and Hygiene (WASH) Sector, and REACH. Additional technical contributions were made by Humanity & Inclusion (HI), CBM and the Centre for Disability in Development (CDD), and Prottyashi.

The assessment consisted of two primary data collection components – a quantitative household survey and a qualitative component consisting of focus group discussions (FGDs). The quantitative component was implemented in all 34 camps in Ukhiya and Teknaf Upazilas. A stratified cluster sampling approach was employed, with the camps as strata and households as clusters. Information related to disability prevalence was collected through the Washington Group Questions (WGQs) on all household members in sampled households aged 2 and above. Information on service utilisation, access barriers and enablers, as well as participation and disaster preparedness was collected on sub-samples of those individuals.

Household-level results are representative at a 95% confidence level and with a 2% margin of error at the response level, and at a 90% confidence level and with a 10% margin of error at the camp-level. Results at the individual level are representative at a 95% confidence level and with a 3% margin of error for 2 to 4 year-olds, and with a 2% margin of error for 5 to 17 year-olds as well as for 18 to 99 year-olds. In total, 2,530 household interviews, covering 11,187 individuals aged 2 and above, were carried out between 30 November 2020 and 7 January 2021.

Basic descriptive analysis was conducted, complemented by statistical significance testing for differences in outcomes between persons with and without disabilities, overall as well as for different age groups and genders,

by types of functional difficulty, and between households with and without persons with disabilities. FGDs were conducted to further contextualise quantitative findings and provide more detailed insights into the specific barriers persons with disabilities and older persons face accessing services, participating in community life and in disaster preparedness, as well as potential solutions. A total of 20 FGDs were conducted with older persons with and without disabilities, adults with disabilities, children with disabilities (aged 11 to 17), and caregivers of children with disabilities, between 12 January and 8 February 2021.

Due to time constraints, not all persons without disabilities or those with difficulties in functioning[1] in the anxiety or depression domains only (5 to 99 year-olds) or in the behaviour domain only (2 to 4 year-olds) were included for the full interview beyond the assessment of disability prevalence. Therefore, questions related to service utilisation, barriers and enablers, participation and disaster preparedness were only asked to a random sample of individuals from those groups. This potentially introduced a sampling bias that could not be statistically corrected, such that results related to service utilisation, barriers and enablers, participation and disaster preparedness for those groups are indicative only. In order to still be able to generate unbiased representative overall results for persons with disabilities despite the sampling bias, the analysis for all persons with disabilities related to service utilisation, barriers and enablers, participation and disaster preparedness excluded persons with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds) or in the behaviour domain only (2 to 4 year-olds).

Lastly, the assessment determined current levels of disability prevalence. With disability being an evolving concept,[2] this does not necessarily reflect disability prevalence or functional difficulties in the same population at any other point in time. Therefore, no direct links can be drawn between indicator outcomes related to past access to services, such as to self-reliance activities/means of living or education before the COVID-19 outbreak, and current reported functional difficulties.

Key findings

Findings show that disability prevalence differs by age group and location. Overall, and both among male and female individuals, **12% of individuals were identified as persons with disabilities**. Moreover, disability prevalence was found to increase with age, ranging from 2% among 2 to 4 year-olds, to 51% among older persons (aged 60 and above). Estimates of disability prevalence also varied geographically, ranging from 6% to 19% depending on the camp.

Among individuals aged 5 and above, the highest proportion of individuals reportedly had difficulties in functioning in the anxiety or depression domains, followed by the mobility domain for adults, and the learning domain for 5 to 17 year-olds. Among 2 to 4 year-olds, the highest proportion of individuals reportedly had difficulties in functioning in the learning domain. In total, **roughly a third of households (35%) reported at least one household member with disabilities**.

Differences in reported barriers, requirements and preferences between persons with and without disabilities, persons with different types of functional difficulties, and persons of different ages and genders varied by indicator.

[1] "Difficulties in functioning" in the following always refers to "a lot of difficulty" or "not being able at all" to do something having been reported in response to the WGQs (as opposed to "some difficulty"), or for questions with different response options, the equivalent response options outlined in the Washington Group guidelines that would identify someone as a person with disabilities.
[2] Compare to the preamble of the Convention on the Rights of Persons with Disabilities (CRPD): disability is an evolving concept and results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

Mobility inside shelters and around camps

Of persons with disabilities, 52% reportedly faced barriers related to mobility in shelters, and 76% reportedly faced barriers related to mobility around camps. Persons with difficulties in functioning in the self-care and mobility domains were more likely than persons with difficulties in functioning not in those domains to be reported as facing barriers moving both inside shelters and around camps.[3] In addition, persons with difficulties in functioning in the upper body movement or vision domains were more likely than persons with difficulties in functioning not in those domains to be reported as facing barriers moving inside shelters.

Among persons with difficulties in functioning in the self-care and upper body movement domains, mobility-related barriers may to some degree have been translated into particularly high proportions of those individuals reportedly never having left their shelter in the week prior to data collection.

Additionally, mobility-related barriers were more commonly reported with increasing age, both among persons with and without disabilities. Overall, the **highest proportions of individuals reportedly facing difficulties moving in shelters (72%) or around camps (89%) were reported among older persons with disabilities**.

The most commonly reported barriers to moving inside shelters were **not enough space to turn around** and **a lack of handrails.** The most commonly reported barriers to moving in camps were **stairs and pathways being too steep**.

Self-care and utilisation of WASH infrastructure

Especially persons with difficulties in functioning in the self-care, upper body movement, and mobility domains were reported as being unable to use latrines or shower without support from others. Age and gender were further found to compound difficulties with self-care, with **particularly high proportions of female older persons with disabilities reportedly being unable to shower without support from others**.

Significantly lower proportions of persons with difficulties in functioning in the self-care and upper body movement domains than persons with difficulties in functioning not in those domains had reportedly used public not accessible latrines or public bathing facilities in the month prior to data collection. At the same time, the reported utilisation of private or accessible latrines, while generally low, was higher among persons with difficulties in functioning in the self-care and upper body movement domains than among persons with difficulties in functioning not in those domains. **These results may indicate additional access barriers towards using not accessible or public infrastructure faced by persons with difficulties in functioning in the self-care and upper body movement domains**.

Other barriers to accessing services

A significantly higher proportion of persons with disabilities (64%) than persons without disabilities (39%) reportedly faced barriers accessing services. Reported barriers were mostly related to difficulties in physical access of services, such as **facilities being too far** and **persons being unable to travel to facilities unassisted**.

[3] The assessment found an overlap between domains (compare Table 12 in annex 6), such that one person was sometimes reported as having difficulties in functioning in several domains at the same time. In order to still be able to analyse the relationship between reported barriers and domains of functional difficulty, results for persons with difficulties in functioning in a specific domain were compared to results for persons with difficulties in functioning in any domain, i.e. persons with disabilities, but no difficulties in functioning in this specific domain. If persons with difficulties in functioning in the specific domain under consideration were particularly affected by the reported barrier, a statistically significant difference in results between those two groups would be expected. If they were not particularly affected, no significant difference between the two groups would be expected. Please refer to annex 8 for more information.

In particular, persons with difficulties in functioning in the self-care and mobility domains were reported as facing barriers.

Age alone was not found to lead to considerable differences in the proportions of individuals reportedly facing barriers. However, in combination with gender, age was found to act as a compounding factor, with **particularly high proportions of female older persons with disabilities having been reported as facing barriers accessing services.**

Access to assistive devices

Access to assistive devices among those reportedly needing them seemed to be limited across all age groups (including among older persons without disabilities). Overall, 56% of persons with disabilities were reported as not having received any assistive devices in the year prior to data collection despite needing them.

Female older persons with disabilities were found to be disproportionately affected by this gap. In total, 67% of female older persons with disabilities had reportedly not received any assistive devices despite needing them, compared to a maximum of 58% of male or female persons with disabilities across all age groups, and 55% of female older persons without disabilities.

Enrolment rates and highest levels of education

Among younger age groups, **significantly lower proportions of children with disabilities than children without disabilities were found to have been enrolled in formal and informal learning centres** before their closure due to the COVID-19 outbreak (in March 2020).

Overall, 65% of children with disabilities aged 5 to 9 had reportedly attended temporary learning centres (TLCs) for at least 4 days a week. In comparison, 88% of children without disabilities in the same age group had reportedly attended TLCs. Among children without disabilities, the proportion of girls reportedly not having been enrolled was higher than that of boys, while the opposite trend was reported among children with disabilities. Overall, **59% of boys with disabilities aged 5 to 14 were reported as having been enrolled in TLCs, compared to 82% of girls with disabilities of the same age group.**

Similarly, the proportions of children reportedly not having completed any education were higher among children with disabilities relative to children without disabilities, particularly among younger age groups, and among boys with disabilities relative to girls with disabilities. These results potentially indicate a trend of persons with disabilities being enrolled into education later than persons without disabilities, rather than not being enrolled at all. At the same time, persons with disabilities may potentially take longer or be slightly less likely to complete their education compared to persons without disabilities.

Means of living

People with difficulties in functioning in the anxiety or depression domains were reportedly more likely than persons with difficulties in functioning in other domains to have engaged in the informal sector both before the COVID-19 outbreak in March 2020 (pre-COVID) and at the time of data collection (post-COVID). Specifically, the **proportions of persons with difficulties in functioning in the anxiety or depression domains reportedly having been engaged in the informal sector were at least three times higher than those of persons with difficulties in functioning in other domains.**

The difference in the proportions of persons with disabilities reportedly having been engaged in the informal sector pre-COVID (18%) and post-COVID (13%) – with the highest rates of engagement found among those with difficulties in functioning in the anxiety or depression domains – was larger than that found among persons without disabilities (13% and 12%). This indicates a **greater loss of access to self-reliance activities among persons with disabilities.** However, no conclusions can be drawn as to whether greater barriers for persons with disabilities may have led to a greater drop in access to self-reliance activities, or if COVID-19-related loss of access to self-reliance activities and other services may have also contributed to, for instance, more prevalent feelings of anxiety or depression. If the latter was the case, the proportion of persons with disabilities at the time of data collection reportedly having been engaged in the informal sector pre-COVID would not exactly reflect the proportion of persons with disabilities having been engaged in the informal sector pre-COVID.

Cognisant of the same limitation, **slightly higher proportions of children (aged 17 and below) with disabilities than children without disabilities were reported as having been engaged in the informal sector pre-COVID**. While this was not the case post-COVID, it cannot be discerned if children with disabilities reportedly having been engaged in the informal sector pre-COVID would have already been reported as persons with disabilities pre-COVID. At the same time, **slightly higher proportions of households with persons with disabilities reported at least one child having been engaged in the informal sector** both pre- and post-COVID (4% in both cases), compared to households without persons with disabilities (2% pre-COVID, and 3% post-COVID).

The **proportion of households with persons with disabilities reporting at least one adult as having been engaged in the informal sector was significantly lower than that of households without persons with disabilities.** In addition, average daily per capita incentives of households receiving incentives and with persons with disabilities was lower than that of households receiving incentives but without persons with disabilities, in particular among less educated households.

Participation

Participation in meetings or events did not differ significantly between persons with and without disabilities, or across age groups. **Only persons with difficulties in functioning in the self-care domain were reportedly significantly less likely then persons with difficulties in functioning not in this domain to have participated in any meetings.**

Most commonly, individuals had reportedly attended NGO meetings. Female individuals in particular had mostly attended only those types of meetings. Any other of the assessed types of meetings had reportedly been disproportionately attended by male individuals. **The gender gap was larger among persons without disabilities than among persons with disabilities.**

Similarly, in terms of having been asked for feedback, differences between disability, age and gender groups were small. Slightly higher proportions of persons without disabilities (29%) than persons with disabilities (23%) had reportedly been asked for feedback. Moreover, slightly higher proportions of female than male individuals in younger age groups, and slightly higher proportions of male than female individuals in older age groups, had reportedly been asked for feedback.

Disaster preparedness

In terms of preferred support in the event of natural hazards, the majority of persons with (88%) and without (92%) disabilities would reportedly like to receive support with shelter repair. **In particular persons with difficulties in functioning in the self-care and upper body movement domains were further reported as wanting to receive**

psychological support. Almost half the persons with difficulties in functioning in the vision domain (46%) would reportedly like to receive support in moving to safe places. The latter was also reported for a significantly higher proportion of male older persons with disabilities (47%) than female older persons with disabilities (28%).

Preferred means of communication to hear about upcoming hazards did not differ between persons with and without disabilities, with 91% and 90%, respectively, reportedly preferring loudspeakers. However, possibly linked to a limited ability to move, **significantly larger proportions of persons with difficulties in functioning in the self-care and upper body movement domains, relative to persons with difficulties in functioning not in those domains, reportedly prefer in-person communication.**

Overall, these findings show that while certain barriers, requirements and preferences may be widespread across the whole population, persons with (different types of) functional difficulties, persons without disabilities, and individuals of different ages and genders may all face specific barriers, gaps in access to services, and have specific preferences and requirements. Different factors, such as a person's age, gender and functional difficulties, may compound each other. However, depending on the situation, certain factors may be more or less relevant in shaping lived experiences. As such, the **specific barriers, gaps, requirements and preferences of different individuals have to be considered at the most granular level possible to ensure the effective and dignified inclusion of all persons with disabilities and older persons.**

In light of the findings and limitations of this assessment, in the future, **more comprehensive insights into the specific barriers faced by persons with disabilities towards accessing services and how this varies by age and gender**, as well as across and within sectors, may help address those. In this context, it will be important to not only consider physical barriers but also less "visible" ones, such as stigma related to certain perceptions and believes, that potentially hinder persons with disabilities' inclusion.

In addition, in the medium term, further investigation into **possible linkages between disability and individuals below the age of 18 engaging in the informal sector as well as enrolment rates into educational facilities** could be considered to help address potential adverse impacts on children with disabilities.

Lastly, there remains a need to **better understand the specific barriers, requirements and preferences of persons with difficulties in functioning in the anxiety or depression domains**.

CONTENTS

List of Acronyms

ADTT	Age and Disability Task Team
ADWG	Age and Disability Working Group
BDT	Bangladeshi Taka
CDD	Centre for Disability in Development
CFM	Child Functioning Module
CiC	Camp-in-Charge
CRPD	Convention on the Rights of Persons with Disabilities
COVID-19	Coronavirus disease 2019
DSG	Data saturation grid
FGD	Focus group discussion
GPS	Global positioning system
HI	Humanity & Inclusion
IOM NPM	International Organization for Migration Needs and Population Monitoring
JRP	Joint Response Plan
NGO	Non-governmental organisation
REVA	Refugee influx emergency vulnerability assessment
SOP	Standard operating procedure
TLC	Temporary learning centre
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
USD	US Dollar
WASH	Water, Sanitation and Hygiene
WGQ	Washington Group Questions
WGSS	Washington Group Short Set

Geographical Classifications

District	Third tier of administration in Bangladesh, forming sub-units of divisions
Upazila	Fourth tier of administration in Bangladesh, forming sub-units of districts

List of Figures, Tables and Maps

INTRODUCTION

Over the past four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Since August 2017, an estimated 715,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.[4] In response to the refugee influx, national and international organisations have been delivering humanitarian assistance alongside the government of Bangladesh. A core component of the 2019 Joint Response Plan (JRP) aimed to address the meaningful and dignified inclusion of all at-risk groups, including persons with disabilities.[5] Building upon these priorities, protection mainstreaming, including the equitable consideration and inclusion of individuals across all age groups and persons with disabilities, was incorporated into the 2020 JRP as a cross-cutting issue.[6]

Rohingya refugee communities consider persons with disabilities one of the most at-risk groups.[7] At the same time, studies have shown households with persons with disabilities to be more at risk – for instance, from an economic perspective, as they are more likely having to take on debt to cover health expenditures – than households without persons with disabilities.[8] Nevertheless, across the response, to date, systematic age- and gender-disaggregated data collection on persons with disabilities as well as older persons has been limited. Moreover, any data that is collected on persons with disabilities' barriers, requirements and preferences is usually collected by proxy from other household members rather than from the concerned individuals themselves. Such data is therefore unlikely to fully reflect the lived experiences, barriers, requirements and preferences of persons with disabilities. In addition, older persons and persons with disabilities are often grouped in data collection exercises, such that there is limited information on the distinct barriers, requirements and preferences of those two groups.[9] Lastly, there is no widely accepted estimate of disability prevalence in Rohingya refugee camps, with estimates of household-level prevalence ranging from 3% to 14% depending on the assessment.[10] This may in part be due to different methodological approaches having been used to assess disability prevalence, such as differences in the number or phrasing of the Washington Group Questions (WGQs) employed and different methodologies used to administer them, leading to a lack of comparability of results. In addition, also these prevalence estimates were usually obtained by proxy measurement from other household members rather than from each individual directly.[11] While an estimation of disability prevalence by proxy through the WGQs is generally deemed acceptable, evidence suggests that this may result in underreporting.[12] In sum, while the heightened risk of persons with disabilities and older persons is generally recognised, a lack of data remains, posing challenges to evidence-based inclusive programming.

Against this background, REACH, with support from the Age and Disability Working Group (ADWG), conducted an Age and Disability Inclusion Needs Assessment across Rohingya refugee populations. The assessment aimed to support key actors working in Cox's Bazar, including coordination bodies and technical agencies and actors, to

[4] Compare UNHCR Operational Portal.
[5] Inter-Sector Coordination Group (ISCG), *2019 Joint Response Plan for Rohingya Humanitarian Crisis, January – December 2019* (Cox's Bazar, 2019a). Available here (accessed 28 February 2021).
[6] ISCG, *2020 Joint Response Plan for Rohingya Humanitarian Crisis, January – December 2020* (Cox's Bazar, 2020a). Available here (accessed 28 February 2021).
[7] World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA) – Cox's Bazar, Bangladesh (April 2020)* (Cox's Bazar, 2020). Available here (accessed 12 February 2020).
[8] ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA), July – August 2020, Rohingya refugees* (Cox's Bazar 2020b). Available here (accessed 28 February 2021); ACAPS-NPM Analysis Hub, *Considering age and disability in the Rohingya response* (Cox's Bazar, 2021). Available here (accessed 28 February 2021).
[9] ACAPS-NPM Analysis Hub, 2021; REACH, *Rohingya refugees with disabilities: Prevalence, meaningful access, and notes on measurement* (Cox's Bazar, 2019). Available here (accessed 28 February 2021).
[10] ACAPS-NPM Analysis Hub, 2021.
[11] Ibid.; REACH, 2019.
[12] Leonard Cheshire and Humanity & Inclusion, *Disability Data Collection: A summary review of the use of the Washington Group Questions by development and humanitarian actors* (London, 2018). Available here (accessed 28 February 2021).

consider the nuanced and specific requirements, access to services and assistance, and involvement of persons with disabilities across all age groups, and older persons living in Rohingya camps, within the response programming. More specifically, through an approach designed to directly capture the concerned populations' voices and experiences in a dignified fashion, the objectives were (1) to understand the prevalence of different kinds of disability in Rohingya refugee camps, across different age groups, gender and location; (2) to increase the understanding of the situation of persons with disabilities, of different ages, in relation to their access to multi-sectoral services and participation in the community; and (3) to understand specific considerations of older persons and persons with disabilities related to disaster preparedness and risk reduction. The assessment was coordinated through the ADWG, and implemented with technical contributions from an Age and Disability Task Team (ADTT). The ADTT consisted of representatives from the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration Needs and Population Monitoring (IOM NPM), the Water, Sanitation and Hygiene (WASH) Sector, and REACH. Further, technical contributions were made by Humanity & Inclusion (HI), CBM and the Centre for Disability in Development (CDD), and Prottyashi.

In the following chapter, the methodology employed for this assessment will be outlined. The scope, sampling strategy, data collection, processing and analysis parameters will be described. Moreover, challenges and limitations will be highlighted. Thereafter, findings will be presented, including findings on disability prevalence, service utilisation, barriers and enablers, education and means of living, participation, and disaster preparedness. The report will close with a concluding summary and outlook.

METHODOLOGY

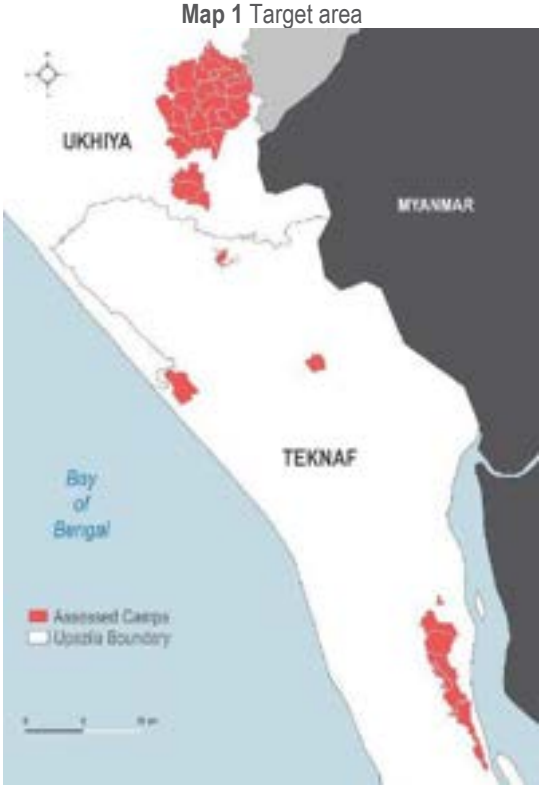
The assessment consisted of two primary data collection components – a quantitative household survey and a qualitative component consisting of focus group discussions (FGDs). The household survey tool was primarily used to assess disability prevalence across age groups and camps. In addition, some information on service utilisation, barriers and enablers, participation and disaster preparedness among persons with disabilities and older persons was collected. The FGDs were used to further contextualise these findings and provide additional insights into the specific barriers persons with disabilities and older persons face accessing services, participating in community life and in relation to disaster preparedness, as well as potential solutions. Lastly, a secondary data review was conducted to be able to triangulate findings.

In the following, the scope of the assessment, the sampling strategy, data collection processes, data analysis, as well as challenges and limitations will be outlined.

Scope

The assessment targeted all Rohingya refugee households living in the 34 camps in Ukhiya and Teknaf Upazilas in Cox's Bazar District. The quantitative component was implemented in all 34 camps (Map 1), collecting information related to disability prevalence on all household members in the sampled households aged 2 and above. Information related to service utilisation, barriers and enablers, participation and disaster preparedness was collected on sub-samples of those individuals. Disability prevalence was assessed using the Washington Group Short Set (WG-SS) Enhanced Questions for adults and the Washington Group/United Nations International Children's Emergency Fund (UNICEF) Child Functioning Modules (CFM) for children aged 2 to 4 and 5 to 17.[13]

Map 1 Target area



[13] A full list of the WGQs used for this assessment can be found in annex 1.

The FGDs were conducted in 5 camps in Teknaf and 10 camps in Ukhiya, ensuring to the degree possible a geographical spread and representation of persons from different disability groups in the FGDs.

Sampling strategy

For the household survey, a stratified cluster sampling approach was used, with the camps as strata and the households as clusters. In total, a minimum of 2,312 households or 68 households per camp were targeted for inclusion in the survey, with the aim of generating household-level results representative at a 95% confidence level and with a 2% margin of error at the response level, and at a 90% confidence level and with a 10% margin of error for camps.

In each camp, households were sampled using randomly generated GPS points, and in each sampled household, information related to disability prevalence was collected through the WGQs on all individuals aged 2 and above. Information related to service utilisation, barriers and enablers, participation and disaster preparedness was not collected for all individuals due to time constraints, but rather for two distinct sub-samples:

(1) One set of information related to service utilisation, barriers and enablers was collected for all older persons, and all persons with disabilities aged 2 and above, as identified through the Washington Group Questions (WGQs), excluding those with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds), or the behaviour domain only (2 to 4 year-olds).
(2) Another set of information related to service utilisation, barriers and enablers, as well as information related to participation and disaster preparedness was collected for all older persons, and all persons with disabilities aged 15 and above, as identified through the WGQs, excluding those with difficulties in functioning in the anxiety or depression domains only, as well as for a random sample of persons with difficulties in functioning in the anxiety or depression domains only aged 15 and above, or persons without disabilities aged 15 and above.

A 10% buffer was included into all sample size calculations to account for (1) non-consenting households, including households not consenting to or not finishing the survey; (2) households without an appropriate respondent, including all households without a consenting individual aged 18 or above; and (3) data cleaning/errors, including completed surveys that would be removed during data cleaning and therefore not be part of the final sample.

Participants for the FGDs were purposively sampled through UNHCR from its implementing partners' project beneficiaries as well as through HI and CBM-CDD from their project beneficiaries. In total, six FGDs were planned with older persons (three with males and three with females), including persons with and without disabilities, six with adults with disabilities (three with males and three with females), four with children with disabilities (two with males and two with females), and four with caregivers of children with disabilities (two with males and two with females), aiming to include participants with different types of disability into each type of FGD.

Data collection and processing

During the household survey, consent was obtained and basic demographic information on the household collected from the head of household, or another consenting adult household member. Information to assess disability prevalence, service utilisation, barriers and enablers, participation and disaster preparedness was collected directly from the concerned individuals if possible (i.e. if they were present, aged 18 and above, and able to respond). In all other cases, this information was collected by proxy from another adult household member. Quantitative data collection took place between 30 November 2020 and 7 January 2021.

In total, 2,530 households or 11,187 individuals aged 2 and above were included in the survey.[14] The latter included 1,341 individuals aged 2 to 4, 3,980 individuals aged 5 to 17, and 5,866 individuals aged 18 to 99. The targeted sample size of 68 households was reached in all camps with the exception of camp 13 (62 households), camp 16 (66 households), and camp 22 (67 households). Household-level results for camps are therefore representative at a 90% confidence level and with a 10% margin of error, or an 11% margin of error for the three under-sampled camps. They are representative at a 95% confidence level and with a 2% margin of error at the response level, and at a 95% confidence level and with a 4% margin of error for households with (n = 885) and without (n = 1,645) persons with disabilities.

At the individual level, the final level of precision reached at a 95% confidence level depends on the different sub-samples addressed for different sets of questions as well as the level of disaggregation (Table 1). Results related to service utilisation, barriers and enablers, participation and disaster preparedness for persons without disabilities as well as for persons with difficulties in functioning in the anxiety or depression domains are indicative only due to a potential sampling biases introduced into each group by including the mixed random sample of those groups described under "Sampling strategy". The mixed nature of this random sample did not allow to statistically correct the bias for each group to achieve representative results.

Table 1 Precision of individual-level results at a 95% confidence level

Set of questions	Sub-sample	Sample size	Margin of error
Current enrolment rates among 3 to 14 year-olds	Persons with disabilities[15]	119	9%
	Persons without disabilities	3,553	2%
Highest level of education	Persons with disabilities[15]	1,312	3%
	Persons without disabilities	8,558	1%
Means of living	Persons with disabilities[15]	1,299	3%
	Persons without disabilities	8,153	1%
Disability prevalence	All	11,187	1%
	2 to 4 year-olds	1,341	3%
	5 to 17 year-olds	3,980	2%
	18 to 99 year-olds	5,866	2%
Service utilisation, barriers and enablers, participation, disaster preparedness (ages 15 and above)[16]	Persons with disabilities[17]	411 (female: 212; male: 199)	5%
	Persons without disabilities	1,200 (female: 639; male: 561)	Indicative
	Vision	87	11%
	Hearing	43	15%
	Mobility	280	6%
	Cognition	72	12%
	Self-care	90	11%
	Upper body movement	89	11%
	Anxiety	367	Indicative
	Depression	261	Indicative
	18 to 99 year-old persons with disabilities[17]	393 (female: 205; male: 188)	5% (female: 7%; male: 8%)
	18 to 99 year-old persons without disabilities	1,068 (female: 574; male: 494)	Indicative

[14] A full list of completed interviews by camp is included in annex 2.
[15] Includes all persons with disabilities.
[16] Domains of functional difficulty not included here were not analysed separately due to insufficient sample sizes.
[17] Includes all persons with disabilities with the exception of those with difficulties in functioning in the anxiety or depression domains only. See "Data analysis" section for further explanation.

Set of questions	Sub-sample	Sample size	Margin of error
	18 to 59 year-old persons with disabilities[17]	237 (female: 122; male: 115)	7% (female: 9%; male: 10%)
	18 to 59 year-old persons without disabilities	842 (female: 492; male: 350)	Indicative
	60+ year-old persons with disabilities[17]	156 (female: 83; male: 73)	8% (female: 11%; male: 12%)
	60+ year-old persons without disabilities	226 (female: 82; male: 144)	7% (female: 11%; male: 9%)
	All 60+ year-old persons[17]	473 (female: 199; male: 274)	5% (female: 7%; male: 6%)
Service utilisation, barriers and enablers (ages 2 and above)[16]	Persons with disabilities[18]	489	5%
	Vision	97	10%
	Hearing	61	13%
	Mobility	302	5%
	Cognition	72	12%
	Self-care	107	10%
	Upper body movement	89	11%
	Communication	52	14%
	Learning	48	15%
	Anxiety	251	Indicative
	Depression	195	Indicative
	5 to 17 year-old persons with disabilities[17]	72	11%
	18 to 99 year-old persons with disabilities[17]	393 (female: 205; male: 188)	5% (female: 7%; male: 8%)
	18 to 59 year-old persons with disabilities[17]	237 (female: 122; male: 115)	7% (female: 9%; male: 10%)
	60+ year-old persons with disabilities[17]	156 (female: 83; male: 73)	8% (female: 11%; male: 12%)
	60+ year-old persons without disabilities	226 (female: 82; male: 144)	7% (female: 11%; male: 9%)
	All 60+ year-old persons	473 (female: 199; male: 274)	5% (female: 7%; male: 6%)

Quantitative data collection was led by REACH and data collected by four teams of Prottyashi and IOM NPM enumerators. Prior to data collection, enumerators underwent a three-day training, jointly facilitated by the ADWG and REACH, to familiarise themselves with the tool and data collection protocols. The training included specialised sessions on protection concerns related to working with persons with disabilities and older persons as well as on communication with persons with disabilities and inclusive facilitation to ensure that data collection would take place with maximum dignity and respect for respondents.[19] Moreover, in advance of the survey, respondents were informed of their right not to participate, not to answer specific questions or to end the interview when they wished. Informed consent was sought, received and documented at the start of each interview. In order to safeguard against exposing enumerators or participants to risks related to COVID-19, distance was maintained and personal protective equipment used during data collection.

[18] Includes all persons with disabilities with the exception of those with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds) and those with difficulties in functioning in the behaviour domain only (2 to 4 year-olds). See "Data analysis" section for further explanation.
[19] The training agenda is included in annex 3.

The tool and data collection protocols were piloted with a sample of Rohingya refugee households to identify and rectify problems before the full roll-out of data collection. Following the pilot, the tool was further refined based on lessons learnt during the pilot related to phrasing/understanding of the questions by both the enumerators and the respondents, displaying/sequencing of questions on the screen or missing response options.

During the interviews, data was entered directly onto tablets using the KoBoCollect mobile application. At the end of each day, surveys were uploaded to the REACH server, checked and cleaned according to a set of pre-established Standard Operating Procedures (SOPs) and including outlier checks, the correct categorisation of "other" responses, the identification and removal or replacement of incomplete, inaccurate or incoherent records, and the recoding and standardisation of entries. All changes to the data were documented in a data cleaning log. Based on observations during the pilot, an average of 2 minutes per household member aged 2 and above was established as the minimum length of the interview required to ensure an acceptable level of data quality. Any surveys below this threshold were removed. In total, 92 of 2,622 completed interviews were deleted from the final dataset due to quality issues related to timing or response inconsistencies that could not be corrected.

Qualitative data collection took place between 12 January and 8 February 2021. In total 20 FGDs were conducted with group sizes ranging from 3 to 7 participants, and including:

- 6 FGDs (3 male and 3 female-only) with 27 adults with disabilities (15 females and 12 males);
- 4 FGDs (2 male and 2 female-only) with 25 children with disabilities aged 11 to 17 (12 females and 13 males);
- 4 FGDs (2 male and 2 female-only) with 24 caregivers of children with disabilities (13 females and 11 male);
- 6 FGDs (3 male and 3 female-only) with 36 older persons aged 60 to 81 (17 females and 19 males).

The FGDs included participants with physical disabilities, mental disabilities, speech impairment, sensory disabilities, intellectual disabilities and cerebral palsy.[20]

FGDs with adults were led and conducted by REACH with technical support from CBM-CDD. FGDs with children with disabilities were conducted by HI. Prior to data collection, enumerators underwent a two-day training to familiarise themselves with the tool and data collection protocols. The training included practice sessions to test the phrasing and understanding of the questions as well as sessions related to communication with persons with disabilities and older persons, and inclusive facilitation.[21] Following the training and prior to the start of data collection, the tool was finalised based on enumerator feedback during the training. In order to safeguard against exposing enumerators or participants to risks related to COVID-19, group sizes were limited, distance was maintained and personal protective equipment used during data collection.

Notes were taken during all FGDs. For FGDs with adults, discussions were recorded after consent had been given by participants, whilst FGDs with children were not recorded. At the end of each day of data collection, debriefings were conducted by REACH and HI, during which notes were reviewed for clarity and accuracy, and completed using the recordings, where applicable.

[20] A full list of completed FGDs, including a disaggregation by participant gender and disability profile, is included in annex 3.
[21] The training agenda can be found in annex 4.

Data analysis

For the quantitative component, a basic descriptive analysis was conducted. In order to assess disability prevalence, in line with the WGQs guidance, individuals were identified as:[22]

- **Persons with disabilities:** If the WGQ-defined threshold had been passed for at least one domain of functional difficulty;
- **Missing data:** If the WGQ-defined thresholds had not been passed for any domain, while related questions for at least one domain had been answered ambiguously, or not been answered at all;
- **Persons without disabilities:** If all questions had been answered unambiguously, but the WGQ-defined thresholds had not been passed for any domain.

The mixed nature of the random sample of 5 to 99 year-old persons with difficulties in functioning in the anxiety or depression domains only, 2 to 4 year-old persons with difficulties in functioning in the behaviour domain only, and persons without disabilities, did not allow to statistically correct the potential bias introduced for each group by not sampling all individuals of those groups, or sampling them separately.[23] In order to still obtain representative results when aggregating findings across all domains of functional difficulties, persons with difficulties in functioning only in the aforementioned domains were excluded from the aggregation of results across all domains for questions related to service utilisation, barriers and enablers, participation and disaster preparedness. During the basic descriptive analysis, results were weighted at the camp level to account for the unequal distribution of households across camps.

In addition to the basic descriptive analysis, results related to service utilisation, barriers and enablers, education, engagement in the informal sector/means of living, participation and disaster preparedness were tested for statistically significant differences in outcomes between persons with and without disabilities, by domain of functional difficulty,[24] by age group (excluding the 2 to 4 years' age group due to the sample size for this age group being too limited) and by gender. The analysis by domain of functional difficulty only included domains with sufficient sample sizes to achieve representative results. Moreover, due to the non-representativeness of results for persons with difficulties in functioning in the anxiety or depression domains, no significance testing was conducted for these groups. For numerical indicators, Student's t-test was used to determine whether or not there was an association between individual characteristics and indicator outcomes. In all other cases, Pearson's chi-square test of independence was used. Relationships were determined to be statistically significant for p-values ≤ 0.05.

FGD notes were translated and input into a data saturation grid (DSG) at the end of the data collection process. The DSG was used as a starting point to identify key discussion points. The translated notes were then further analysed in NVivo, drawing out trends, themes, and key messages across interviews.[25]

[22] For a detailed description of the analytical approach related to the WGQs, please refer to the guidelines on the Washington Group Short Set (WG-SS) Enhanced Questions for adults and the Washington Group/United Nations International Children's Emergency Fund (UNICEF) Child Functioning Modules (CFM) for children.
[23] Refer to "Sampling strategy" section for more information.
[24] The assessment found an overlap between domains (compare Table 12 in annex 6), such that one person was sometimes reported as having difficulties in functioning in several domains at the same time. In order to still be able to analyse the relationship between reported barriers and domains of functional difficulty, results for persons with difficulties in functioning in a specific domain were compared to results for persons with difficulties in functioning in general, i.e. persons with disabilities, but not with difficulties in functioning in this specific domain. If persons with difficulties in functioning in the specific domain under consideration were particularly affected by the reported barrier, a statistically significant difference in results between those two groups would be expected. If they were not particularly affected, no significant difference between the two groups would be expected. Please refer to annex 8 for more information.
[25] The full qualitative analysis can be found here.

Challenges and limitations

Challenges and limitations of the assessment include:

- **Representativeness:** Due to time constraints, not all persons without disabilities or those with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds), or in the behaviour domain only (2 to 4 year-olds), could be asked the questions on service utilisation, barriers and enablers, participation and disaster preparedness. These questions were therefore only asked to a mixed random sample of individuals from those groups. This, however, potentially introduced a sampling bias for each group, such that results related to service utilisation, barriers and enablers, participation and disaster preparedness for those groups are indicative only.
    - **Analysis for persons with disabilities:** As a result of the above limitation, in order to still obtain representative overall results for persons with disabilities, results for persons with disabilities related to service utilisation, barriers and enablers, participation and disaster preparedness exclude persons with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds), or in the behaviour domain only (2 to 4 year-olds).
- **Analysis by domain of functional difficulty:** Due to limited sample size, an analysis by domain of functional difficulty could only be conducted for domains with sufficient sample sizes to achieve representative results.[26]
    - **Co-occurrence of functional difficulties:** Persons with disabilities were often reported as having functional difficulties in several domains at the same time. Therefore, results by domain of functional difficulty must be interpreted cognisant of the fact that they may be the result of a combination of functional difficulties rather than attributable to a single functional difficulty.[27]
- **Disability and highest level of education/pre-COVID engagement in the informal sector:** The assessment determined current disability prevalence or functional difficulties. With disability being an evolving concept, this does not necessarily reflect disability prevalence or functional difficulties in the same population at any other point in time.[28] In particular, difficulties in functioning in the anxiety or depression domains may have been impacted to some degree by the COVID-19 outbreak, associated control measures, and their impact on humanitarian service provision throughout much of 2020. Therefore, findings related to persons with disabilities' highest levels of education, pre-COVID enrolment in educational facilities or pre-COVID engagement in the informal sector have to be interpreted cognisant of the fact that they represent current persons with disabilities' highest levels of education, pre-COVID enrolment rates and pre-COVID engagement in the informal sector. They may only be indicative of the highest levels of education, pre-COVID enrolment rates and pre-COVID engagement in the informal sector of persons with disabilities at the time when the education was obtained or self-reliance activities were pursued.
- **Analysis by age group:** The age-disaggregated analysis related to service utilisation, barriers and enablers, participation, and disaster preparedness excludes the 2 to 4 years' age group, as the sample size for this age group was too small for a meaningful disaggregation.
- **Proxy reporting:** Data on individuals aged 17 or younger as well as on adult individuals unable to respond on their own behalf was collected by proxy from other household members. Results may therefore not directly reflect the lived experiences of the concerned individuals.

[26] Compare Table 1 under "Data collection and processing" for a full list of domains included in this analysis.
[27] Compare Table 12 in annex 6.
[28] Compare to the preamble of the Convention on the Rights of Persons with Disabilities (CRPD): disability is an evolving concept and results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

- **Respondent bias:** Certain indicators, such as barriers to accessing services, may be under- or over-reported due to the subjectivity and perceptions of respondents. For instance, respondents might have the tendency to provide what they perceive to be the “right” answer to certain questions ("social desirability bias").
- **Perceptions:** Questions on individuals’ perceptions may not directly reflect the realities of service provision in refugee camps but only respondents’ perceptions of them.
- **FGD participants:** In order to facilitate communication with participants, for qualitative data collection, FGD participants were identified from UNHCR partner, HI and CBM-CDD beneficiaries. Therefore, qualitative results reflect project beneficiaries’ perceptions, needs, barriers, and preferences. They may not be reflective of persons with disabilities across the entire Rohingya population.

FINDINGS

Disability prevalence

In the following sub-sections, first, results related to each domain of functional difficulty will be presented separately. Secondly, disability prevalence by domain of functional difficulty, and by age group and gender will be presented. Lastly, overall disability prevalence, trends across age groups, and disability prevalence by location, will be discussed.

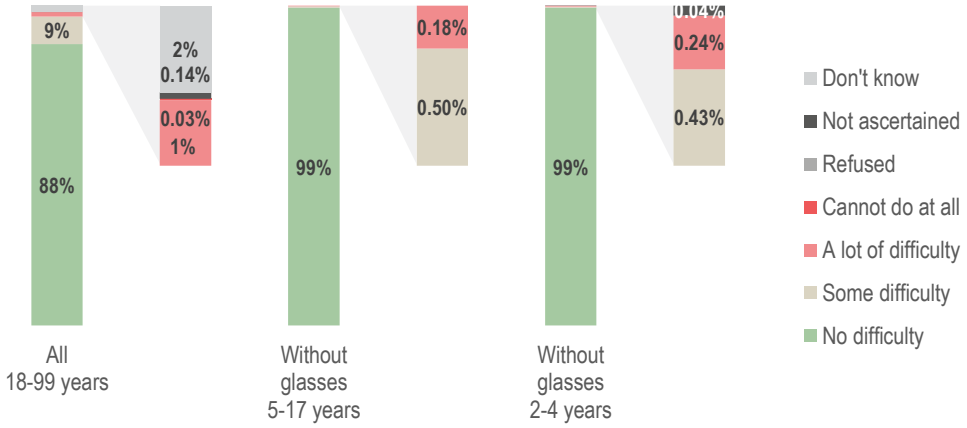
Washington Group Question results

First, WGQ results for domains assessed across all age groups – vision, communication, hearing and mobility – will be presented. This will be followed by results for domains specific to the 5 to 17 and 18 to 99 years' age groups – cognition, self-care and upper body movement, anxiety and depression – and results for the learning domain, which was assessed only for 2 to 4 and 5 to 17 year-olds. Afterwards, results for domains specific only to the 5 to 17 years' age group – behaviour, accepting change and making friends – will be presented. Lastly, results for domains specific to the 2 to 4 years' age group – behaviour, playing and dexterity – will be shown.

Vision

Very small proportions of children were reported as wearing glasses or contact lenses. Overall, 0.4% of children aged 2 to 4, and 0.2% of children aged 5 to 17 reportedly wore glasses or contact lenses. However, in both age groups, roughly 0.7% of children reportedly not wearing glasses or contact lenses were reported as having at least some difficulty seeing. This indicates that potentially not all children in need of vision assistive products are using any. Among adults, the proportion of individuals reportedly having at least some difficulty seeing, even if wearing glasses, was considerably higher. Overall, 9% of adults reportedly had some difficulty seeing and another 1% reportedly had a lot of difficulty seeing (Figure 1).

Figure 1 % of individuals reportedly having difficulty seeing, by age group[29]

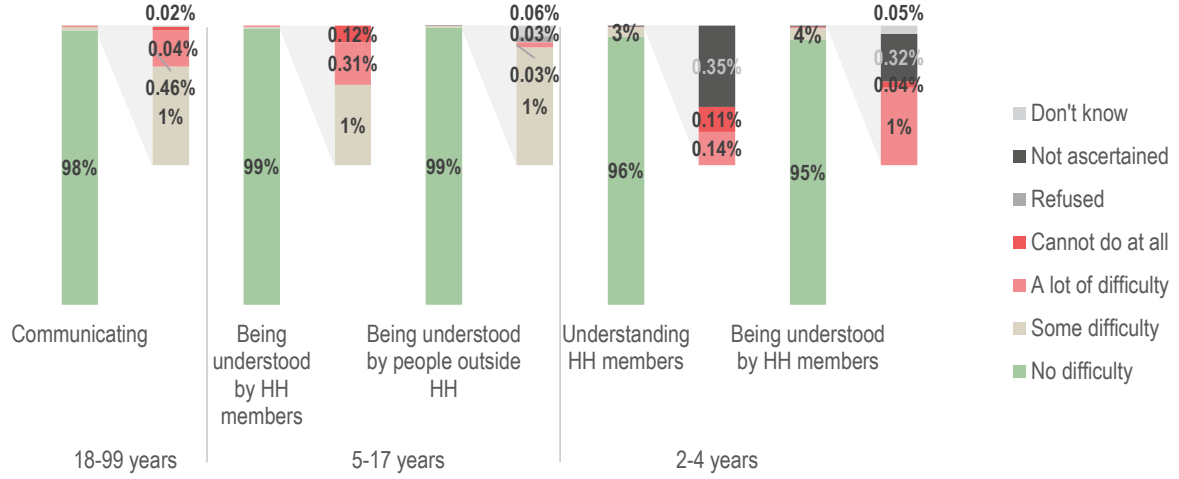


[29] For 2 to 4 and 5 to 17 year-olds, results are only shown for individuals reportedly not wearing glasses or contact lenses (2 to 4 years, n = 1,334; 5 to 17 years, n = 3,972). Results for individuals wearing glasses or contact lenses are not representative. For adults, no distinction between individuals wearing glasses or contact lenses and those not wearing glasses or contact lenses was made.

Communication

The largest proportion of individuals reportedly having at least some difficulty in the communication domain was found among 2 to 4 year-olds, of whom 4% were reported as having at least some difficulty understanding household members, and 5% were reported as having at least some difficulty being understood by household members. Among adults, 2% reportedly have at least some difficulty communicating. Among 5 to 17 year-olds, 1% reportedly have at least some difficulty being understood by household members or being understood by people outside the household, respectively (Figure 2).

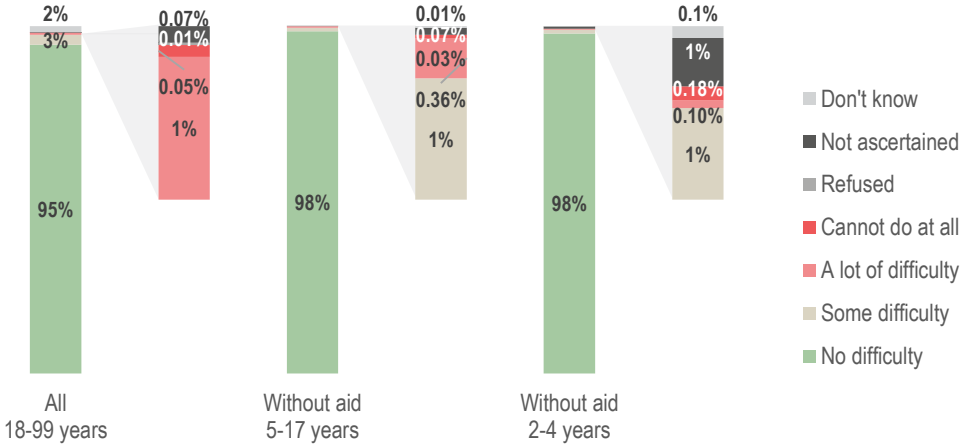
Figure 2 % of individuals reportedly having difficulty communicating, being understood or understanding others, by age group



Hearing

Overall, 4% of adults reportedly have at least some difficulty hearing even when using a hearing aid. While 0.7% of 2 to 4 year-olds, and 0.5% of 5 to 17 year-olds were reportedly using hearing aids, 1% in each age group of those not using hearing aids was also reported as having at least some difficulty hearing (Figure 3).

Figure 3 % of individuals reportedly having difficulty hearing, by age group[30]



[30] For 2 to 4 and 5 to 17 year-olds, results are only shown for individuals reportedly not using hearing aids (2 to 4 years, n = 1,333; 5 to 17 years, n = 3,961). Results for individuals using hearing aids are not representative. For adults, no distinction between individuals using hearing aids and those not using hearing aids was made.

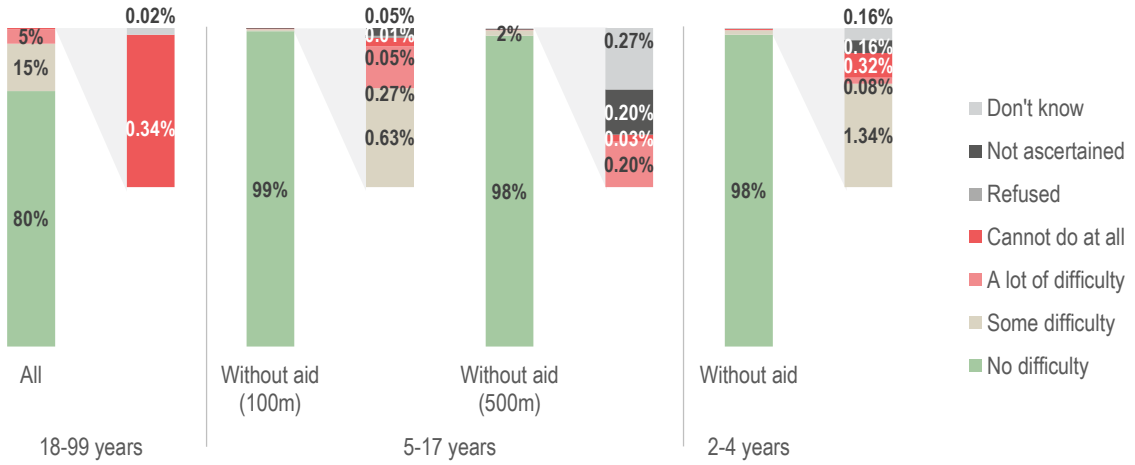
Mobility

Overall, 20% of adults reportedly have difficulty walking or climbing stairs, with 15% reportedly having some difficulty, 5% a lot of difficulty, and a further 0.34% of adults reportedly not being able to walk at all.

Among 5 to 17 year-olds, 0.1% were reported as using equipment or receiving assistance walking. Of those not using any equipment or receiving any assistance walking, 1% reportedly have at least some difficulty walking 100 m on level ground compared to other children of the same age. Moreover, of those not using any equipment or receiving any assistance walking, and not having been reported as having a lot of difficulty or not being able at all to walk 100 m on level ground, 2% reportedly have at least some difficulty walking 500 m on level ground compared to other children of the same age. Lastly, 0.4% of 2 to 4 year-old individuals were reported as using equipment or receiving assistance walking.

Of the 2 to 4 year-olds reportedly not using any equipment or receiving assistance walking, 2% reportedly have at least some difficulty walking compared to other children of the same age (Figure 4).

Figure 4 % of individuals reportedly having difficulty walking, by age group[31]



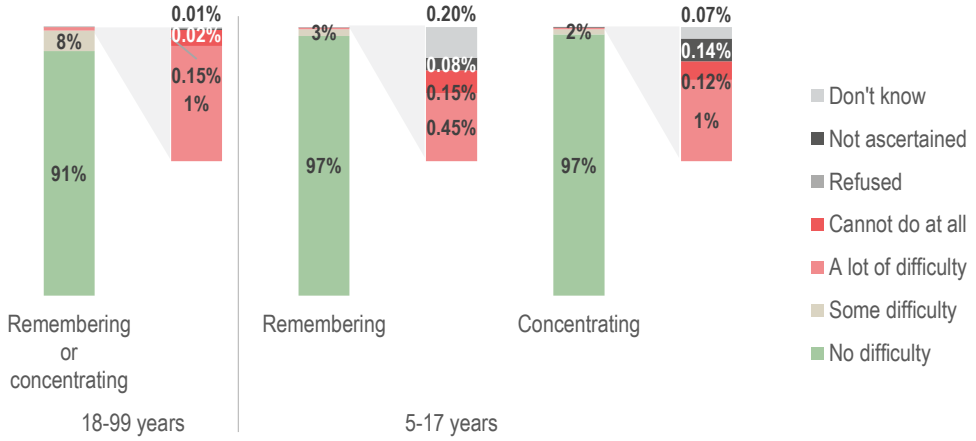
Cognition (5 to 99 years)

Related to cognition, 9% of adults and 3% of 5 to 17 year-olds reportedly have at least some difficulty remembering or concentrating.

Among both age groups, individuals most commonly reportedly have some difficulty (8% of adults, or 2% to 3% of 5 to 17 year-olds) rather than a lot of difficulty or not being able to remember or concentrate at all (Figure 5).

[31] For 2 to 4 and 5 to 17 year-olds, results are only shown for individuals reportedly not using equipment or receiving assistance walking (2 to 4 years, n = 1,340; 5 to 17 years (100 m), n = 3,975). For 5 to 17 year-old individuals, difficulties walking 500 m were only assessed for those not reported as having a lot of difficulty or not being able at all to walk 100 m (n = 3,963). Results for individuals using equipment or receiving assistance walking are not representative. For adults, no distinction between individuals using equipment or receiving assistance walking and those not using equipment or receiving assistance walking was made.

Figure 5 % of individuals reportedly having difficulty remembering or concentrating, by age group[32]

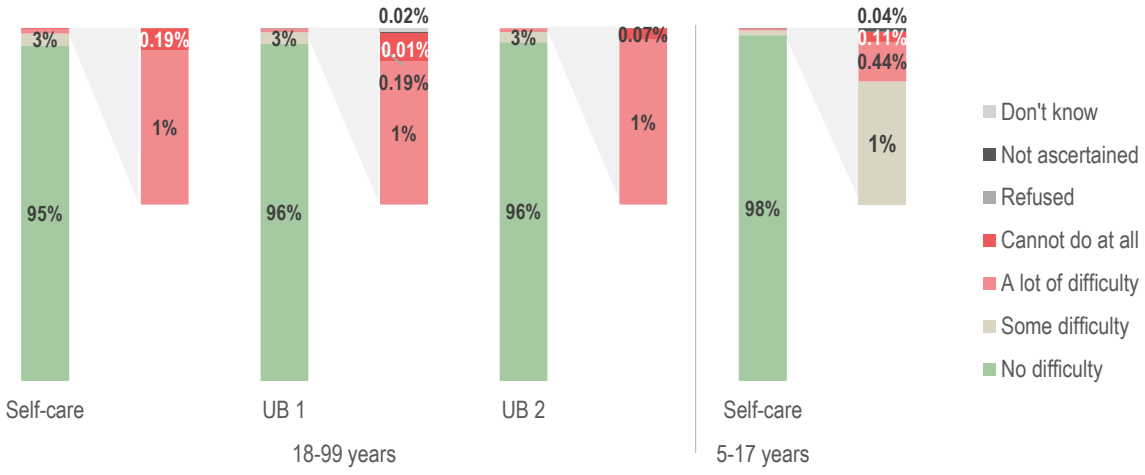


Self-care (5 to 99 years) / upper body movement (18 to 99 years)

Overall, 5% of adults reportedly have at least some difficulty with self-care, such as washing all over or dressing, with 3% reportedly having some difficulty and 1% reportedly having a lot of difficulty. In response to both upper body movement questions, 3% of adults reported or were reported as having some difficulty, and 1% reported or were reported as having a lot of difficulty.

Among 5 to 17 year-olds, 1% reportedly have some difficulty with self-care, while another 0.5% reportedly have a lot of difficulty or cannot take care of themselves at all (Figure 6).

Figure 6 % of individuals reportedly having difficulty with self-care and upper body movement, by age group[33]



Anxiety (5 to 99 years)

More than half the adults reportedly feel worried, nervous or anxious at least a few times a year. Most commonly, feelings of anxiety are experienced daily (as reported for 22% of adults) or monthly (17%) (Figure 7). Of those reportedly experiencing feelings of anxiety at least a few times a year, the level of anxiety experienced was "a lot" for 42%, and "a little" for 47%, (Figure 8).

[32] For adults, difficulty remembering or concentrating was assessed together, while for children aged 5-17, they were assessed separately.
[33] UB 1 and UB2 refer to the two questions related to the upper body movement domain, assessed only for adults – (1) difficulty raising a 2 litres' bottle of water from waist to eye level; and (2) difficulty using hands and fingers.

Among those experiencing feelings of anxiety on a daily or weekly basis, the proportion of those reporting "a lot" of feelings of anxiety was relatively high with 55%. In contrast, of adults reportedly experiencing feelings of anxiety on a monthly basis or a few times a year, the majority (64%) reportedly only experience "a little" feeling of anxiety.[34] This may be indicative of the intensity of feelings of anxiety increasing with the frequency with which such feelings are experienced.

Among 5 to 17 year-olds, 13% reportedly seem very anxious, worried or nervous at least a few times a year. However, at the same time, for 11% of 5 to 17 year-olds, respondents were not able to assess feelings of anxiety. This indicates challenges for respondents to judge other household members' feelings of anxiety, and presents a potential drawback of the assessment of "less visible" functional difficulties by proxy (Figure 7).

Figure 7 % of individuals reportedly feeling worried, nervous or anxious, by age group

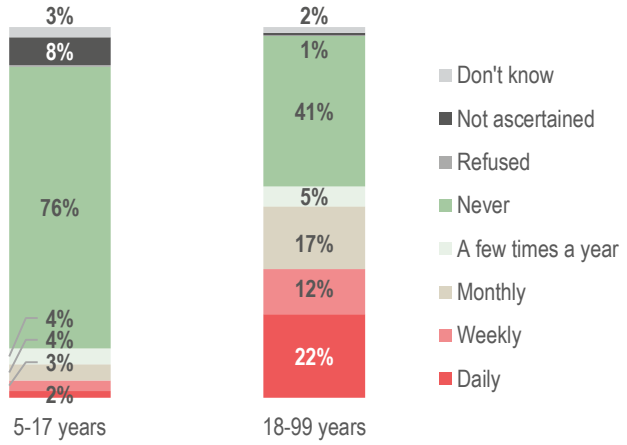
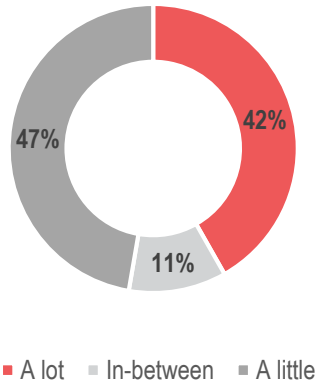


Figure 8 Of adults reportedly feeling worried, nervous or anxious at least a few times a year, % of individuals reporting level of anxiety



Depression (5 to 99 years)

Overall, 51% adults reportedly feel depressed at least a few times a year, most commonly on a monthly basis, as reported for 16% of adults (Figure 9). Of those reportedly experiencing feelings of depression at least a few times a year, the experienced level of depression often tended to be strong. Overall, 46% reportedly experienced "a lot" of feelings of depression when experiencing them, and only 12% reportedly experienced "a little" feeling of depression (Figure 10).

Similar to the experience of feelings of anxiety, 59% of adults reportedly experiencing feelings of depression on a daily or weekly basis experience "a lot" of feelings of depression. In contrast, 58% of those experiencing feelings of depression on a monthly basis or a few times a year reportedly "only" experience "a little" feeling of depression.[35]

Among 5 to 17 year-olds, 13% were reported as seeming very sad or depressed at least a few times a year. However, also in this case, the proportion of 5 to 17 year-olds, for whom respondents did not answer or did not know how to answer was relatively high (11%) (Figure 9).

[34] Results are representative with a 3% margin of error (those reportedly experiencing anxiety daily or weekly, n = 2,054; those reportedly experiencing anxiety monthly or a few times a year, n = 1,305).
[35] Results are representative with a 3% margin of error (those reportedly experiencing depression daily or weekly, n = 1,451; those reportedly experiencing depression monthly or a few times a year, n = 1,547).

Figure 9 % of individuals reportedly feeling depressed, by age group

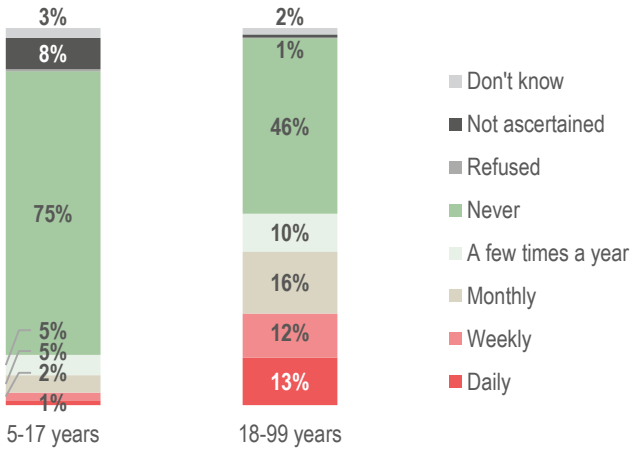
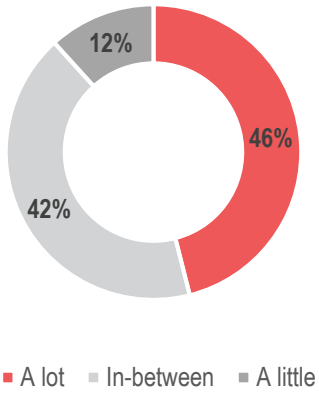


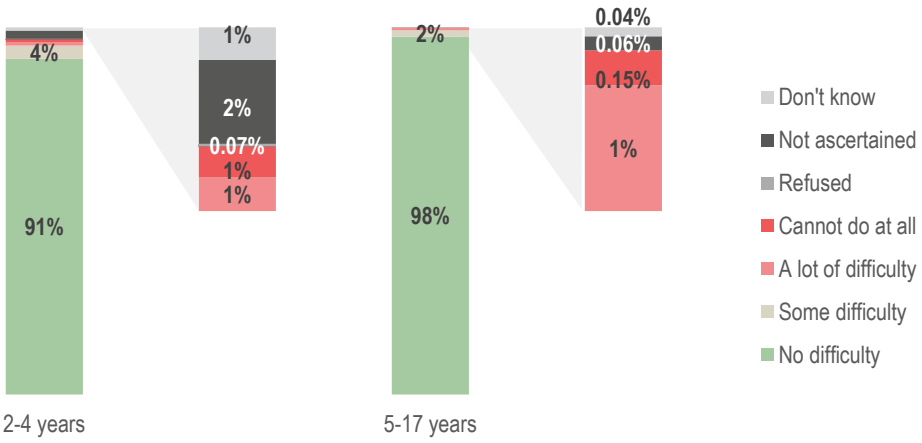
Figure 10 Of adults reportedly feeling depressed at least a few times a year, % of individuals reporting level of depression



Learning (2 to 17 years)

The proportion of individuals reportedly having difficulties learning was larger among 2 to 4 year-olds than among 5 to 17 year-olds. Overall, 5% of 2 to 4 year-olds reportedly had at least some difficulty learning, compared to 2% of 5 to 17 year-olds. At the same time, the proportion of individuals for whom caregivers were not able to or refused to assess learning difficulties was slightly higher among 2 to 4 year-olds than among 5 to 17 year-olds. This indicates potentially greater challenges for caregivers in assessing younger individuals' learning difficulties (Figure 11).

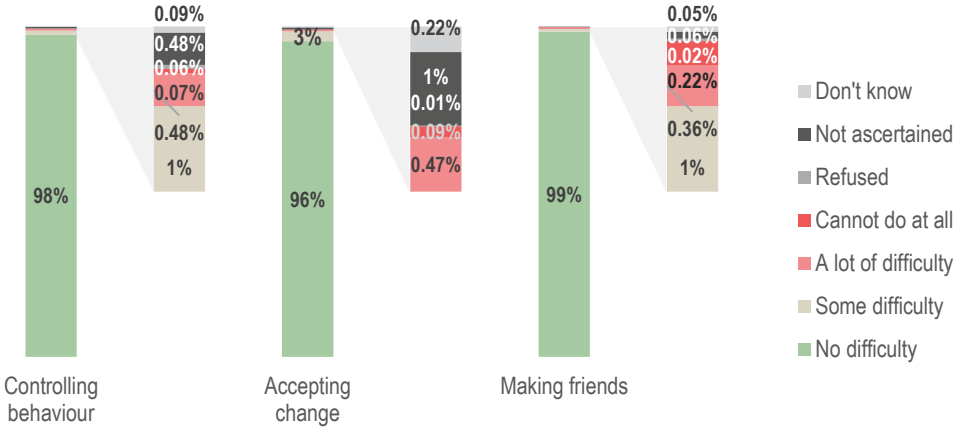
Figure 11 % of individuals reportedly having difficulty learning, by age group



Behaviour, accepting change, making friends (5 to 17 years)

Difficulties in controlling behaviour, accepting change, and making friends were only assessed for 5 to 17 year-olds. Overall, 4% of these individuals reportedly have at least some difficulty accepting change, 2% reportedly have at least some difficulty controlling their behaviour, and 1% reportedly have at least some difficulty making friends. The reported proportion of individuals having a lot of difficulty in any of these domains was also highest in the accepting change domain (close to 0.5%). At the same time, this is also the only one of those three domains, for which for more than 1% of individuals, information is missing (Figure 12).

Figure 12 % of 5 to 17 year-old individuals reportedly having difficulty controlling behaviour, accepting change, or making friends



Playing, dexterity, behaviour (2 to 4 years)

Among the 2 to 4 year-olds, 1% of individuals were reported as having difficulty playing, with 0.5% reportedly having some difficulty and 0.7% reportedly having a lot of difficulty. One percent (1%) were reported as having some difficulty in the dexterity domain, the only domain for which no individual was reported as having a lot of difficulty or not being able to pick up small things at all (Figure 13). Lastly, 3% of 2 to 4 year-olds reportedly have more or a lot more violent behavioural tendencies than other children of the same age, while the majority reportedly have less or no violent tendencies at all, and roughly 1% could not be assessed (Figure 14).

Figure 13 % of 2 to 4 year-old individuals reportedly having difficulty playing or picking up small objects

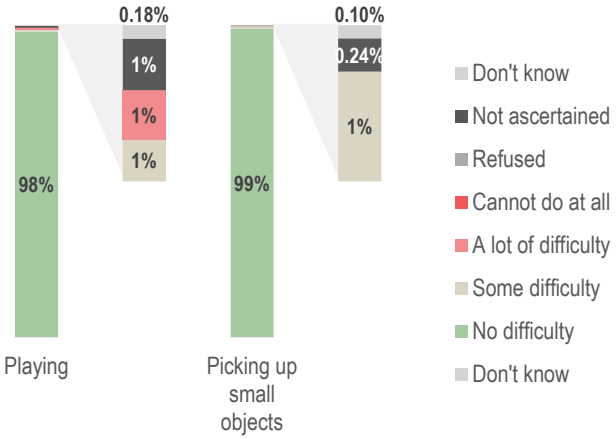
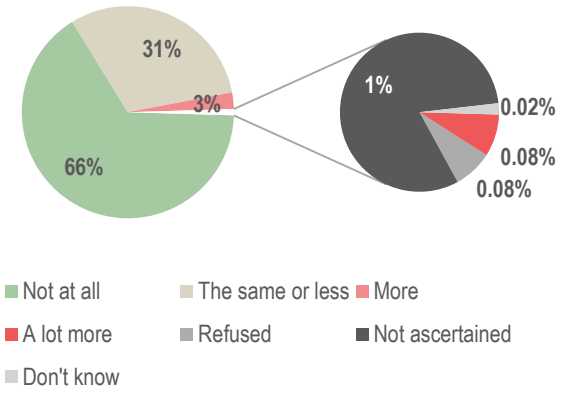


Figure 14 % of 2 to 4 year-olds kicking, biting or hitting other children or adults compared to other children of the same age



Disability prevalence by domain, age group and gender

Among adults, overall 20% of individuals were identified as persons with disabilities, i.e. reportedly having at least a lot of functional difficulty in one or more domains. The highest proportions of adults had difficulties in functioning[36] in the anxiety domain (14%), followed by the depression (9%) and the mobility (5%) domains. Roughly equal proportions of individuals, between 1.3% and 1.5%, reportedly had difficulties in functioning in the self-care, upper

[36] Difficulties in functioning" in the following always refers to "a lot of difficulty" or "not being able at all" to do something having been reported in response to the WGQs (as opposed to "some difficulty"), or for questions with different response options, the equivalent response options outlined in the Washington Group guidelines that would identify someone as a person with disabilities.

body movement, vision or cognition domains. The lowest proportions of individuals of less than 1% had difficulties in functioning in the hearing or communication domains (Figure 15).

The proportion of persons with disabilities was slighter higher among male (21%) than among female (19%) individuals. However, generally, across domains, there were no notable differences in the proportions of male and female individuals identified as persons with disabilities (Figure 16).

Figure 15 % of 18 to 99 year-old individuals identified as persons with disabilities, by domain

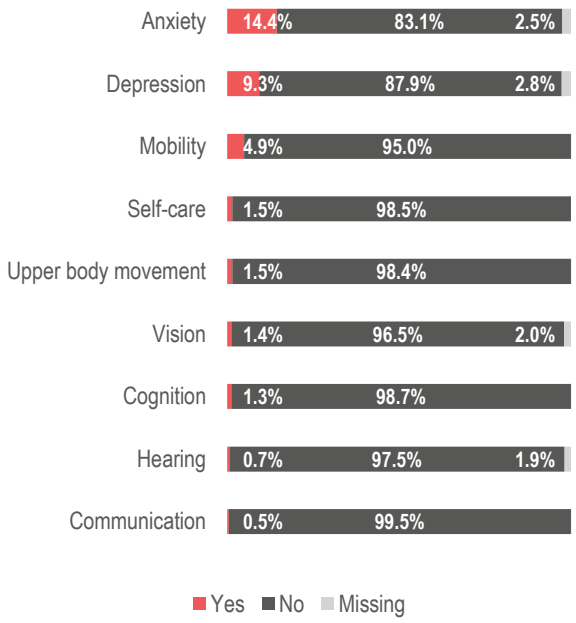
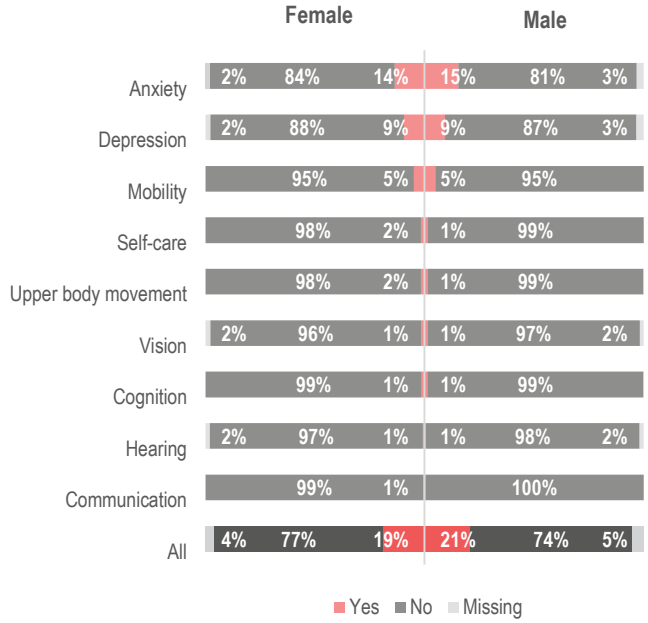


Figure 16 % of 18 to 99 year-old individuals identified as persons with disabilities by domain and overall, by gender[37]



Among the 5 to 17 year-olds, only in the anxiety and depression domains, more than 1% of individuals reportedly had difficulties in functioning. In most other domains, disability prevalence ranged from 0.4% to 0.7%, while in the vision domain, only 0.2% of individuals reportedly had difficulties in functioning (Figure 17).

Overall, 3% of individuals were identified as persons with disabilities, with no notable differences in disability prevalence between male and female individuals (Figure 18).

Due to the relatively high proportions of individuals, for whom respondents were not able to assess the frequency of feelings of anxiety or depression, between 11% and 12% of individuals could not be identified neither as persons with nor as persons without difficulties in functioning in those domains. This contributed to an overall proportion of missing data of 13% in this age group.

[37] Results are representative with a 2% margin of error (female individuals, n = 3,146; male individuals, n = 2,719).

Figure 17 % of 5 to 17 year-old individuals identified as persons with disabilities by domain

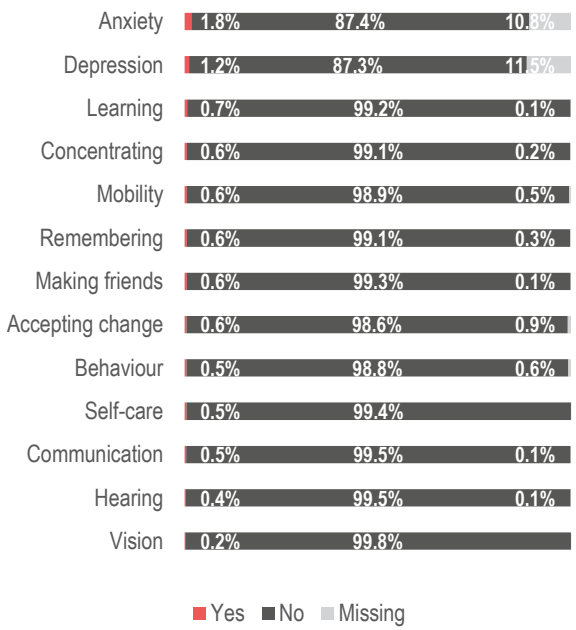
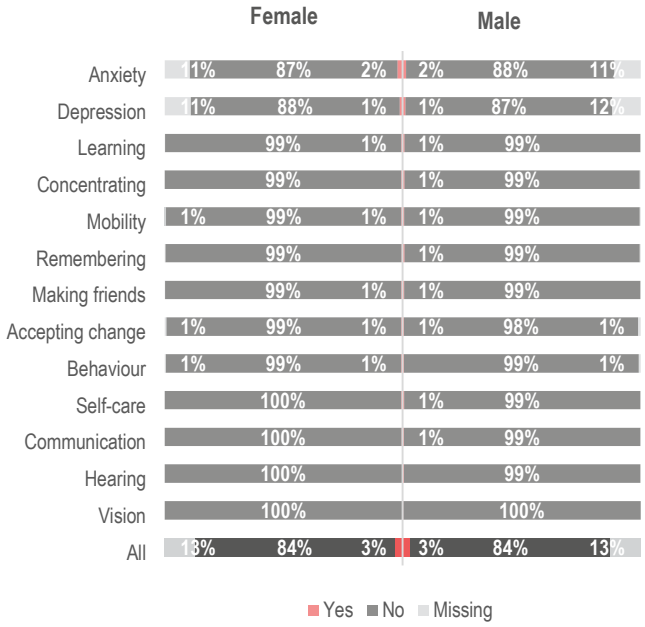


Figure 18 % of 5 to 17 year-old individuals identified as persons with disabilities by domain and overall, by gender[38]



Among 2 to 4 year-olds, 2% of individuals reportedly had difficulties in functioning in the learning domain, with this domain also having the highest proportion of missing data (3%). In the playing and communication domains, 0.7% and 0.6% of individuals reportedly had difficulties in functioning, while in all other domains, disability prevalence was less than 0.5% (Figure 19).

Overall, 2% of 2 to 4 year-old individuals were identified as persons with disabilities, with 1% of female individuals and 3% of male individuals of this age group having been identified as persons with disabilities (Figure 20).

Figure 19 % of 2 to 4 year-old individuals identified as persons with disabilities by domain

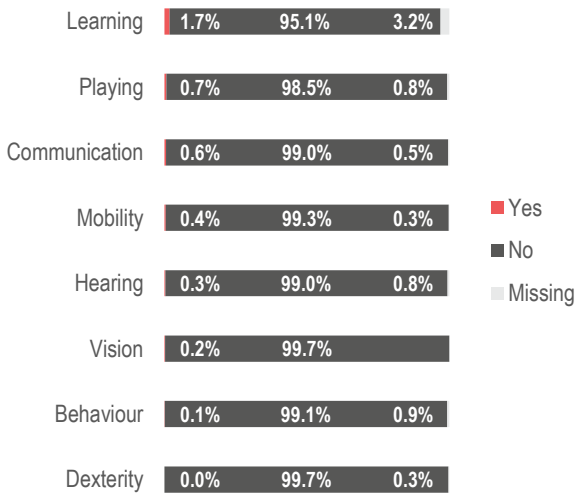
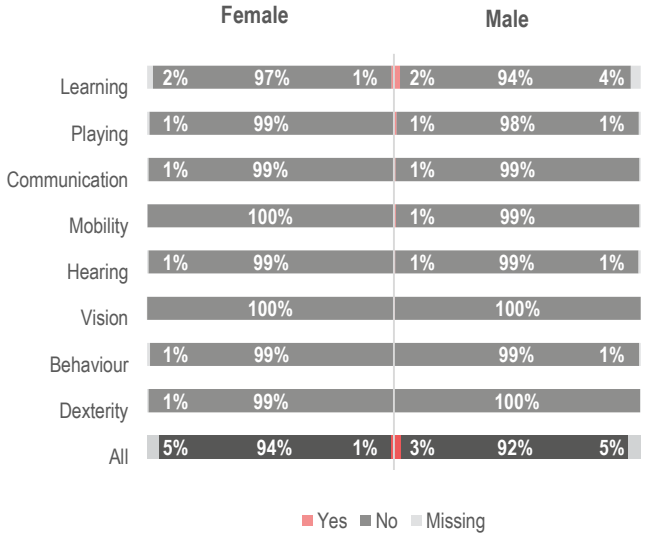


Figure 20 % of 2 to 4 year-old individuals identified as persons with disabilities by domain and overall, by gender[39]



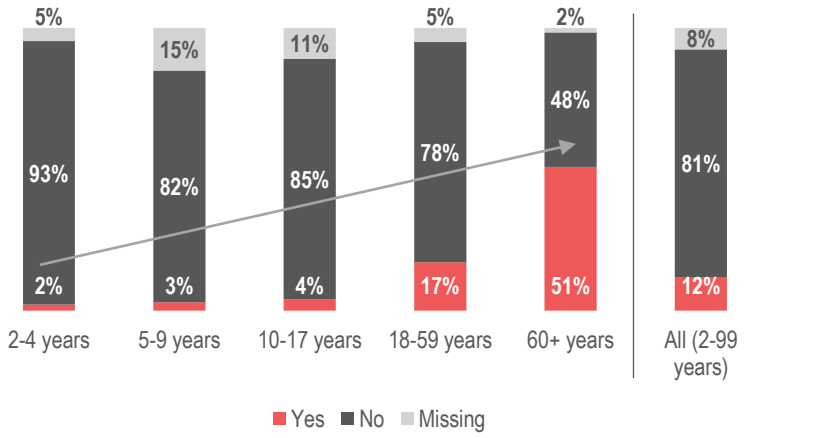
[38] Results are representative with a 3% margin of error (female individuals, n = 1,943; male individuals, n = 2,037).
[39] Results are representative with a 5% margin of error (female individuals, n = 658; male individuals, n = 676).

Overall disability prevalence, trends across age groups and disability prevalence by location

Overall, 12% of individuals were identified as persons with disabilities. While there appeared to be no noticeable gender difference (both 12% of female individuals and 12% of male individuals were identified as persons with disabilities), findings suggest an increasing disability prevalence with increasing age. Figure 21 shows disability prevalence with the 5 to 17 and 18 to 99 years' age groups having been further broken down into two distinct age groups each. It becomes evident that even among children and youths, there may be a slight increasing trend in disability prevalence with increasing age – with uncertainty being largest for results for the 5 to 17 years' age group due to the relatively high proportions of missing data.

The difference in estimated disability prevalence between the 5 to 9 and the 10 to 17 year-olds is largely driven by increases in the proportions of individuals with difficulties in functioning in the anxiety and depression domains. While 1.2% of 5 to 9 year-olds reportedly had difficulties in functioning in the anxiety domain, this proportion increases to 2.4% among 10 to 17 year-olds. Similarly, the proportion of individuals with difficulties in functioning in the depression domain increases from 0.9% among 5 to 9 year-olds to 1.6% among 10 to 17 year-olds. In all other domains, the proportions of 10 to 17 year-olds reportedly having difficulties in functioning were slightly lower than the respective proportions of 5 to 9 year-olds, with the exception of the vision domain. In the vision domain, a slight increase from 0.1% of 5 to 9 year-olds with difficulties in functioning to 0.2% of 10 to 17 year-olds with difficulties in functioning in this domain was found.

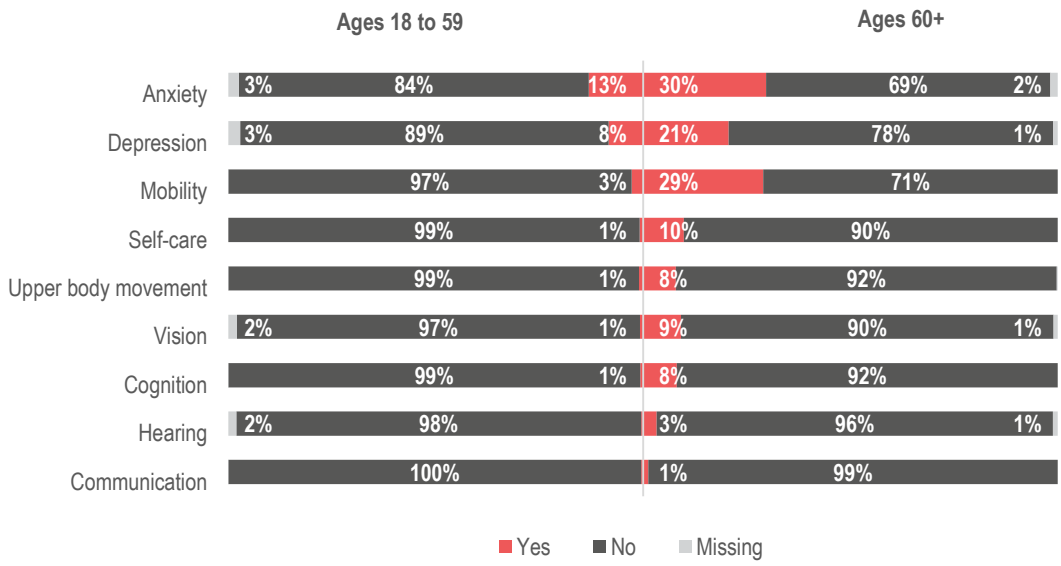
Figure 21 % of individuals identified as persons with disabilities, by age group and overall[40]



Among older persons (aged 60 and above), who were found to comprise 3.2% of female individuals and 4.9% of male individuals in the population, more than half (51%) were identified as persons with disabilities, compared to 17% of adults aged 18 to 59 (Figure 21). Across all domains, with the exception of the hearing and communication domains, disability prevalence among older persons was multiple times higher than among individuals aged 18 to 59. Most notably, almost one third of older persons reportedly had difficulties in functioning in the anxiety (30%) and mobility (29%) domains, a fifth in the depression domain (21%), and between 8% and 10% in the cognition, vision, upper body movement and self-care domains (Figure 22).

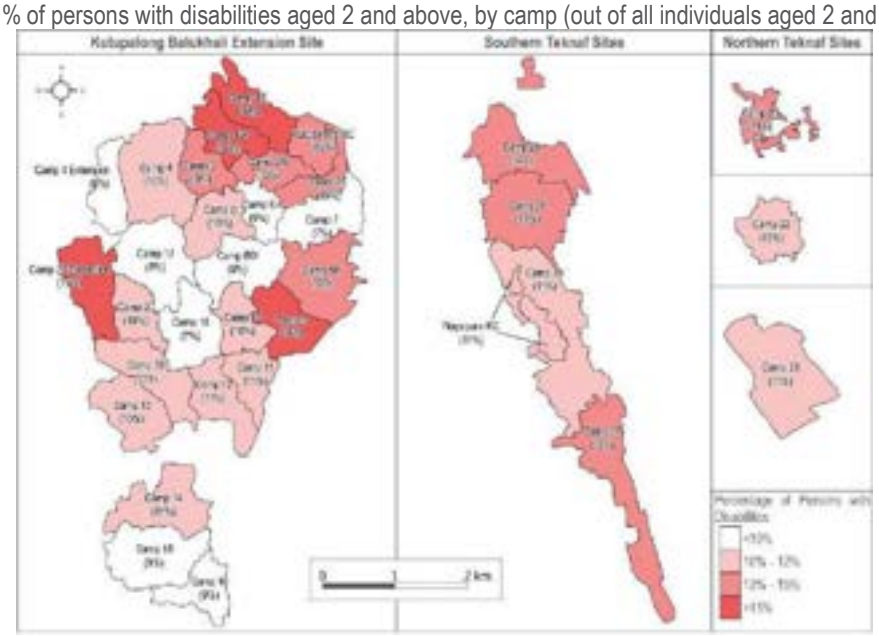
[40] Results for 5 to 9 year-olds and 10 to 17 year-olds are representative with a 3% margin of error (5 to 9 year-olds, n = 1,873; 10 to 17 year-olds, n = 2,107). Results for 18 to 59 year-olds are representative with a 2% margin of error (n = 5,393). Results for 60+ year-olds are representative with a 5% margin of error (473).

Figure 22 % of 18 to 59 year-old and older persons identified as persons with disabilities, by domain[41]



Comparing between locations, the highest disability prevalence among individuals aged 2 and above was found in camps 1E (19%), 9 (18%) and 20E (17%). The lowest prevalence was found in camps 7 (7%), 18 (7%) and 6 (6%) (Map 2).

Map 2 % of persons with disabilities aged 2 and above, by camp (out of all individuals aged 2 and above)*

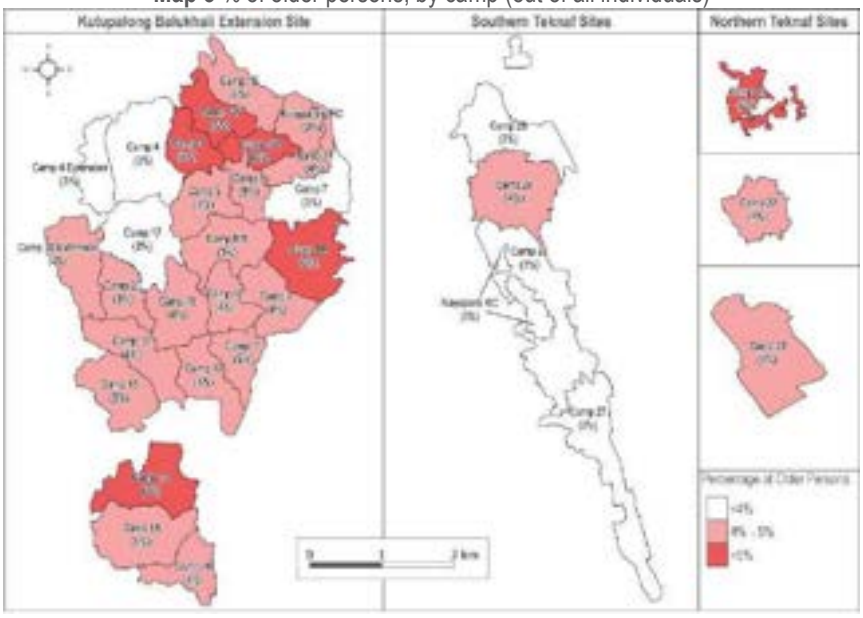


*Disability prevalence maps can be found in A4-format online.

With disability prevalence increasing with increasing age, this is to some degree mirrored by the geographical distribution of the proportion of older persons across camps. The highest proportions of older persons were found in camps 3, 8E and 2W (6% in all three camps), while the lowest proportions were found in camps 27 (3%), 7 (3%) and 25 (2%) (Map 3).

[41] Results for 18 to 59 year-olds are representative with a 2% margin of error (n = 5,393). Results for 60+ year-olds are representative with a 5% margin of error (473).

Map 3 % of older persons, by camp (out of all individuals)



Lastly, aggregating individual-level prevalence of persons with disabilities and older persons up to the household level yields an average of 35% of households with at least one person with disabilities, and 17% of households with at least one older person. Differences in prevalence across camps are similar to those found at the individual level, ranging from 21% of households with at least one person with disabilities in camp 18 to 53% of households with at least one person with disabilities in camp 9; and from 8% of households with at least one older person in camp 25 to 29% of households with at least one older person in camp 3.[42]

These disability prevalence estimates are higher than those found in other studies that estimated 8%[43] or 14%[44] of households as having at least one household member with disabilities using the WG-SS of questions at the individual level, or studies that estimated 3%,[45] 9%,[46] or 10%[47] of households as having a household member with disabilities asking the WGQs at the household level, with the estimate of 3% having been obtained remotely. However, results do reflect previous studies in that individual-level disability prevalence across the domains included in the short set is highest in the mobility domain, and less than 2% in any of the other domains included in the WG-SS of questions.[48]

This suggests that results are generally in line with previous studies in relation to disability prevalence across domains, while at the same time yielding higher overall disability prevalence estimates due to methodological differences. First, assessing disability using the short set questions at the individual level seems to yield slightly higher estimates than using the same questions at the household level. Secondly, including other questions in addition to the short set ones, particularly the anxiety and depression domains, clearly impacts estimates of disability prevalence. As such, disability estimates obtained using different sets of WGQs are not directly comparable. If persons with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds), or the behaviour domain only (2 to 4 year-olds) were not counted as persons with disabilities in the present assessment, thus aligning the WGQs closer to the short set of questions, only 17% of households would have been

[42] Compare maps in annex 7.
[43] REACH, *Water, Sanitation, and Hygiene (WASH) Household Monsoon Season Follow-up Assessment (October 2019)* (Cox's Bazar 2019). Available here (accessed 28 February 2021).
[44] REACH, *Water, Sanitation, and Hygiene Household Survey* (May 2019).
[45] ISCG, 2020b.
[46] UNHCR & REACH, *Settlement and Protection Profiling: Round 5* (Cox's Bazar, 2019). Available here (accessed 28 February 2021).
[47] ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA). In-Depth, August – September 2019* (Cox's Bazar, 2019b). Available here (accessed 28 February 2021).
[48] REACH, *Water, Sanitation, and Hygiene Household Survey.*

identified as having a household member with disabilities. This represents a reduction in estimated disability prevalence at the household level by half. While this figure is closer to previous estimates, it is still slightly higher. This is likely related to the number of WGQs still being larger than that used in other assessments, even if excluding the anxiety and depression domains, as well as to the inclusion of the CFMs for individuals aged 2 to 17. **Thus, clearly the set of WGQs employed in an assessment as well as the methodology used to administer them has a considerable impact on final estimates of disability prevalence, and results need to be interpreted with this in mind.**

Service utilisation, barriers and enablers[49]

A significantly[50] higher proportion of persons with disabilities (69%) than persons without disabilities (14%) consider themselves as having a health condition that makes it difficult to do certain activities. At the same time, not all persons with disabilities equally consider themselves as having a health condition that makes it difficult to do certain activities, with results differing by domain of functional difficulty. In particular, almost all persons with difficulties in functioning in the upper body movement (93%) and self-care (87%) domains, and roughly three quarters of persons with difficulties in functioning in the mobility (76%) and vision (74%) domains consider themselves as having a health condition that makes it difficult to do certain activities. In comparison, between 44% and 61% of persons with difficulties in functioning in the hearing, anxiety or depression domains consider themselves as having a health condition that makes it difficult to do certain activities (Figure 23). **Thus, while expectedly persons with disabilities are more likely than persons without disabilities to consider themselves as having a health condition that makes it difficult to do certain activities, the type of functional difficulty persons with disabilities have plays a considerable role in their self-perceived degree of self-sufficiency.**

More than half the older persons (56%) consider themselves as having a health condition that makes it difficult to do certain activities. However, also in this age group, the proportion of persons with disabilities reportedly considering themselves as having difficulties (82%) is significantly[51] larger or roughly twice the proportion of persons without disabilities considering themselves as having difficulties (39%). Furthermore, the proportion of older persons with disabilities reportedly considering themselves as having difficulties doing certain activities is significantly[52] larger than the respective proportion of persons with disabilities aged 18 to 59 (62%). Among adults without disabilities, this difference between older and not older persons is even larger, with 39% of older persons without disabilities considering themselves as having difficulties, compared to only 9% of adults aged 18 to 59 without disabilities[53] (Figure 24).

In sum, among persons with disabilities, the proportions of those considering themselves unable to do certain things are generally high, in which case age may act as a compounding factor leading to even higher proportions. On the other hand, among persons without disabilities, age alone can lead to significantly higher proportions of individuals considering themselves as having difficulties doing certain activities; with reported proportions of older persons considering themselves as having difficulties being lower than among older persons with disabilities but higher than among younger age groups. **As such, both age and disability have to be considered important – independent but possibly compounding – factors in determining self-perceived degrees of self-sufficiency.**

[49] Results in this section are indicative only for persons with difficulties in functioning in the anxiety or depression domains, as well as for persons without disabilities. Overall results for persons with disabilities exclude persons with difficulties in functioning in the anxiety or depression domains only (5 to 99 year-olds), or the behaviour domain only (2 to 4 year-olds). See "Challenges and limitations" for further explanations.
[50] p-value < 0.0001
[51] p-value < 0.0001
[52] p-value < 0.001
[53] p-value < 0.0001

Figure 23 % of persons with and without disabilities aged 15 and above considering themselves as having a health condition that makes it difficult to do certain activities, overall and by domain of disability[54]

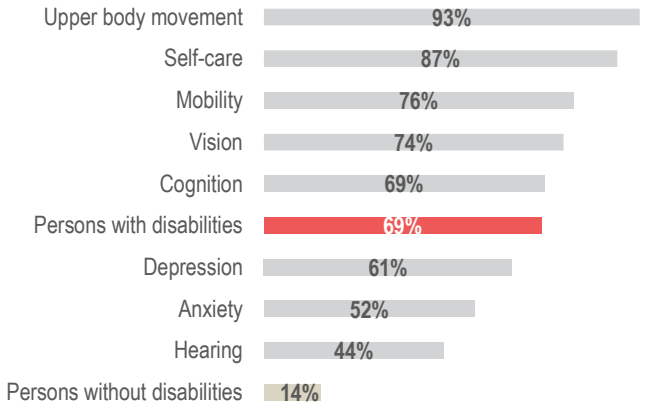
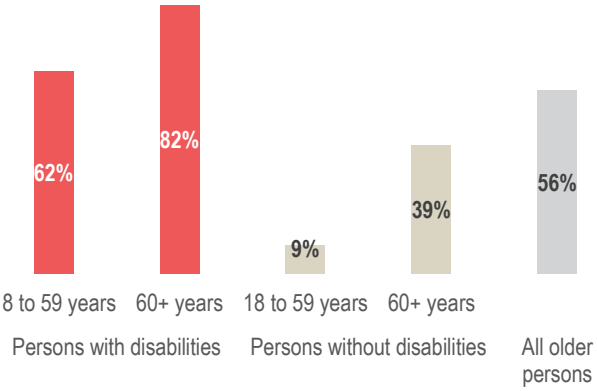


Figure 24 % of persons with and without disabilities aged 18 and above and older persons considering themselves as having a health condition that makes it difficult to do certain activities, by age group



Lastly, both among persons with disabilities and among persons without disabilities, there were no significant differences in the proportions of male and female individuals considering themselves as having a health condition that makes it difficult to do certain activities. However, among all older persons, including both those with and without disabilities, a significantly[55] larger proportion of female individuals (65%) than male individuals (50%) reportedly considered themselves as having a health condition that makes it difficult to do certain activities. This is indicative of gender being an additional factor in determining self-perceived degrees of self-sufficiency among older persons.

In sum, age, gender and disability may all act as compounding factors increasing individuals' difficulties carrying out certain activities. However, these results also show that persons with different types of functional difficulties, across different age groups, and of different genders are all likely to face unique challenges, which have to be considered as such.

Against this background, in the following sections, results related to service utilisation, barriers and enablers for persons with different types of functional difficulties, and of different age and gender groups will be presented. First, barriers related to mobility, and self-care will be discussed, followed by other reported barriers to accessing multi-sectoral services, and access to assistive devices.

Mobility inside shelters and around camps

Roughly half the persons with disabilities (52%) reportedly face difficulties moving in shelters and roughly three quarters (76%) reportedly face difficulties moving around camps. While difficulties moving in shelters were not assessed for persons without disabilities, the proportion of persons without disabilities reportedly facing difficulties moving around camps (29%) was significantly[56] lower than that of persons with disabilities. Both in relation to mobility inside shelters and in relation to mobility around camps, particularly high proportions of persons with difficulties in functioning in the self-care, upper body movement, mobility and vision domains were reported as facing difficulties (Figure 25 and Figure 26).

[54] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[55] p-value < 0.01
[56] p-value < 0.0001

Figure 25 % of persons with disabilities aged 2 and above reportedly facing difficulties moving inside shelters without support from others, overall and by domain of disability[57]

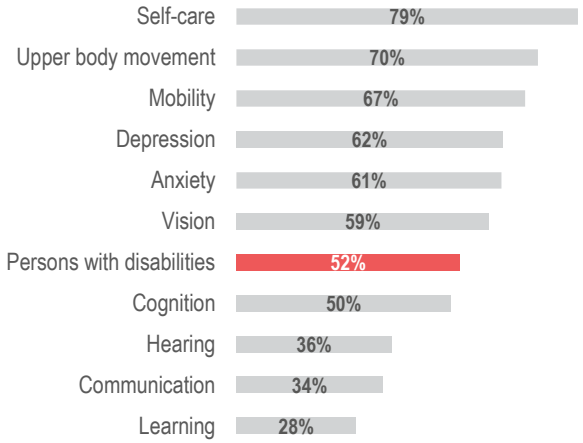
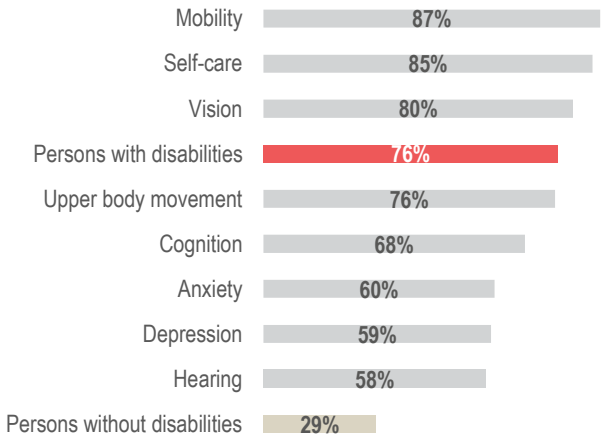


Figure 26 % of persons with and without disabilities aged 15 and above reportedly facing difficulties moving around camps, overall and by domain of disability[57]



Most commonly, challenges moving in shelters were related to a lack of space to turn around and a lack of handrails. These present challenges to more than a third of persons with difficulties in functioning in the self-care, upper body movement, mobility or vision domains (Table 2).

Comparing results by domain of functional difficulty shows that persons with difficulties in functioning in the self-care, mobility or upper body movement domains were significantly more likely than persons with difficulties in functioning not in those domains to report at least one barrier towards moving inside shelters.[58] Looking at the different barriers, all five challenges shown in Table 2, were reported for significantly larger proportions of persons with difficulties in functioning in the self-care or mobility domains than persons with difficulties in functioning not in those domains. Further to this, door openings being too small were reported for a significantly larger proportion of persons with difficulties in functioning in the upper body movement domain than persons with difficulties in functioning not in this domain. Lastly, a lack of handrails and not enough space to turn around were reported for significantly larger proportions of persons with difficulties in functioning in the vision domain than persons with difficulties in functioning not in this domain.

As such, persons with difficulties in functioning in the self-care, mobility and upper body movement domains, as well as possibly in the vision domain, are more likely than persons with difficulties in functioning not in those domains to experience challenges moving inside shelters as a result of the reported barriers.[59]

[57] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[58] Compare Table 13 in annex 8. The assessment found an overlap between domains (compare Table 12 in annex 6), such that one person was sometimes reported as having difficulties in functioning in several domains at the same time. In order to still be able to analyse the relationship between reported barriers and domains of functional difficulty, results for persons with difficulties in functioning in a specific domain were compared to results for persons with difficulties in functioning in general, i.e. persons with disabilities, but not with difficulties in functioning in this specific domain. If persons with difficulties in functioning in the specific domain under consideration were particularly affected by the reported barrier, a statistically significant difference in results between those two groups would be expected. If they were not particularly affected, no significant difference between the two groups would be expected. Please refer to annex 8 for more information.
[59] While a comprehensive analysis into this topic is beyond the scope of the assessment, the high proportions of persons with difficulties in functioning in the anxiety and depression domains reportedly experiencing barriers moving inside shelters are likely related to the co-occurrence of functional difficulties. For instance, of the persons with difficulties in functioning in the anxiety or depression domains reportedly experiencing a lack of handrails as a barrier, roughly three quarters also reported difficulties in functioning in the self-care, upper body movement, mobility or vision domains (compare also Table 12 in annex 6).

Table 2 % of persons with disabilities aged 2 and above reportedly facing difficulties moving inside shelter without support from others by reason, overall and by domain of disability[57]

	Door openings too small	Thresholds between rooms	Floor not level	Lack of handrails	Not enough space to turn around
Persons with disabilities	**8%**	**8%**	**9%**	**31%**	**34%**
Self-care	19%	13%	16%	49%	53%
Upper body movement	16%	11%	16%	35%	46%
Mobility	11%	12%	12%	42%	44%
Depression	10%	15%	8%	45%	36%
Anxiety	8%	13%	11%	44%	37%
Vision	5%	10%	6%	42%	45%
Cognition	7%	8%	5%	32%	32%
Hearing	10%	2%	6%	15%	26%
Communication	7%	2%	6%	17%	26%
Learning	7%	9%	2%	17%	21%

In line with a lack of space having been the most frequently reported barrier during the household survey, within the FGDs, commonly mentioned shelter improvement requirements included: a need for enough space inside shelters for persons with disabilities to be able to move (as mentioned in four FGDs), bigger shelter (three FGDs), more durable shelter (six FGDs), and in general shelter repairs; particularly repairing the floor with cement (seven FGDs).[60]

> *"It is better if the house is big. It would be easy to move around with a wheelchair."* – FGD with children with disabilities

The most commonly reported barriers moving around camps included stairs and pathways being too steep, both of which were reported as being barriers for more than half the persons with disabilities. Additionally, paths being unstable or uneven, and difficulty crossing roads were reported as barriers in particular for large proportions of persons with difficulties in functioning in the self-care domain (Table 3). All assessed challenges were reported for significantly[61] higher proportions of persons with disabilities than persons without disabilities.

Similar to the challenges related to being able to move in shelters, persons with difficulties in functioning in the self-care and mobility domains were found to be significantly more likely than persons with difficulties in functioning not in those domains to report or being reported as facing challenges moving around camps.[62] With the exception of it being easy to get lost, all reasons shown in Table 3 were reported for significantly larger proportions of persons with difficulties in functioning in the mobility domain than persons with difficulties in functioning not in this domain. Additionally, paths being unstable or uneven and difficulty crossing roads were reported for significantly larger proportions of persons with difficulties in functioning in the self-care domain than for persons with difficulties in functioning not in this domain.[63] **Thus, while persons with disabilities were found to generally be more likely to face barriers moving around camps, difficulties in functioning in the mobility and self-care domains in particular seem to lead to a heightened risk of facing the reported barriers.**[64]

[60] Detailed FGD results can be found here.
[61] p-value < 0.0001
[62] Self-care: p-value < 0.05; mobility: p-value < 0.0001
[63] Compare Table 14 in annex 8.
[64] While a comprehensive analysis into this topic is beyond the scope of the assessment, the high proportions of persons with difficulties in functioning in the anxiety and depression domains reportedly experiencing barriers moving around camps are likely related to the co-occurrence of functional difficulties. For instance, of the persons with difficulties in functioning in the anxiety or depression domains reportedly experiencing pathways being too steep as a barrier, between half and three quarters also reported difficulties in functioning in the self-care or mobility domains. Moreover, high proportions of persons with difficulties in functioning in the vision and upper body movement domains were reported as facing barriers moving around camps. However, the reported proportions do not differ significantly from the proportions of persons with difficulties in functioning not in those domains reportedly facing barriers. This indicates that persons with difficulties in functioning in the vision and upper body movement domains alone are likely not at a significantly higher risk of experiencing the aforementioned barriers. The high reported proportions are more likely to also be explained by the co-occurrence of functional difficulties.

Table 3 % of persons with and without disabilities aged 15 and above reportedly facing difficulties moving around camps by reason, overall and by domain of disability[65]

	Easy to get lost	Paths unstable/ uneven	Difficulty crossing roads	Surfaces slippery/ uneven	Stairs too steep	Pathways too steep
Persons with disabilities	**10%**	**22%**	**23%**	**36%**	**52%**	**54%**
Persons without disabilities	**2%**	**6%**	**4%**	**11%**	**17%**	**19%**
Mobility	11%	26%	27%	40%	63%	66%
Self-care	14%	33%	42%	44%	51%	63%
Vision	10%	22%	31%	45%	53%	57%
Upper body movement	6%	23%	26%	33%	51%	54%
Cognition	16%	18%	27%	29%	40%	42%
Anxiety	10%	14%	22%	28%	35%	39%
Depression	8%	17%	21%	30%	35%	41%
Hearing	5%	15%	20%	29%	30%	30%

In line with the above results, across FGDs, a commonly suggested improvement in camps to make daily life easier for persons with disabilities was repairing, levelling or making roads wider, such that people can move more easily.

> *"My daughter can't go to the toilet alone. […] Wheelchairs are needed. The road is very high and low. Roads should be levelled, so that wheelchairs can be pushed."* – FGD with children with disabilities

> *"The road to my block is bad. The road has to be prepared first. And the stairs have to be arranged there. The condition of the road was worse before, but the handles on the stairs are now ruined."* – FGD with adults with disabilities

> *"The stairs are high. There is nothing to hold on to. It is scary to get up. It would be better to have a handrail to catch near the stairs."* – FGD with children with disabilities

Significantly[66] larger proportions of persons with disabilities in older age groups than persons with disabilities in younger age groups were reported as facing barriers both moving inside shelters and moving around camps. Moreover, the proportions of older persons with disabilities facing barriers moving inside shelters (72%) or around camps (89%) were significantly[67] larger than the respective proportions of older persons without disabilities (of whom 29% were reportedly facing difficulties moving inside shelters and 55% were reportedly facing difficulties moving around camps). The same holds true for adults aged 18 to 59, with a significantly[68] larger proportion of those with disabilities (71%) than those without disabilities (25%) reportedly facing difficulties moving around camps (Figure 27 and Figure 28). **As such, both a person's age and disability appear to play a role in determining difficulties with mobility.**

For instance, of individuals with difficulties in functioning in the vision domain reportedly facing pathways being too steep as a barrier, roughly two third also reported difficulties in functioning in the mobility or self-care domains. In turn, among individuals with difficulties in functioning in the vision domain reportedly not facing pathways being too steep as a barrier, only roughly one third also reported difficulties in functioning in the mobility or self-care domains (compare also Table 12 in annex 6).

[65] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

[66] p-value < 0.0001

[67] p-value < 0.0001

[68] p-value < 0.0001

Figure 27 % of persons with disabilities aged 5 and above and older persons reportedly facing difficulties moving inside shelter without support from others, by age group[69]

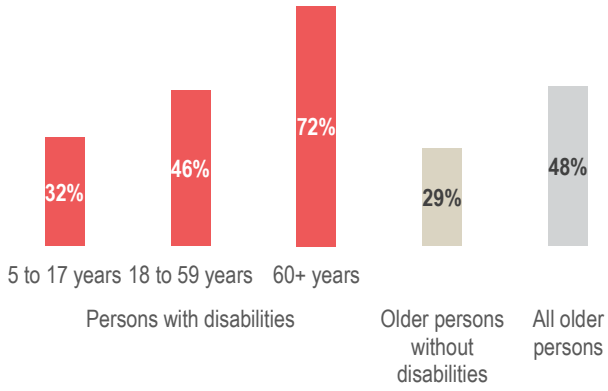
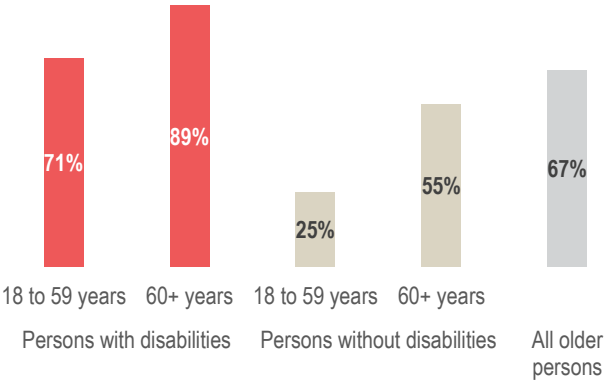


Figure 28 % of persons with and without disabilities aged 18 and above and older persons reportedly facing difficulties moving around camps, by age group[69]



Generally, there is a tendency of slightly higher proportions of female individuals reporting or having been reported as facing barriers moving in shelters or around camps. With regard to moving in shelters, however, this difference was only significant[70] for all older persons, with 56% of female older persons reportedly facing difficulties compared to 42% of male older persons (Figure 29). With regard to moving around camps, on the other hand, this difference was significant[71] for all older persons as well as for adult persons without disabilities aged 18 to 59 (Figure 30).

In sum, disability and age seem to be stronger contributing factors than gender to experiencing difficulties moving in shelters and around camps, at least in relation to the physical mobility-related barrier assessed here. However, among older persons, and to a lesser degree among adults without disabilities aged 18 to 59, gender does seem to play an additional role in determining whether or not people face barriers moving inside shelters or around camps.

Figure 29 % of persons with disabilities aged 2 and above and older persons reportedly facing difficulties moving inside shelter without support from others, by age group and gender[72]

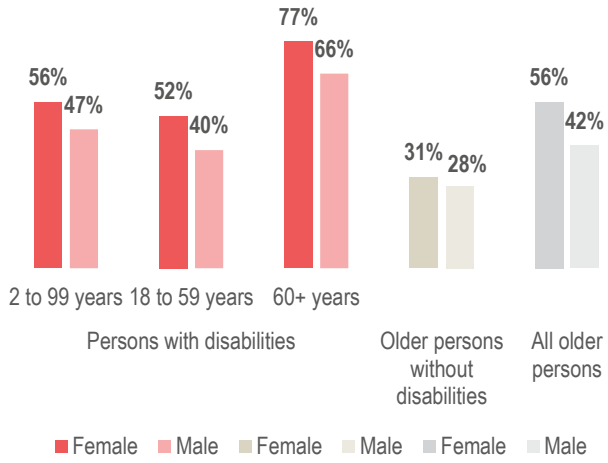
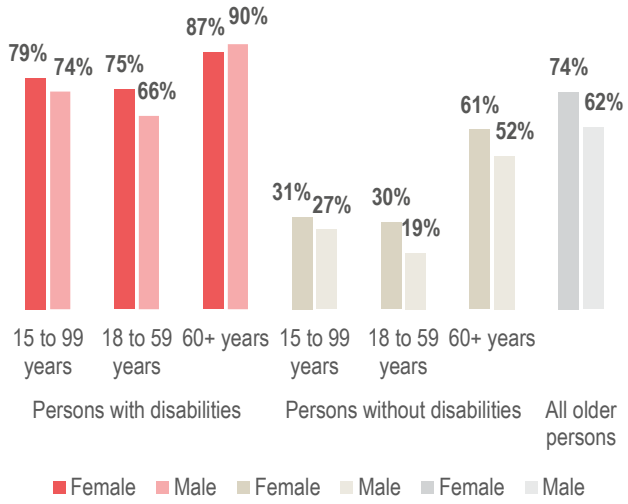


Figure 30 % of persons with and without disabilities aged 15 and above and older persons reportedly facing difficulties moving around camps, by age group and gender[72]



[69] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[70] p-value < 0.01
[71] p-value < 0.0001 in both cases
[72] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

Overall, a significantly[73] higher proportion of those reportedly facing mobility barriers around camps (37%) than those reportedly not facing any barriers moving around camps (27%) were reported as never having left their shelter in the week prior to data collection.[74] Moreover, a significantly[75] higher proportion of persons with disabilities (41%) (Figure 31) than persons without disabilities (30%) (Figure 32) had reportedly never left their shelter in the week prior to data collection. This might be partly linked to the greater barriers persons with disabilities face moving around camps, especially among persons with difficulties in functioning in the self-care or upper body movement domains. Specifically, 63% and 50%, respectively, of persons with difficulties in functioning in the self-care or upper body movement domains had reportedly never left their shelter in the week prior to data collection, with those proportions being significantly[76] higher than the respective proportions among persons with difficulties in functioning not in those domains (35% and 37%, respectively).

No significant differences were found in the proportions of older and not older persons with or without disabilities reportedly never having left their shelter in the week prior to data collection. This is indicative of age at least among adult individuals not being a factor in determining whether individuals are leaving their shelter.

Conversely, gender differences were found both among persons with and without disabilities, with female individuals having been significantly[77] more likely to report or being reported as never having left their shelter in the week prior to data collection. Indeed, 54% of female persons with disabilities and 44% of females without disabilities had reportedly not left their shelter during this timeframe, while this was reported for "only" 26% and 14% of male individuals with or without disabilities, respectively. **Therefore, while female persons with disabilities may face additional challenges leaving shelters compared to female persons without disabilities, whether or not individuals are leaving their shelters appears to be linked in part to gender (and likely gender-related social norms) irrespective of disability.**

Figure 31 % of persons with disabilities aged 2 and above reportedly never having left their shelter in the week prior to data collection[78]

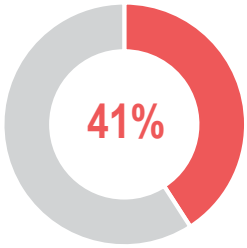


Figure 32 % of persons without disabilities aged 2 and above reportedly never having left their shelter in the week prior to data collection

Self-care and utilisation of WASH infrastructure

One third of persons with disabilities reportedly are unable to use latrines (34%) and/or shower/bathe (30%) without support from others. The highest proportions of persons with disabilities unable to go to the toilet or shower without support were reported among persons with difficulties in functioning in the self-care and upper body movement domains. In both domains, the proportions of individuals unable to shower was roughly 10 percentage points higher than the proportions of individuals unable to use latrines (Figure 33). Moreover, among persons with difficulties in

[73] p-value < 0.0001
[74] Results for those reportedly facing mobility challenges are representative with a 4% margin of error (n = 763). Results for those reportedly not facing any mobility challenges are representative with a 3% margin of error (n = 1,147).
[75] p-value < 0.001
[76] Self-care: p-value < 0.0001; upper body movement: p-value < 0.05
[77] p-value < 0.0001 in both cases
[78] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

functioning in these domains, as well as among persons with difficulties in functioning in the mobility domain, the proportions of persons with disabilities reported as not being able to use latrines or shower without support were significantly higher than the respective proportions of persons with difficulties in functioning not in those domains. **This indicates particular challenges with showering/bathing or using latrines among individuals with difficulties in functioning in the self-care, upper body movement and mobility domains.**[79]

The most commonly reported reasons for not being able to use the toilet or shower without support for all persons with disabilities were largely linked to physical barriers. In particular, the most commonly reported reasons for not being able to shower without support included not being able to reach the water (as reported for 65% of persons with disabilities reportedly not able to shower without support[80]), no place to sit while showering (38%), and an unavailability of sanitary items inside the unit (27%). The most commonly reported reasons for not being able to use latrines without support included needing support while sitting on the toilet (as reported for 67% of persons with disabilities reportedly not able to use toilets[81]), the toilet being too distant (50%), and needing support using squat latrines (33%).

Furthermore, during the FGDs, barriers accessing water to use latrines were frequently reported. There was a common sentiment that having water access directly at the toilet would facilitate using latrines for persons with disabilities. Moreover, physical accessibility of WASH facilities as a result of road conditions, in particular during the rainy season, in combination with mobility challenges, was a commonly reported barrier.

> *"I have less energy in my hands, so I have trouble lifting the water vessel. Our toilets are far away, it is difficult to go to the toilet, it is difficult to fetch water. My family members help with the water in the toilet."* – FGD with children with disabilities

> *"I sit down and crawl to the toilet. It would be better if someone took me […]. Water has to be taken while going to the toilet. It would be better if they could provide a water system in the toilet."* – FGD with children with disabilities

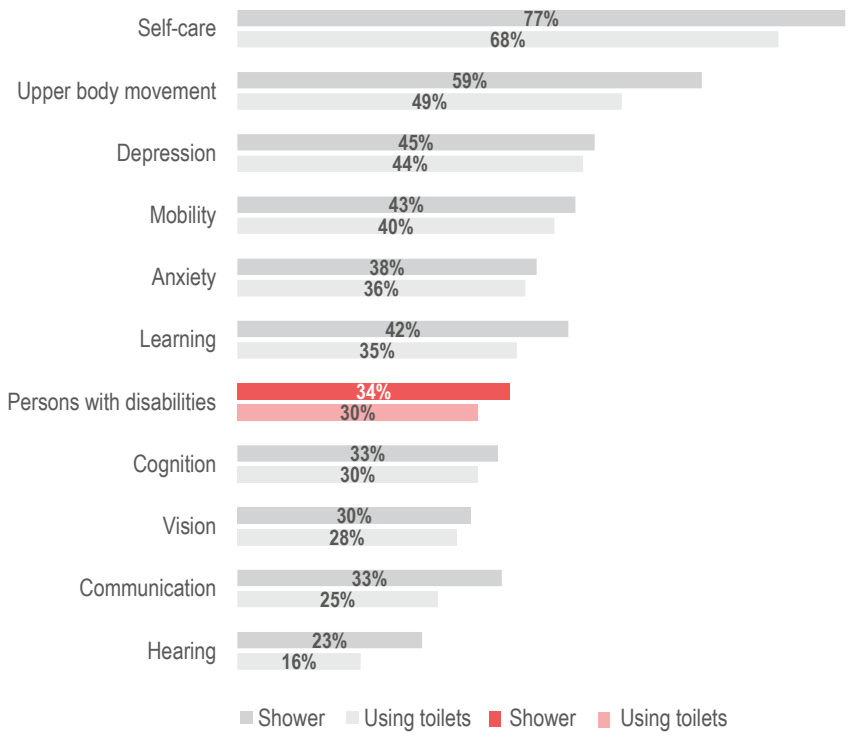
> *"The toilet and bathing place are far away from my house. I have difficulty in coming and going, it would be better if they were closer."* – FGD with children with disabilities

> *"The problem for my son to go to latrine in the rainy season is that the road becomes very slippery, so the road problem has to be solved. […] Surroundings have to be levelled."* – FGD with caregivers of children with disabilities

> *"If it rains, it is difficult to go to the latrine. It's so far away."* – FGD with adults with disabilities

[79] Compare Table 15 in annex 8. While a comprehensive analysis into this topic is beyond the scope of the assessment, the high proportions of persons with difficulties in functioning in the anxiety and depression domains reportedly unable to shower/bathe or use latrines without support are likely related to the co-occurrence of functional difficulties. For instance, of the persons with difficulties in functioning in the anxiety or depression domains reportedly not able to shower/bathe without support from others, roughly 90% also reported difficulties in functioning in the self-care, upper body movement or mobility domains (compare Table 12 in annex 6).
[80] Results are representative with an 8% margin of error (n = 170).
[81] Results are representative with an 8% margin of error (n = 151).

Figure 33 % of persons with disabilities aged 2 and above reportedly not able to shower/bathe or use latrines/go to the toilet without support from others, overall and by domain of disability[82]



While overall there were no large differences in the proportions of persons with and without disabilities reportedly having used different WASH facilities in the month prior to data collection, similar to the above results, results did differ by domain of functional difficulty. Specifically, significantly lower proportions of persons with difficulties in functioning in the self-care and upper body movement domains than persons with difficulties in functioning not in those domains were reported as having used public not accessible latrines or public bathing facilities. At the same time, significantly larger proportions of persons with difficulties in functioning in the self-care domain than persons with difficulties in functioning not in the self-care domain were reported as having used private not accessible latrines, as well as public and private accessible latrines.[83]

Additionally, significantly larger proportions of persons with difficulties in functioning in the upper body movement or mobility domains than persons with difficulties in functioning not in those domains were reported as having used private accessible latrines.[84] These results are indicative of potential access challenges related to public not accessible latrines as well as public bathing facilities, particularly among persons with difficulties in functioning in the self-care and upper body movement domains. Nevertheless, the very low proportions of individuals reportedly having used private not accessible latrines or accessible latrines further indicate potential gaps in the availability of or access to latrines that would make self-care easier for those individuals (Table 4).[85]

[82] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[83] Private latrines were defined as latrines considered "private" by the household. Accessible latrines were defined as latrines specifically fitted to the needs of persons with disabilities, e.g. through the construction of a disabled-friendly stalls, or the installation of ramps or handrails.
[84] Compare

Table 16 in annex 8.
[85] Lower utilisation of public not accessible latrines among persons with difficulties in functioning in the upper body movement and self-care domains may, however, also be linked to other reasons not considered in this assessment, such as incontinence.

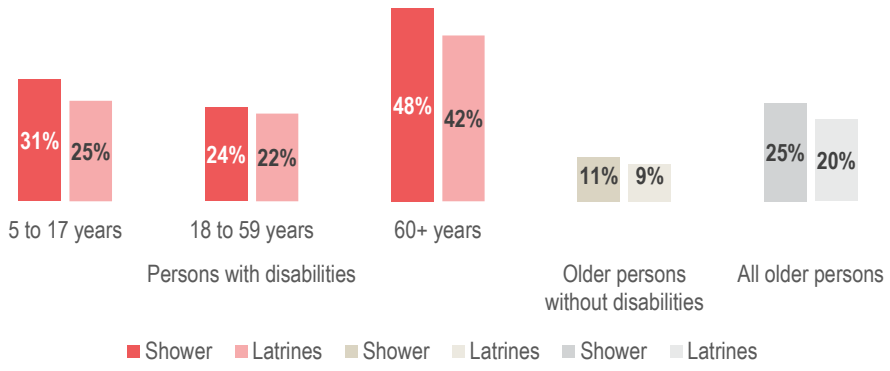
Table 4 % of persons with and without disabilities aged 15 and above reportedly having used different WASH services in the month prior to data collection, overall and by domain of disability[86]

	Not accessible latrines		Accessible latrines		Bathing facilities		Handwashing facilities	
	Public	Private	Public	Private	Public	Private	Public	Private
Persons with disabilities	83%	14%	0.5%	2%	32%	60%	12%	37%
Persons without disabilities	88%	10%	0.2%	0.1%	28%	65%	9%	41%
Self-care	65%	23%	2%	7%	19%	62%	11%	34%
Upper body movement	71%	20%	1%	7%	17%	64%	17%	35%
Depression	85%	10%	0.4%	2%	28%	65%	10%	43%
Mobility	80%	15%	0.5%	3%	30%	60%	11%	40%
Anxiety	84%	12%	0.2%	3%	30%	63%	9%	35%
Cognition	93%	6%	0%	1%	31%	55%	15%	34%
Vision	91%	8%	0%	0%	27%	59%	17%	38%
Hearing	93%	6%	0%	0%	41%	48%	11%	52%

An inability to use latrines or shower without support from others becomes significantly[87] more likely among persons with disabilities in the 60+ years' age group, compared to younger age groups. In the 60+ years' age group, 42% and 48%, respectively, of persons with disabilities reported or were reported as not being able to shower or use latrines without support from others, compared to a maximum of 31% of individuals among younger age groups (Figure 34).

At the same time, among older persons without disabilities, only 11% and 9%, respectively, were reportedly unable to shower or use latrines without support from others (Figure 34). With those proportions being significantly[88] smaller than the respective proportions of older persons with disabilities, **age is likely to act as a compounding factor leading to older persons with disabilities being more likely to face challenges with self-care than younger persons with disabilities. However, age alone does not lead to the same large proportions of older persons (without disabilities) facing barriers to self-care in camps.**

Figure 34 % of persons with disabilities aged 5 and above and older persons reportedly not able to shower/bathe or use latrines/go to the toilet without support from others, by age group[89]



[86] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[87] p-value < 0.0001
[88] p-value < 0.0001
[89] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

The proportions of older persons with or without disabilities reportedly having used different WASH facilities are also comparable to the proportions of all persons with or without disabilities having used those facilities shown in Table 4, as well as the respective proportions among the 18 to 59 years' age group. Thus, age alone does not seem to play a considerable role in the choice of utilisation of different WASH facilities.

If, however, results are further disaggregated by gender, some significant differences between male and female individuals, in particular among older persons, become evident. A significantly[90] larger (roughly twice the) proportion of female older persons than male older persons are reportedly not able to shower or use latrines without support from others. Regarding showering, this gender gap seemingly concerns older persons both with and without disabilities (Figure 35).[91] When assessing the use of latrines, this gap was only found to be significant for older persons with disabilities (Figure 36).[92]

Figure 35 % of persons with disabilities aged 2 and above and older persons reportedly not able to shower/bathe without support from others, by age group and gender[93]

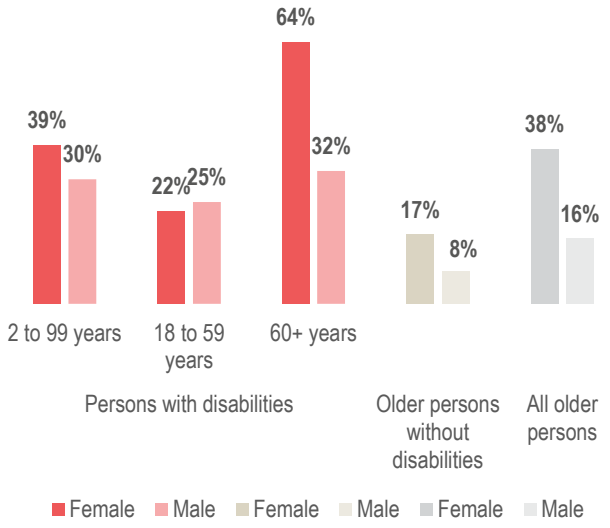
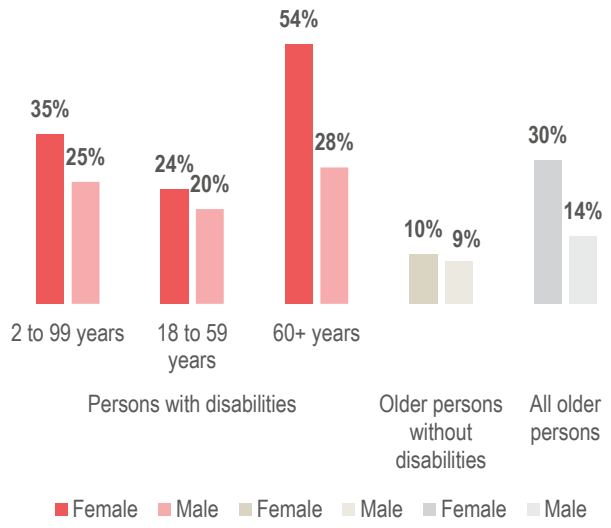


Figure 36 % of persons with disabilities aged 2 and above and older persons reportedly not able to use latrines/go to the toilet without support from others, by age group and gender[93]



It is likely that differences between male and female individuals in the reported use of different WASH are linked not only to issues of access but also other factors, such as social norms affecting women's freedom of movement. With differences not always being significant (at a 95% confidence level), results do indicate a trend of female older persons having used private not accessible latrines at higher proportions, while having used public not accessible latrines at lower proportions compared to male older persons.

Larger differences are evident in relation to the bathing facilities reportedly having been used by male and female individuals. In particular, significantly lower proportions of female than male individuals, among older persons and persons without disabilities, reportedly used public facilities, and significantly larger proportions used private facilities. Lastly, slightly higher proportions of female persons with disabilities than male persons with disabilities reportedly used private handwashing facilities, in particular among older persons with disabilities (Table 5).

[90] p-value < 0.0001 in both cases
[91] Persons with disabilities: p-value < 0.001; persons without disabilities: p-value < 0.05
[92] p-value < 0.01
[93] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

Table 5 % of persons with and without disabilities aged 15 and above and older persons reportedly having used different WASH services in the month prior to data collection, by age group and gender[94]

Age group	Gender	Not accessible latrines		Accessible latrines		Bathing facilities		Handwashing facilities	
		Public	Private	Public	Private	Public	Private	Public	Private
Persons with disabilities									
Ages 15 to 99	Female	83%	15%	1%	2%	29%	61%	10%	**44%***
	Male	83%	12%	0.4%	3%	34%	59%	14%	**31%***
Ages 18 to 59	Female	84%	12%	1%	3%	31%	57%	12%	42%
	Male	81%	13%	1%	4%	27%	67%	16%	30%
Ages 60+	Female	80%	21%	0%	1%	**25%***	**68%***	5%	**50%***
	Male	85%	10%	0%	2%	**42%***	**50%***	13%	**31%***
Persons without disabilities									
Ages 15 to 99	Female	87%	11%	0.3%	0%	**23%****	**71%*****	7%	42%
	Male	89%	8%	0%	0.2%	**35%****	**59%*****	10%	41%
Ages 18 to 59	Female	88%	11%	0.2%	0%	24%	70%	7%	43%
	Male	89%	10%	0%	0%	31%	64%	10%	41%
Ages 60+	Female	**78%***	13%	1%	0%	**12%****	**75%****	8%	38%
	Male	**90%***	7%	0%	1%	**38%****	**54%****	7%	37%
All older persons									
Ages 60+	Female	81%	**16%***	1%	1%	**19%*****	**72%****	5%	43%
	Male	87%	**9%***	0%	1%	**37%*****	**56%****	8%	35%

In sum, these results are indicative of persons with disabilities, and in particular persons with difficulties in functioning in the self-care, upper body movement and mobility domains, being more likely to face difficulties with self-care. Especially among persons with difficulties in functioning in the self-care and upper body movement domains, physical barriers to self-care may in part be reflected in a lower use of public latrines and bathing facilities. The simultaneously relatively low reported use of private as well as accessible infrastructure might on the one hand be indicative of also low use of such infrastructure *per se,* but on the other hand also of gaps in the availability of or access to such infrastructure.

Overall, however, the use of different WASH services does not seem to differ considerably between persons with and without disabilities, neither by age group. Finally, the largest differences between male and female individuals in the use of different WASH services were found in relation to public and private bathing facilities, in particular among older persons and persons without disabilities. While especially female older persons with disabilities were more likely to report difficulties with self-care than male older persons with disabilities, those differences in the reported use of WASH services between male and female individuals are likely linked not only to physical or similar barriers but also to a large degree to gender norms that exist irrespective of disability.

Other barriers to accessing services

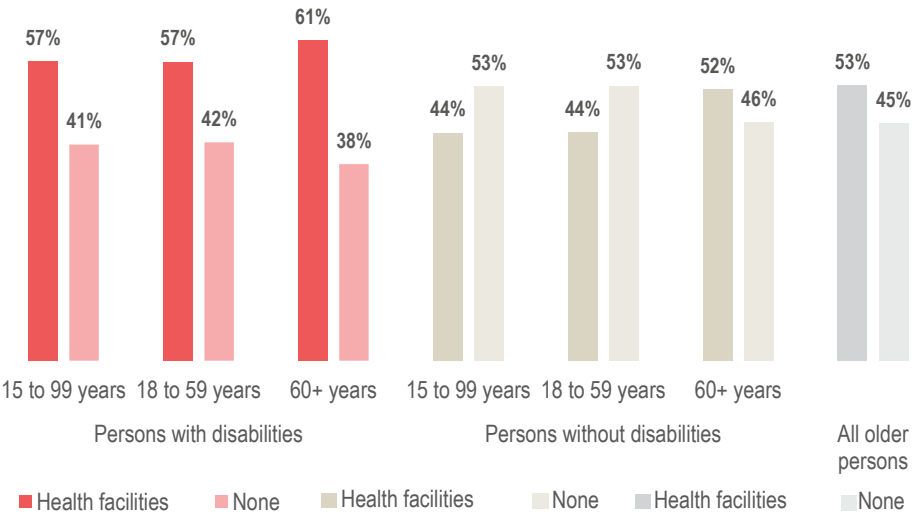
Health services were the only services out of a range of services reportedly having been accessed by more than 1% of persons with disabilities and more than 3% of persons without disabilities in the month prior to data collection. Across age groups, the proportion of persons with disabilities reportedly having accessed health services in the month prior to data collection was roughly ten percentage points higher than that of persons without disabilities. In

[94] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only. Significant differences with at least a 95% level of confidence are denoted as follows: p-value < 0.05 (*), p-value < 0.01 (**), p-value < 0.001 (***), and p-value < 0.0001 (****).

turn, the proportion of persons without disabilities reportedly not having accessed any of the assessed services[95] was roughly ten percentage points higher than that of persons with disabilities.

Overall, 41% of persons with disabilities and 53% of persons without disabilities as well as 45% of all older persons had reportedly not accessed any of the assessed services in the month prior to data collection. On the other hand, health services had reportedly been accessed by 57% of persons with disabilities and 44% of persons without disabilities, as well as 53% of all older persons (Figure 37). This is likely partially reflective of the higher requirements for health services among persons with disabilities.

Figure 37 % of persons with and without disabilities aged 15 and above and older persons reportedly having accessed health facilities or none of a range of services in the month prior to data collection, by age group[96]



Despite higher proportions of persons with disabilities than persons without disabilities reportedly having accessed health facilities, **a significantly[97] higher proportion of persons with disabilities (64%) than persons without disabilities (39%) reportedly also faces barriers accessing services in camps.** While differences between domains of functional difficulty were not large, persons with difficulties in functioning in the self-care and mobility domains were significantly[98] more likely than persons with difficulties in functioning not in those domains to be reported as facing barriers (Figure 38).

All barriers with the exception of facilities being unsafe to use were significantly more likely to be reported for persons with disabilities than persons without disabilities. The most commonly reported barriers were largely related to difficulties physically accessing facilities rather than difficulties using facilities (Figure 39). As such, the high proportions of persons with difficulties in functioning in the self-care and mobility domains having reported barriers may likely be linked to the greater barriers those individuals face moving around camps.

[95] The assessed services include: health facilities, educational facilities, child-friendly spaces, adult-friendly spaces, women-friendly spaces, and multi-purpose centres.
[96] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[97] p-value < 0.0001
[98] Self-care: p-value < 0.05; mobility: p-value < 0.01

Figure 38 % of persons with and without disabilities aged 15 and above reportedly facing any barriers accessing services, overall and by domain of disability[99]

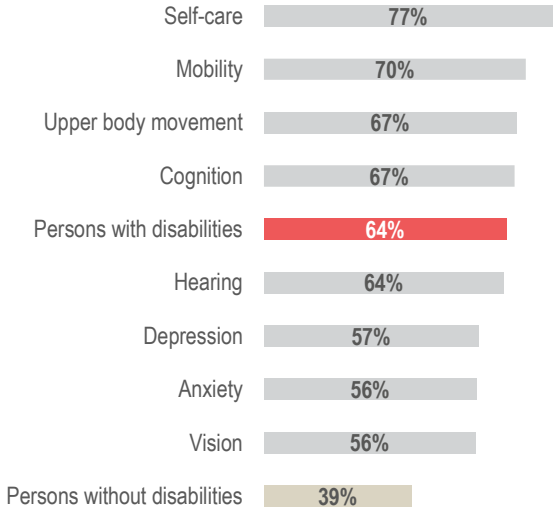
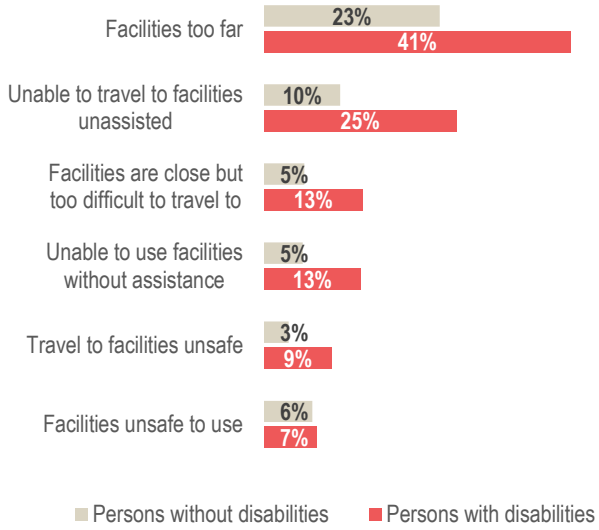


Figure 39 % of individuals with and without disabilities aged 15 and above reportedly facing barriers accessing services, by type of barrier[99]



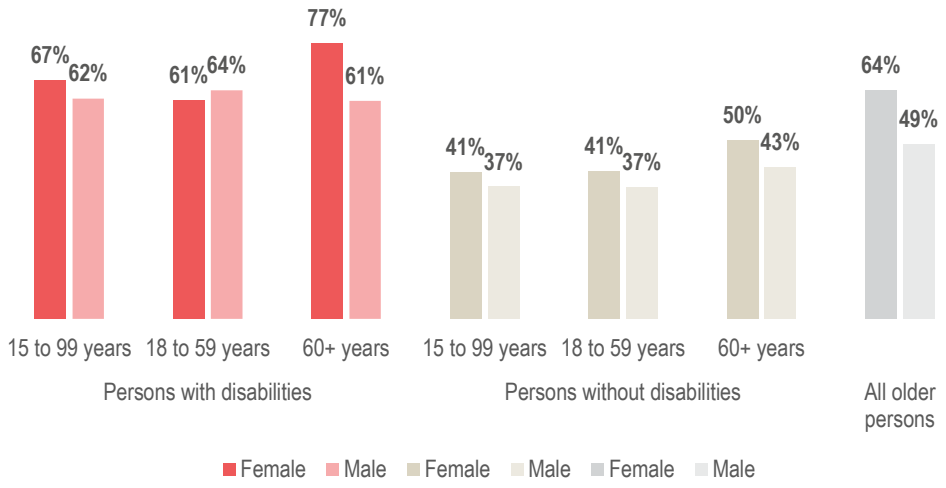
Results for older persons with or without disabilities are comparable to overall results for persons with or without disabilities. When disaggregating results by age group and gender, however, findings show that **female older persons, and in particular those with disabilities, were significantly[100] more likely than male individuals to be reported as facing barriers accessing services.** Overall, 77% of female older persons with disabilities were reported as facing barriers accessing services, compared to 61% of male older persons with disabilities. Similarly, 64% of all female older persons were reported as facing barriers, compared to 49% of all male older persons (Figure 40).

The barriers disproportionately affecting female older persons, and in particular those with disabilities, include persons being unable to travel to facilities unassisted (as reported for 32% of female older persons with disabilities, compared to 22% of male older persons with disabilities, or 23% of all female older persons, compared to 15% of all male older persons), persons being unable to use facilities without assistance (23% of female older persons with disabilities, and 3% of male older persons with disabilities, or 14% of all female older persons, compared to 5% of all male older persons), and travel to facilities being unsafe (14% of female older persons with disabilities, compared to 4% of male older persons with disabilities, or 8% of all female older persons, compared to 3% of all male older persons).

At the same time, 55% of all female older persons – or 60% of female older persons with disabilities and 55% of female older persons without disabilities – reported having accessed health services in the month prior to data collection. This compares to 51% of all male older persons – or 63% of male older persons with disabilities and 50% of male older persons without disabilities. **Thus, while female older persons, especially those with disabilities, may be more likely to face barriers accessing services, this does not seem to lead to disproportionately less female older persons actually having accessed this kind of service (at least in relation to health services).**

[99] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[100] Older persons with disabilities: p-value < 0.05; all older persons: p-value < 0.01

Figure 40 % of persons with and without disabilities aged 15 and above and older persons reportedly facing any barriers accessing services, by age group and gender[101]



Barriers assessed during the household survey were largely related to barriers physically accessing facilities. During the FGDs, more commonly, issues of quality as well as a lack of money to access health services were reported. Across the majority of FGDs (13 out of 20), a need for better access to treatment of disability-related health conditions was raised. Moreover, in four FGDs, respondents reported needing money to be able to pay for better treatment, possibly outside camps. In particular, there seemed to be a perception that the forms of treatment needed were unavailable and/or of low quality in camps, and that sometimes inadequate treatment was received.

> *"There is no [targeted] treatment for [persons with disabilities] in the camp. It would be better to go outside the camp and arrange treatment. […] The medical services that are available for [persons with disabilities] in the hospital outside the camp should be brought into the camp."* – FGD with caregivers of children with disabilities

> *"I want eye treatment but I can't get it. They do not treat the eyes here. Since the advent of COVID-19, the eyes have gotten worse, I am having trouble reading for the eyes."* – FGD with children with disabilities

In addition, in three of the four FGDs with caregivers of children with disabilities as well as half the FGDs with older persons, a lack of information on health treatment was raised.

> *"I don't know where to get help for my child's treatment. That's what I want to know. I asked my mahjee, he could not give the correct answer."* – FGD with caregivers of children with disabilities

> *"I want to get news about good treatment. But I don't know where to get treatment."* – FGD with older persons with and without disabilities

Similarly, in half the FGDs with adults with disabilities, respondents reported having requested medical support but not having received any.

> *"I was asking NGO volunteers for good medicine, but I did not get any support from them."* – FGD with adults with disabilities

[101] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

In addition to improved health care, and in line with needs generally reported in camps,[102] a need for more and better food (nine FGDs), as well as for cash support was raised (five FGDs), with a reduction in food rations continuing to be the most commonly mentioned impact of COVID-19 on programming as perceived by respondents (nine FGDs).

Access to assistive devices

There appears to be a lack of access to assistive devices among persons with disabilities needing them, with more than half the persons with disabilities (56%) reportedly not having received any assistive devices in the year prior to data collection despite needing them. This is comparable to results of other assessments.[103] Overall, only 22% of persons with disabilities reportedly had received any form of assistive device (Figure 41). The most common assistive devices received included: eye glasses (reportedly received by 18% of persons with difficulties in functioning in the vision domain), walking sticks, toilet chairs, and wheelchairs (reportedly received by 3% to 11% of persons with difficulties in functioning in the mobility, self-care or upper body movement domains) (Figure 42). Other types of assistive devices were reportedly received by a maximum of just 2% of persons with disabilities.

Figure 41 % of persons with disabilities aged 2 and above reportedly having received assistive devices in the year prior to data collection

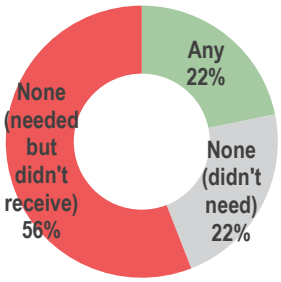
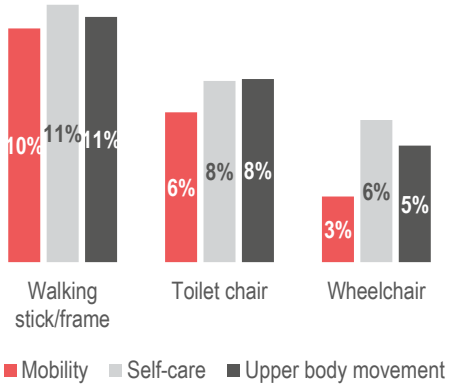


Figure 42 % of persons with difficulties in functioning in the mobility, self-care or upper body movement domains aged 2 and above reportedly having received different types of assistive devices in the year prior to data collection, by type of device



Despite barriers to moving with wheelchairs in camps, as also recognized during FGDs and described above, the assistive devices most commonly reported as required were wheelchairs (reported as required in half the FGDs). A lack of wheelchairs was sometimes mentioned to be preventing access to various services.[104]

> *"I sit down and crawl to the toilet. It would be better if someone took me. I used to go to school in a wheelchair. Now I am having a lot of trouble, because it is broken."* – FGD with children with disabilities

Other assessments found spectacles, axillary elbow crutches, and chairs to shower/bathe or use the toilet as well as pressure relief mattresses, pressure relief cushions and hearing aids to be most frequently reported as being

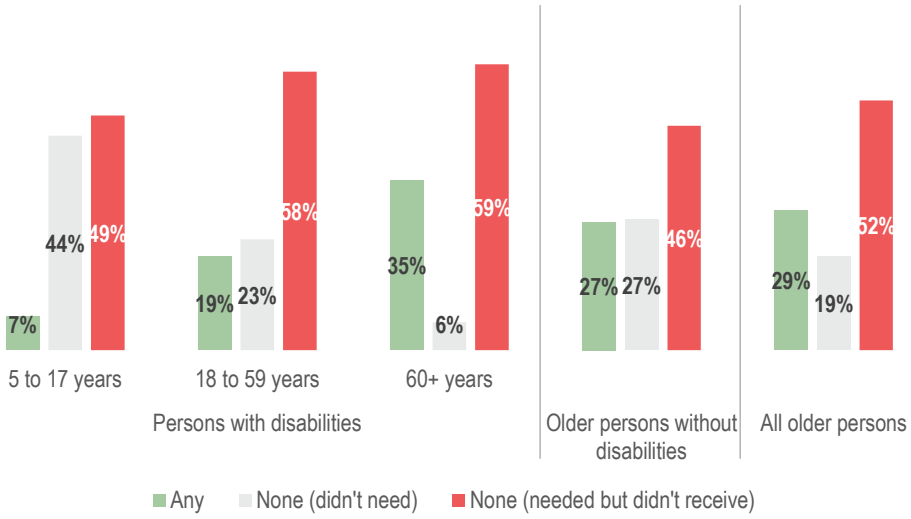
[102] ISCG, 2020b.
[103] REACH, *Rapid Assistive Technology Assessment (rATA)* (Cox's Bazar, 2021a).
[104] However, given the camp environment, as long as environmental barriers are not addressed, it has to be noted that wheelchairs will in most cases likely only serve to facilitate mobility around shelters as opposed to mobility more widely around camps.

required.[105] In turn, the assistive devices most commonly reported as having been received in this assessment (as reported in four FGDs, all of which with adults with disabilities) were walking sticks.

At the same time, in 12 of the 16 FGDs, during which this was discussed (excluding the 4 FGDs with children with disabilities), respondents reported never having requested any support specifically related to their disability. **This may be indicative of the large gaps in access to assistive devices in part being due to persons with disabilities not requesting any support, even if they require it.** Similarly, in another assessment, the most commonly reported barriers to accessing assistive devices reported among individuals needing them included a lack of support, product unavailability, and not being able to afford products. The same assessment found a need for more information on where to access assistive devices as well as for financial support, in order to improve access to assistive products.[106]

The proportion of persons with disabilities reportedly having received assistive devices increases significantly[107] with increasing age. At the same time, the proportion of persons with disabilities reportedly not needing any assistive devices decreases significantly[108] with increasing age. Consequently, the proportion of persons with disabilities reportedly not having received any assistive devices despite needing them is close to or over 50% across all age groups. **Thus, older persons with disabilities may be more likely to have received assistive devices. However, with the proportion of those not needing any devices decreasing in this age group, the gap in terms of the proportion of those not having received any assistive devices despite needing them also remains high and similar to other age groups.** Moreover, while among older persons without disabilities, the proportion reportedly needing and not having received assistive devices is significantly[109] lower than among older persons with disabilities, it is also high at 46% (Figure 43). As such, even if slightly less so, the gap in terms of access to assistive devices also exists among older persons without disabilities.

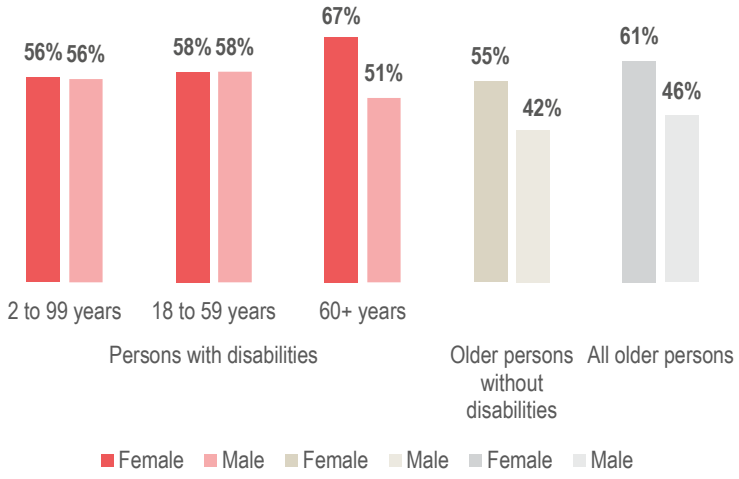
Figure 43 % of persons with disabilities aged 5 and above and older persons reportedly having received assistive devices in the year prior to data collection, by age group[110]



[105] REACH, 2021a.
[106] Ibid.
[107] p-value < 0.0001
[108] p-value < 0.0001
[109] p-value < 0.05
[110] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

Further disaggregating results by gender shows that **female older persons are particularly affected by this gap in access to assistive devices.** In particular, significantly[111] higher proportions of female older persons with disabilities (67%) or all female older persons (61%) than male older persons with disabilities (51%) or all male older persons (46%) had reportedly not having received any assistive devices in the year prior to data collection despite needing them (Figure 44).

Figure 44 % of persons with disabilities aged 2 and above and older persons reportedly not having received assistive devices despite needing them in the year prior to data collection, by age group and gender[112]



Education and means of living

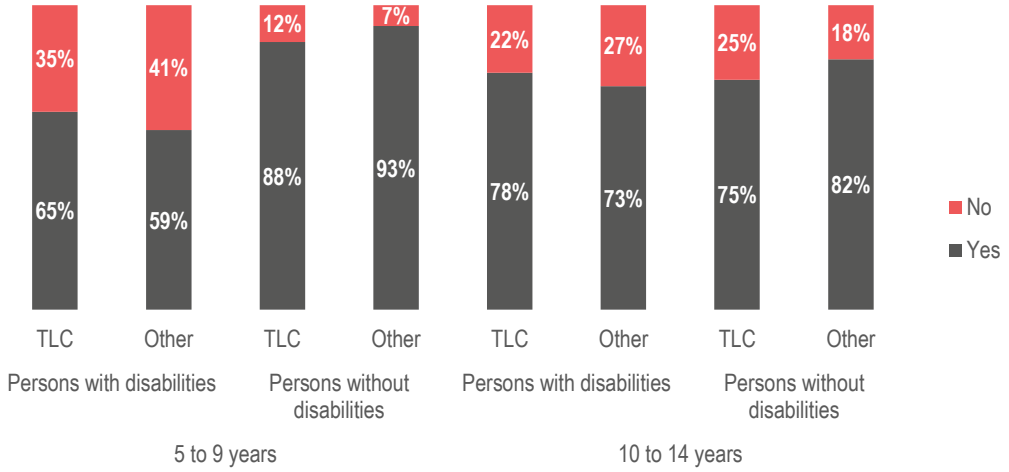
In the following sub-sections, results related to education and means of living will be outlined. Specifically, findings related to enrolment rates prior to the closure of education facilities due to the COVID-19 outbreak as well as educational attainments and engagement in the informal sector among male and female persons with or without disabilities across different age groups will be presented.

Enrolment and highest levels of education

In particular younger persons with disabilities were reportedly enrolled into temporary learning centres (TLCs) or attending informal education at significantly[113] lower rates than persons without disabilities in the same age group. Overall, 65% of 5 to 9 year-old persons with disabilities had reportedly attended TLCs for at least 4 days a week prior to the closure of education centres due to the COVID-19 outbreak, compared to 88% of 5 to 9 year-olds persons without disabilities (Figure 45). Similarly, the proportion of 5 to 9 year-old persons with disabilities reportedly not having completed any education (29%) was higher than that of persons without disabilities of the same age group (5%); and the proportion of 5 to 9 year-old persons with disabilities reportedly having completed pre-primary (20%) or primary (23%) education was lower than that of 5 to 9 year-old persons without disabilities (32% and 42%) (Figure 46).[114]

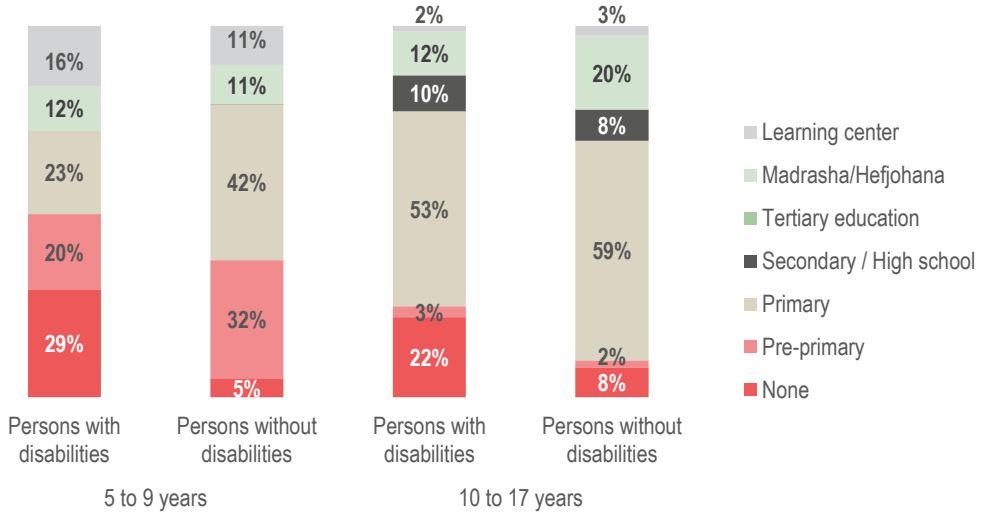
[111] Older persons with disabilities: p-value < 0.05; all older persons: p-value < 0.01
[112] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[113] p-value < 0.0001
[114] It has to be considered that the data represents enrolment rates irrespective of the degree of participation of children with and without disabilities in their education. As such, no inferences on the quality of education for those enrolled or potential differences in the quality experienced or the inclusion of children with and without disabilities can be made.

Figure 45 % of persons with and without disabilities aged 5 to 14 reportedly having attended a TLC for at least 4 days a week or having attended home-based learning activities, a *madrassa* or *moktab* ("Other") prior to the closure of education centres due to COVID-19, by age group[115]



Among 10 to 14 year-olds, the difference in reported enrolment rates between persons with and without disabilities seen among 5 to 9 year-olds disappears. Roughly equal proportions of around 75% of persons both with and without disabilities aged 10 to 14 had reportedly been enrolled in formal or informal learning opportunities for at least 4 days a week prior to the COVID-19 outbreak (Figure 45). Similarly, almost equal proportions of persons with and without disabilities aged 10 to 17 had reportedly completed different levels of education. However, also among 10 to 17 year-olds, the proportion of persons with disabilities not having completed any education (22%) remains almost triple that of persons without disabilities (8%). In comparison, it is almost six times as high among 5 to 9 year-old persons with disabilities compared to persons without disabilities of the same age group (Figure 46).

Figure 46 % of persons with and without disabilities aged 5 to 17 by reported highest level of completed education, by age group[116]



[115] Results for 5 to 9 year-old persons with disabilities are representative with a 13% margin of error (n = 59). Results for 5 to 9 year-old persons without disabilities are representative with a 3% margin of error (n = 1,534). Results for 10 to 14 year-old persons with disabilities are representative with a 15% margin of error (n = 46). Results for 10 to 14 year-old persons without disabilities are representative with a 3% margin of error (n = 1,228).
[116] Results for 5 to 9 year-old persons with disabilities are representative with a 13% margin of error (n = 59). Results for 5 to 9 year-old persons without disabilities are representative with a 3% margin of error (n = 1,534). Results for 10 to 17 year-old persons with disabilities are representative with a 11% margin of error (n = 86). Results for 10 to 17 year-old persons without disabilities are representative with a 3% margin of error (n = 1,798). Results for 18 to 99 year-old persons with disabilities are representative with a 3% margin of error (n = 1,153). Results for 18 to 99 year-old persons without disabilities are representative with a 2% margin of error (n = 4,435).

Due to the limited sample size, no disaggregation by disability, age group, and gender was possible. However, disaggregating results by disability and gender irrespective of age group shows that **male persons with disabilities aged 5 to 14 were disproportionately reported as not having attended TLCs before the COVID-19 outbreak**. Overall, only 59% of boys with disabilities had reportedly attended TLCs, compared to 82% of girls with disabilities.[117] At the same time, among persons without disabilities aged 5 to 14, significantly[118] lower proportions of girls were reported as having been enrolled both in TLCs and in informal education (Figure 47). Moreover, disaggregating results for all individuals by gender and age group (irrespective of disability), and in line with previous studies,[119] shows that the proportion of 10 to 14 year-old female individuals reportedly not enrolled in education was significantly[120] higher than that of male individuals of the same age group (Figure 48).

Figure 47 % of persons with and without disabilities aged 5 to 14 reportedly having attended a TLC at least 4 days a week or having attended home-based learning activities, a *madrassa* or *moktab* ("Other") prior to the closure of education centres due to COVID-19, by gender[121]

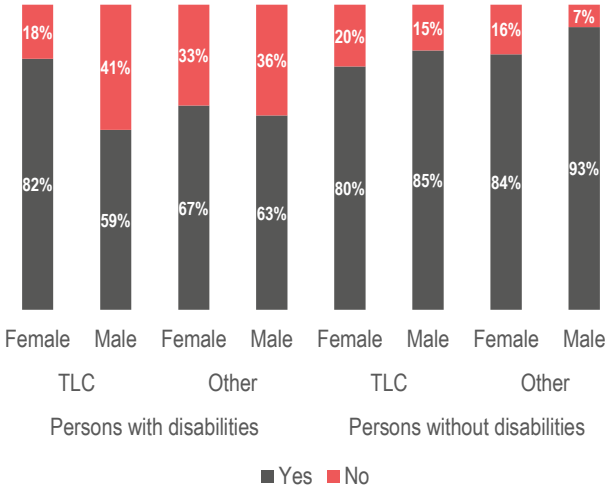
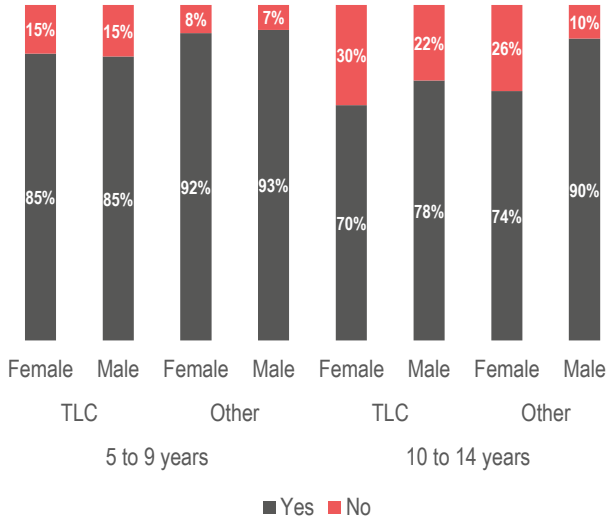


Figure 48 % of individuals aged 5 to 14 reportedly having attended a TLC at least 4 days a week or having attended home-based learning activities, a *madrassa* or *moktab* ("Other") prior to the closure of education centres due to COVID-19, by age group and gender[122]



Educational attainments among boys and girls aged 5 to 9 are comparable. However, among individuals aged 10 to 17, boys' educational attainments are slightly higher, with slightly lower proportions of boys reportedly not having completed any education. Additionally,12% of boys reportedly completed secondary education, compared to 4% of girls (Figure 49). However, similar to pre-COVID enrolment rates, when looking at all individuals aged 5 to 17 and disaggregating by disability and gender, higher proportions of boys with disabilities had reportedly not completed any education, compared to girls. Most notably, 11% of girls with disabilities were reported as having completed education at learning centres, compared to 4% of boys with disabilities (Figure 50). **With learning centres being the primary form of education in camps, this difference between boys and girls might be indicative of gender differences among persons with disabilities in particular in the camp context, rather than being related to differences in access to education back in Myanmar.**

[117] p-value < 0.05
[118] TLCs: p-value < 0.01; informal education: p-value < 0.0001
[119] ISCG, 2020b; REACH, 2021.
[120] TLCs: p-value < 0.01; informal education: p-value < 0.0001
[121] Results for female individuals with disabilities are representative with a 14% margin of error (n = 49). Results for female individuals without disabilities are representative with a 3% margin of error (n = 1,338). Results for male individuals with disabilities are representative with a 14% margin of error (n = 56). Results for male individuals without disabilities are representative with a 3% margin of error (n = 1,424).
[122] Results are representative with a 4% margin of error (5 to 9 year-old female individuals, n = 903; 10 to 14 year-old female individuals, n = 709; 5 to 9 year-old male individuals, n = 970; 10 to 14 year-old male individuals, n = 736).

Figure 49 % of individuals aged 5 to 17 by reported highest level of completed education, by age group and gender[123]

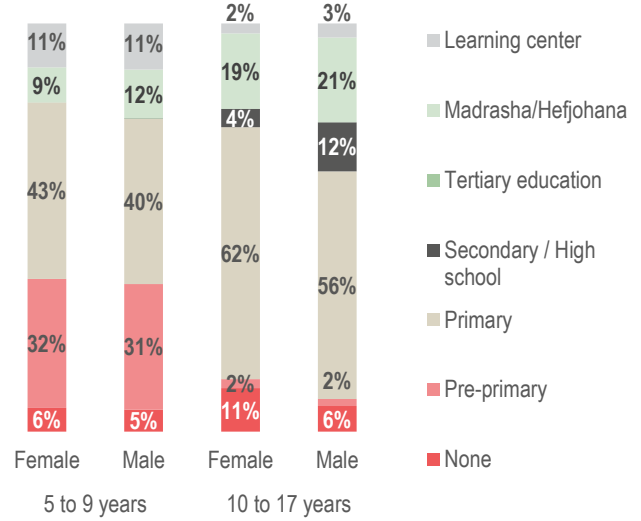
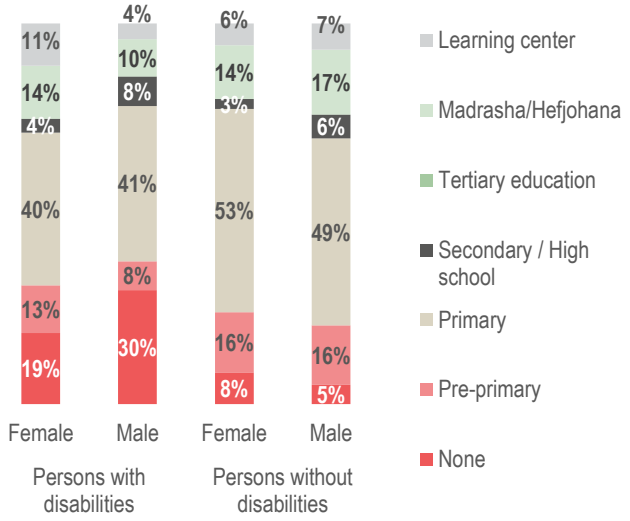


Figure 50 % of persons with and without disabilities aged 5 to 17 by reported highest level of completed education, by gender[124]



Overall, these results seem to indicate a trend of persons with disabilities being likely to be enrolled into education at a later stage than persons without disabilities rather than not being enrolled at all, while at the same time potentially taking longer or being slightly less likely to complete their education. While, generally among all children, older girls may be more likely not to receive an education, among children with disabilities, boys seem to disproportionately have missed out on education pre-COVID.

However, as it is not known from the data if reported disabilities were already present pre-COVID, limited conclusions can be drawn as to whether the pre-COVID barriers to accessing education may to some degree have disproportionately affected children with disabilities, e.g. among younger children and boys; or if post-COVID reported functional difficulties – in particular anxiety or depression – may potentially in part also be the result of a lack of opportunities, or be unrelated. Generally, older individuals might not have been affected by the same functional difficulties when they were younger. As such, especially for older individuals, findings related to educational attainments cannot necessarily be related to disability at the time when education was obtained. They can neither necessarily be directly related to access to different levels of education among persons with or without disabilities specifically in the camp context, as many individuals would still have received their education prior to their arrival at the camps.

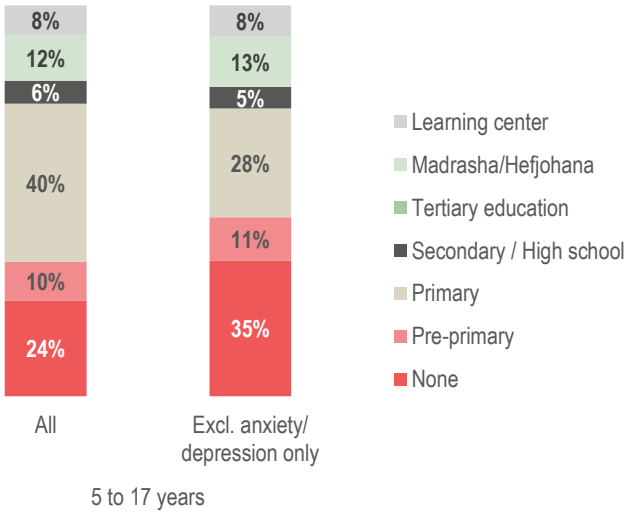
Lastly, there is the possibility that in particular current reported anxiety- or depression-related functional difficulties might in part be a result of the COVID-19 outbreak and the heightened uncertainty it introduced into people's lives. Thus, findings related to pre-COVID enrolment rates reflect current persons with disabilities' pre-COVID enrolment rates, and not necessarily exactly pre-COVID persons with disabilities' enrolment rates. For these reasons, no disaggregations of the highest level of education or pre-COVID enrolment rates by domain of functional difficulty are shown, while with regard to pre-COVID enrolment rates, sample sizes for such a disaggregation would also be too small.

[123] Results for 5 to 9 year-old female persons are representative with a 4% margin of error (n = 903). Results for 5 to 9 year-old male persons without disabilities are representative with a 4% margin of error (n = 970). Results for 10 to 17 year-old female persons are representative with a 3% margin of error (n = 1,040). Results for 10 to 17 year-old male persons are representative with a 3% margin of error (n = 1,067).
[124] Results for female persons with disabilities are representative with a 12% margin of error (n = 69). Results for female persons without disabilities are representative with a 3% margin of error (n = 1,626). Results for male persons with disabilities are representative with a 12% margin of error (n = 76). Results for male persons without disabilities are representative with a 3% margin of error (n = 1,706).

Nevertheless, with persons with difficulties in functioning in the anxiety or depression domains representing the largest share of persons with disabilities, this group is likely to drive overall results for persons with disabilities to a certain degree. Indeed, excluding this group from the aggregated analysis across persons with disabilities yields slightly higher proportions of persons with disabilities reportedly not having completed any education. Sample sizes for such a disaggregation for 5 to 9 and 10 to 17 year-olds are too small. However, Figure 51 shows that 35% of 5 to 17 year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, reportedly have not completed any education, and 39% have completed up to primary education. Comparably, 24% of all 5 to 17 year-old persons with disabilities have reportedly not completed any education, and 50% have completed education up to primary level.

These findings may be indicative of persons with physical, mental/cognitive or sensory disabilities actually being more likely than persons without disabilities or those with difficulties in functioning in the anxiety or depression domains not to have completed any education. However, also in this case, given that especially heightened levels of anxiety or depression might in part be the result of flight and uncertainty in people's lives in camps, no direct links can be drawn between current reported disabilities and reported completed levels of education when individuals obtained the education.

Figure 51 % of persons with disabilities aged 5 to 17 by reported highest level of completed education, for all persons with disabilities and all persons with disabilities excluding those with difficulties in functioning in the anxiety or depression domains only, by age group[125]



Reasons for children with disabilities not attending learning centres mentioned during the FGDs included bullying as well as a lack of support from other household members.

> *"When I go to school, when I go to fetch water, other children, big people speak a bad language to me, call me disabled. Then I feel very bad. I think I will never leave the house, but my parents say, if you want to see the future, you have to go to school. […] I have trouble walking. They call me broken when I go to school. I don't want to go to school. My mother helps me with everything."* – FGD with children with disabilities

[125] Results for 5 to 17 year-old persons with disabilities are representative with a 7% margin of error (n = 145). Results for 5 to 17 year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with a 12% margin of error (n = 72). Results for 18 to 59 year-old persons with disabilities are representative with a 4% margin of error (n = 916). Results for 18 to 59 year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with a 7% margin of error (n = 237). Results for 60+ year-old persons with disabilities are representative with a 7% margin of error (n = 237). Results for 60+ year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with an 8% margin of error (n = 156).

> *"I can't do anything on my own. My mother died. My step sister gives me all the work. Everyone in the house scolds me a lot."* – FGD with children with disabilities

Lastly, in other studies, a lack of transportation has been found to be a major barrier towards children with disabilities' access to education.[126]

Means of living

Engagement in the informal sector among all persons with disabilities

Overall, 18% of persons with disabilities, and 13% of persons without disabilities aged 4 and above were reportedly engaged in the informal sector before the COVID-19 outbreak began in March 2020 (pre-COVID), compared to 13% of persons with disabilities and 12% of persons without disabilities aged 4 and above at the time of data collection (post-COVID).

Breaking these results down by domain of functional difficulty shows that the proportion of persons with disabilities reportedly having been engaged in the informal sector both pre- and post-COVID was highest among those with difficulties in functioning in the anxiety and depression domains. This is followed by persons with difficulties in functioning in the mobility and vision domains. Rates of engagement in the informal sector were lowest among persons with difficulties in functioning in the self-care and hearing domains (Figure 52).

Persons with disabilities appear to have been more likely than persons without disabilities to lose their access to self-reliance activities. For persons with difficulties in functioning in the vision domain, the proportion of individuals reportedly having been engaged in the informal sector dropped by roughly three quarters in the post-COVID period compared to the pre-COVID period. For persons with difficulties in functioning in the anxiety, depression and mobility domains, it dropped by roughly a third (Figure 52).

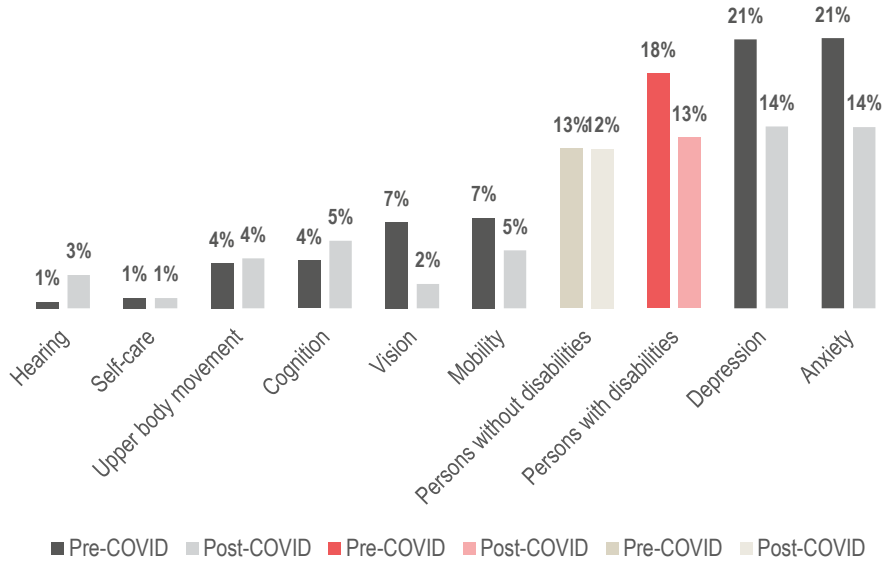
At the same time, the COVID-19 outbreak, associated restrictions in programming and a related loss of access to self-reliance activities and other types of assistance, a lack of information in particular related to livelihoods and other services that had been restricted following the COVID-19 outbreak, and an erosion of coping capacities, may have contributed to aggravated feelings of uncertainty among refugees at the time of data collection compared to the pre-COVID period.[127] Therefore, particularly the group of persons with difficulties in functioning in the anxiety and depression domains reportedly having been engaged in the informal sector pre-COVID may consist of both individuals that already frequently experienced high levels of anxiety or depression pre-COVID and those that did not.

As such, on the one hand, the data appears to indicate that those reportedly having frequently experienced high levels of anxiety or depression at the time of data collection – as well as persons with difficulties in functioning in the mobility or vision domains – may be more likely to have experienced loss of access to self-reliance activities than, for instance, persons without disabilities. On the other hand, in particular with reference to persons with difficulties in functioning in the anxiety or depression domains, whether or not feelings of anxiety or depression may have contributed to more restricted access to self-reliance activities under COVID-19 conditions, or loss of access to self-reliance activities following the COVID-19 outbreak may have contributed to more widespread feelings of anxiety or depression of those that were previously engaged in the informal sector cannot be deduced from the

[126] REACH, *Assessment of the Education Sector Response to the Rohingya Crisis* (Cox's Bazar, 2021b). Available here (accessed 28 February 2021).
[127] ACAPS-NPM Analysis Hub, *4 Months of COVID-19 programming restrictions* (Cox's Bazar, 2020). Available here (accessed 28 February 2021); ISCG, 2020b.

analysis. The relationship between the COVID-19 outbreak and related restrictions on programming, feelings of depression and anxiety, and loss of access to self-reliance activities, cannot be analysed further on the basis of the current data due to limited sample sizes and a lack of relevant secondary data.

Figure 52 % of persons with and without disabilities aged 4 and above reportedly having been engaged in the informal sector before the COVID-outbreak began in March 2020 (pre-COVID) and at the time of data collection (post-COVID), overall and by domain of disability[128]



Engagement in the informal sector among persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only

Persons with difficulties in functioning in the anxiety or depression domains were the ones most commonly reported as having been engaged in the informal sector both pre- and post-COVID, compared to persons with difficulties in functioning in other domains. As a result, excluding those with difficulties in functioning in the anxiety or depression domains only from the analysis yields lower proportions of persons with disabilities reportedly having been engaged in the informal sector, in particular among children and adults aged 18 to 59.

Among adults aged 18 to 59, a significantly[129] lower proportion of persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, had reportedly been engaged in the informal sector, compared to persons without disabilities in the same age group, both pre- and post-COVID. This is only the case post-COVID when comparing all persons with disabilities to those without disabilities (Figure 53).[130] **These results reflect the lower rates of engagement in the informal sector among persons with difficulties in functioning in domains other than the anxiety or depression domains, compared to persons without disabilities and those with difficulties in functioning in the anxiety or depression domains.**

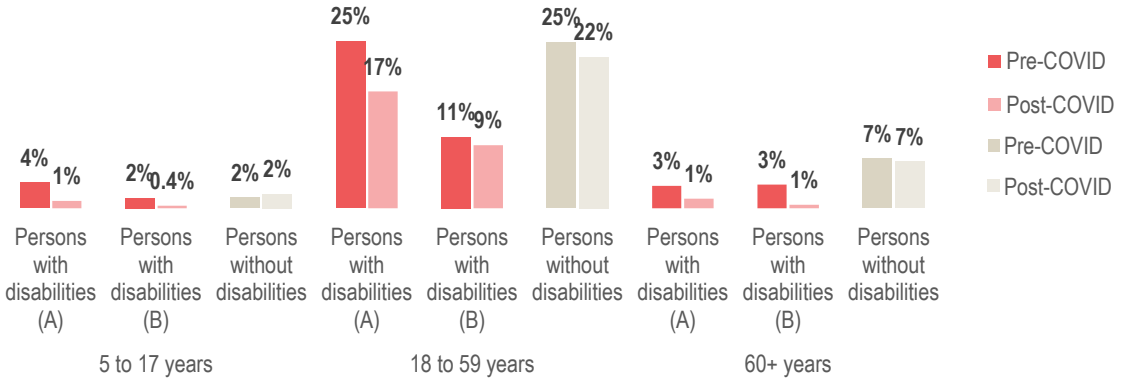
[128] Results for persons with difficulties in functioning in the hearing domain are representative with a 13% margin of error (n = 59). Results for persons with difficulties in functioning in the self-care domain are representative with a 10% margin of error (n = 107). Results for persons with difficulties in functioning in the upper body movement domain are representative with a 11% margin of error (n = 89). Results for persons with difficulties in functioning in the cognition domain are representative with a 12% margin of error (n = 72). Results for persons with difficulties in functioning in the vision domain are representative with a 11% margin of error (n = 94). Results for persons with difficulties in functioning in the mobility domain are representative with a 6% margin of error (n = 298). Results for persons with difficulties in functioning in the depression domain are representative with a 4% margin of error (n = 925). Results for persons with difficulties in functioning in the anxiety domain are representative with a 4% margin of error (n = 605).
[129] p-value < 0.0001 in both cases
[130] p-value < 0.01

Engagement in the informal sector among children

Among children, pre-COVID results were different from those for older age groups. Specifically, higher proportions of children with disabilities, including all children with disabilities, had reportedly been engaged in the informal sector (4%) than children without disabilities (2%). However, this difference is only significant at a 90% confidence level.[131] When excluding children with difficulties in functioning in the anxiety or depression domains only from this analysis, equal proportions of children with and without disabilities (2% each) had reportedly been engaged in the informal sector pre-COVID. Post-COVID, slightly lower proportions of children with disabilities had reportedly been engaged in the informal sector compared to children without disabilities, with this difference only being significant at a 90% confidence level for children with disabilities excluding those with difficulties in functioning in the anxiety or depression domains only (Figure 53).[132]

While these results might indicate a slight trend of children with disabilities – including those with difficulties in functioning in the anxiety or depression domains only – being more likely to have been engaged in the informal sector than children without disabilities, these results should be interpreted with caution and cognisant of the fact that they show the proportion of persons for whom a functional difficulty was reported at the time of data collection having been engaged in the informal sector pre-COVID. **They do not necessarily exactly reflect the proportion of persons with disabilities having been engaged in the informal sector pre-COVID, with in particular anxiety- or depression-related functional difficulties possibly having been impacted by the COVID-19 outbreak.**

Figure 53 % of persons with disabilities – all (A) and excluding persons with disabilities only in the anxiety or depression domains (B) – and persons without disabilities reportedly having been engaged in the informal sector before the COVID-outbreak began in March 2020 (pre-COVID) and at the time of data collection (post-COVID), by age group[133]



Engagement in the informal sector by age group and gender

Among older persons, the proportions of persons with disabilities, both including and excluding those with difficulties in functioning in the anxiety or depression domains only, reportedly having been engaged in the informal sector pre-COVID (3%) and post-COVID (1%) were slightly lower than the respective proportions of older persons without

[131] p-value < 0.1
[132] p-value < 0.1
[133] Results for 5 to 17 year-old persons with disabilities are representative with a 7% margin of error (n = 145). Results for 5 to 17 year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with a 12% margin of error (n = 72). Results for 5 to 17 year-old persons without disabilities are representative with a 2% margin of error (n = 3,3332). Results for 18 to 59 year-old persons with disabilities are representative with a 4% margin of error (n = 916). Results for 18 to 59 year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with a 7% margin of error (n = 237). Results for 18 to 59 year-old persons without disabilities are representative with a 2% margin of error (n = 4,209). Results for 60+ year-old persons with disabilities are representative with a 7% margin of error (n = 237). Results for 60+ year-old persons with disabilities, excluding those with difficulties in functioning in the anxiety or depression domains only, are representative with an 8% margin of error (n = 156). Results for 60+ year-old persons with disabilities are representative with a 7% margin of error (n = 226).

disabilities (7% both pre- and post-COVID). However, generally, the proportions of older persons reported as having been engaged in the informal sector were low compared to the respective proportions of adults aged 18 to 59 (Figure 53).

Across all age groups and irrespective of disability, most individuals reported as having been engaged in the informal sector were male. In particular, among 5 to 17 year-old persons with disabilities, all individuals reported to have been engaged in the informal sector were male. Among 5 to 17 year-old persons without disabilities, 1% of females were reported as having been engaged in the informal sector both pre- and post-COVID, compared to 2% of male individuals pre-COVID and 4% of male individuals post-COVID.

Among 18 to 59-year olds, between 2% and 3% of female persons with and without disabilities were reported as having been engaged in the informal sector pre- or post-COVID, compared to 49% and 51%, respectively, of male persons with and without disabilities pre-COVID, and 34% and 47%, respectively, of male persons with and without disabilities post-COVID.

Among older persons, a maximum of 1% of female persons with or without disabilities were reported as having been engaged in the informal sector pre- or post-COVID, compared to 5% and 11%, respectively, of male older persons with and without disabilities pre-COVID, and 2% and 10%, respectively, of male older persons with and without disabilities post-COVID (Figure 54 and Figure 55).

Figure 54 % of persons with and without disabilities reportedly having been engaged in the informal sector before the COVID-outbreak began in March 2020, by age group and gender[134]

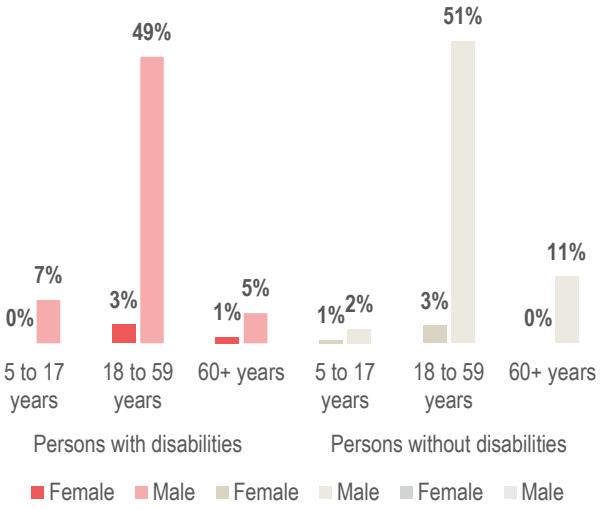
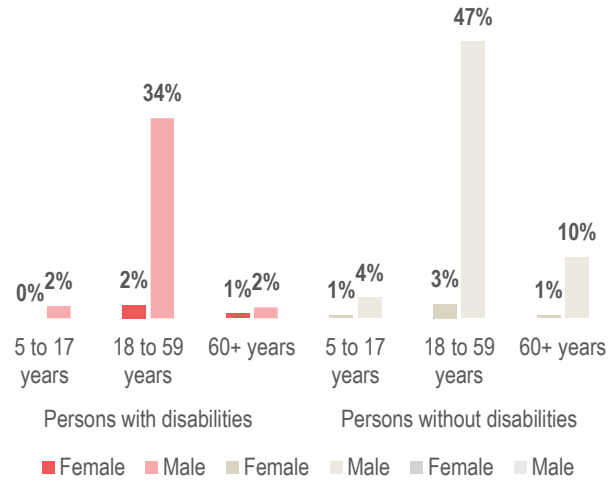


Figure 55 % of persons with and without disabilities reportedly having been engaged in the informal sector at the time of data collection, by age group and gender



In sum, engagement in the informal sector among persons with disabilities differs strongly between those with difficulties in functioning in the anxiety or depression domains and those with difficulties in functioning in other domains. Expectedly, individuals aged 18 to 59 are the ones predominantly being engaged

[134] Results for 5 to 17 year-old female persons with disabilities are representative with a 12% margin of error (n = 69). Results for 5 to 17 year-old male persons with disabilities are representative with a 12% margin of error (n = 76). Results for 5 to 17 year-old female persons without disabilities are representative with a 3% margin of error (n = 1,626). Results for 5 to 17 year-old male persons without disabilities are representative with a 3% margin of error (n = 1,706). Results for 18 to 59 year-old female persons with disabilities are representative with a 5% margin of error (n = 478). Results for 18 to 59 year-old male persons with disabilities are representative with a 5% margin of error (n = 438). Results for 18 to 59 year-old female persons without disabilities are representative with a 2% margin of error (n = 2,339). Results for 18 to 59 year-old male persons without disabilities are representative with a 3% margin of error (n = 1,869). Results for 60+ year-old female persons with disabilities are representative with a 10% margin of error (n = 115). Results for 60+ year-old male persons with disabilities are representative with a 9% margin of error (n = 122). Results for 60+ year-old female persons without disabilities are representative with a 11% margin of error (n = 82). Results for 60+ year-old male persons without disabilities are representative with a 9% margin of error (n = 144).

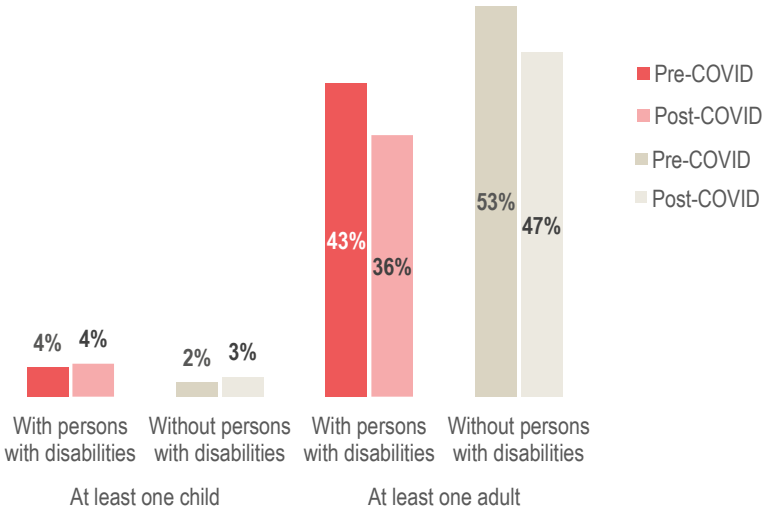
in the informal sector, as are male individuals compared to female individuals, irrespective of age and disability. Only among children, possibly, there is a slight trend of persons with disabilities at the time of data collection, including those with difficulties in functioning in the anxiety and depression domains only, having been more likely than persons without disabilities to have been engaged in the informal sector pre-COVID. However, no causal links can be drawn between current reported functional difficulties and the proportions of individuals reported as having been engaged in the informal sector.

Engagement in the informal sector among households with and without persons with disabilities

At the household level, the proportion of households with persons with disabilities reporting at least one child as having been engaged in the informal sector (4% both pre- and post-COVID) was slightly higher than that of households without persons with disabilities (2% pre-COVID and 3% post-COVID).[135] The proportion of households with persons with disabilities reporting at least one adult as having been engaged in the informal sector, on the other hand, was significantly[136] lower (43% pre-COVID and 36% post-COVID) than that of households without persons with disabilities (53% pre-COVID and 47% post-COVID) (Figure 56).

During FGDs, family members were largely reported to be the only ones supporting persons with disabilities in their daily lives. As such, the fact that households with persons with disabilities are less likely to report adult members having been involved in the informal sector might be due in part to individuals aged 18 to 59 taking on caregiver roles for their household members with disabilities, leaving them with less time to engage in the informal sector. At the same time, adult household members with disabilities (excluding those with difficulties in functioning in the anxiety or depression domains only) may be less likely to be engaged in the informal sector, further reducing household engagement. These factors may then potentially contribute to increased proportions of individuals below the age of 18 in those households reportedly engaging in the informal sector, compared to households without persons with disabilities. However, the proportions of children reported as having been engaged in the informal sector were very small, generally indicating this not to have been a widespread phenomenon – even though possibly under-reported – and limiting further analysis.

Figure 56 % of households with and without persons with disabilities reporting at least one child or at least one adult to have been engaged in the informal sector before the COVID-outbreak began in March 2020 (pre-COVID) and at the time of data collection (post-COVID)



[135] Pre-COVID: p-value < 0.01; post-COVID: p-value < 0.05
[136] p-value < 0.0001

Average reported daily incentives

Average reported daily incentives received appeared to be slightly lower for persons with disabilities than for persons without disabilities; however, those differences (both pre- and post-COVID) were found not to be significant. At the same time, reported per capita incentives of households receiving incentives and with household members with disabilities was slightly lower than that of households receiving incentives and without household members with disabilities. However, this difference was only significant[137] post-COVID (Table 6).

Expectedly, with a larger proportion of households with persons with disabilities than households without persons with disabilities reportedly not having any household members engaged in the informal sector, this difference in daily per capita incentives is larger when comparing all households with and without persons with disabilities, i.e. including also those not receiving any incentives. In this case, households with persons with disabilities reportedly received significantly lower average daily per capita incentives of Bangladeshi Taka (BDT) 35[138] and BDT 28 pre- and post-COVID, respectively, than households without persons with disabilities, reportedly having received BDT 44 and BDT 39 pre- and post-COVID, respectively.[139]

Table 6 Of 18+ year-old persons with and without disabilities reportedly having been engaged in the informal sector, average reported daily incentive (left), and of households with individuals engaged in the informal sector, and with and without persons with disabilities, average daily household per capita incentives (right), before the COVID-19 outbreak began in March 2020 (pre-COVID) and at the time of data collection (post-COVID)[140]

Average daily incentive per adult individual (BDT)			Average daily household per capita incentives (BDT)		
	Pre-COVID	Post-COVID	Pre-COVID	Post-COVID	
Persons with disabilities	311	305	78	74	Households with persons with disabilities
Persons without disabilities	324	321	82	81	Households without persons with disabilities

In addition to the presence of household members with disabilities, the highest level of education of adult household members appeared to play a role in determining average daily household per capita incentives received. Specifically, the reported amount of received incentives increased among better educated households compared to less educated households. Particularly, post-COVID, the gap between households with and without household members with disabilities is considerably larger among less educated households than among better educated households. Concretely, households without formal education or with primary education only among adult household members and with household members with disabilities reported 12% to 13% lower average daily household per capita incentives than households with the same levels of education among adult household members but without household members with disabilities (Table 7).[141]

[137] p-value < 0.05
[138] BDT 1 = 0.0117916 US Dollars (USD) (XE Currency Converter, available here, accessed 10 March 2021).
[139] p-value < 0.0001 in both cases
[140] Per capita incentives were calculated dividing the sum of the reported daily incentives received by all individuals engaged in the informal sector in a household by the number of household members. This does not take into account the regularity of receipt of incentives or the number of days a month individuals engaged in the informal sector received incentives.
[141] Results for households with persons with disabilities and without formal education are representative with an 8% margin of error (n = 161). Results for households with persons with disabilities and with primary education are representative with a 9% margin of error (n = 131). Results for households with persons with disabilities and with secondary education and above are representative with a 10% margin of error (n = 117). Results for households without persons with disabilities and without formal education are representative with a 5% margin of error (n = 385). Results for households without persons with disabilities and with primary education are representative with a 6% margin of error (n = 309). Results for households without persons with disabilities and with secondary education and above are representative with a 7% margin of error (n = 219).

Table 7 Of households with individuals engaged in the informal sector, average daily household per capita incentives before the COVID-19 outbreak began in March 2020 (pre-COVID) and at the time of data collection (post-COVID), by presence of household members with disabilities and highest level of education of adult household members

Highest level of education of adult household members	Average daily household per capita incentives (BDT)	
Households with persons with disabilities	Pre-COVID	Post-COVID
No formal education	71	67
Primary	79	71
Secondary and above	85	86
Households without persons with disabilities		
No formal education	75	77
Primary	82	81
Secondary and above	92	89

Participation[142]

In the following sub-sections, results related to participation in meetings or events, preferred means of communication to receive information on camp services, and the provision of feedback on camp services will be presented.

Participation in meetings/events

No significant differences in the proportions of persons with and without disabilities reportedly having participated in community meetings or events in the month prior to data collection were found. Overall, 25% of persons with disabilities and 30% of persons without disabilities had reportedly attended at least one meeting or event.

However, reported levels of participation appear to differ between persons with different functional difficulties. The proportions of persons with difficulties in functioning in the depression or anxiety domains reportedly having attended meetings were highest (33% in the depression domain and 32% in the anxiety domain) and twice as high as the proportions of persons with difficulties in functioning in the domains with the lowest participation – self-care and hearing (both 16%) (Figure 57). **Differences in levels of participation were only found to be significant[143] for persons with difficulties in functioning in the self-care domain, though. Overall, 16% of persons with difficulties in functioning in the self-care domain had reportedly participated in meetings and/or events in the month prior to data collection, compared to 28% of persons with difficulties in functioning not in this domain.**

Most frequently, persons both with and without disabilities had reportedly attended non-governmental organisation (NGO) meetings (as reportedly attended by 24% of persons without disabilities and 18% of persons with disabilities). Any other type of meeting had reportedly been attended by a maximum of 6% of individuals (Figure 58).

[142] Results in this section are indicative only for persons with difficulties in functioning in the anxiety or depression domains, as well as for persons without disabilities. Overall results for persons with disabilities exclude persons with difficulties in functioning in the anxiety or depression domains only. See "Challenges and limitations" for further explanations.
[143] p-value < 0.05

Figure 57 % of persons with and without disabilities aged 15 and above reportedly having attended any community meetings/events in the month prior to data collection, overall and by domain of disability[144]

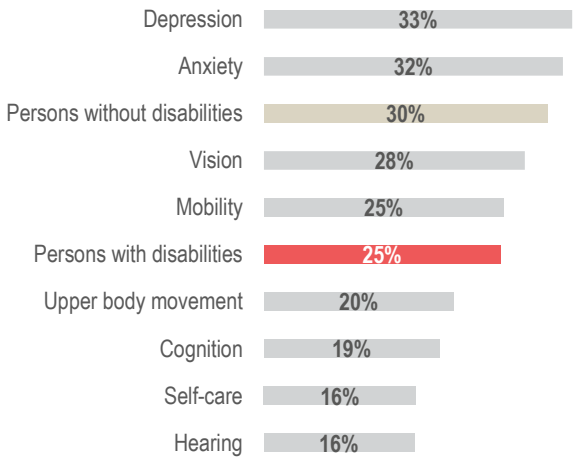
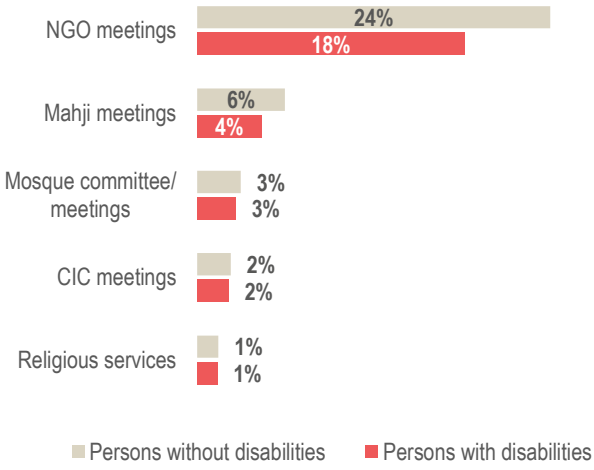
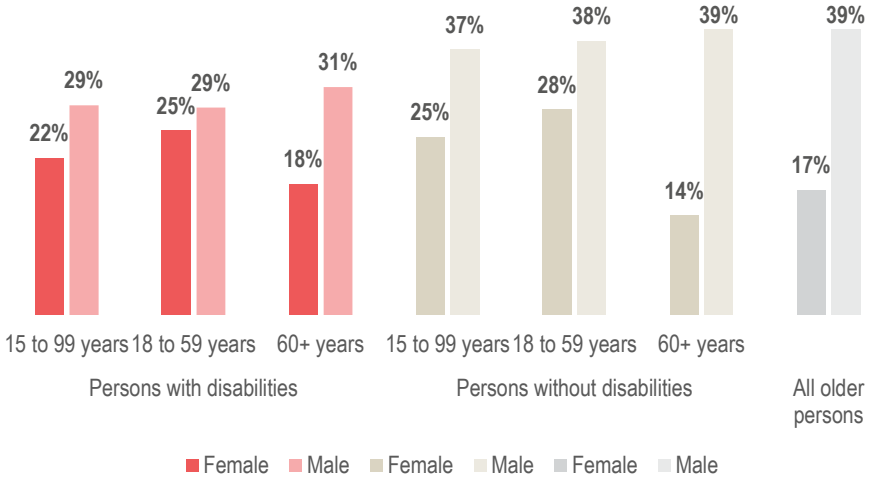


Figure 58 % of persons with and without disabilities aged 15 and above reportedly having having attended community meetings/events in the month prior to data collection, by type of meeting[144]



Participation in meetings among older and not older persons with or without disabilities was comparable to the overall results for persons with or without disabilities. However, reported participation among female individuals was lower than among male individuals, in particular for persons without disabilities. While differences in participation between male and female individuals were not significant for persons with disabilities, across age groups, the proportions of female individuals without disabilities reportedly having participated in meetings or events were significantly[145] lower than those of male individuals without disabilities. They were also significantly[146] lower among all older persons (Figure 59). **Thus, with disability and age overall not appearing to have a significant impact on participation in community meetings, gender gaps do differ between persons with and without disabilities, as well as between age groups. Smaller gender gaps were found among persons with disabilities than among persons without disabilities, as well as among younger age groups compared to older age groups.**

Figure 59 % of persons with and without disabilities aged 15 and above and older persons reportedly having attended any community meetings/events in the month prior to data collection, by age group and gender[147]

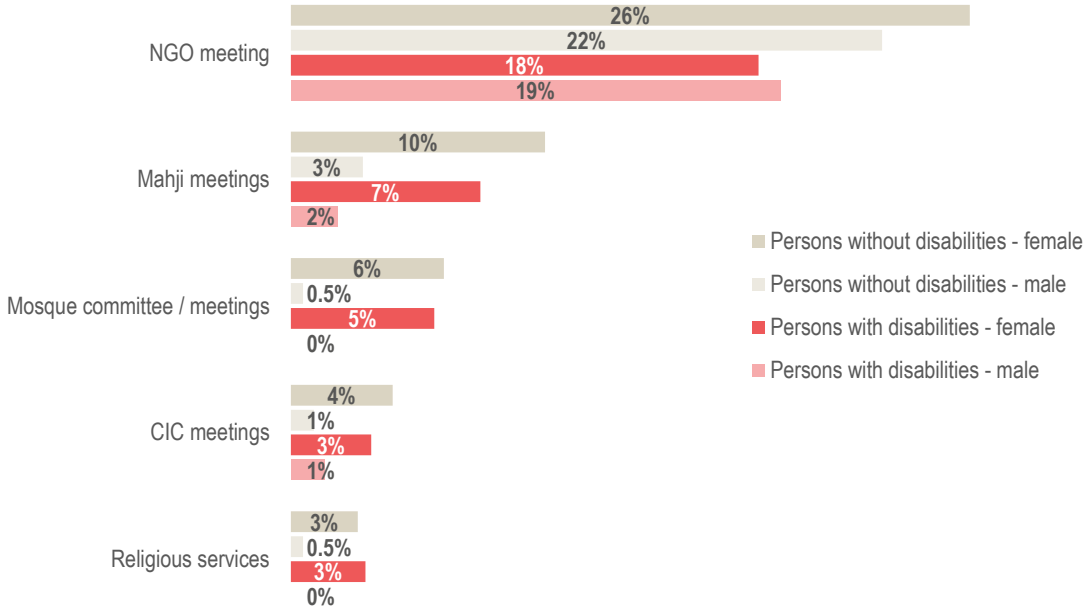


[144] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[145] 15 to 99 years: p-value < 0.0001; 18 to 59 years: p-value < 0.01; 60+ years: p-value < 0.0001
[146] p-value < 0.0001
[147] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

Female individuals reportedly largely only participated in NGO meetings. Those were the only meetings – and for persons with disabilities, also Camp-in-Charge (CiC) meetings – for which no significant differences in the proportions of all male and female persons with or without disabilities reportedly having participated in the month prior to data collection were found, as roughly equal proportions of male and female individuals with or without disabilities reportedly attended NGO meetings (Figure 60).

Only among older persons and older persons without disabilities, the proportions of female individuals reportedly having attended NGO meetings were significantly[148] lower than the proportions of male individuals reportedly having attended. Specifically, 13% and 15%, respectively, of female older persons without disabilities or all female older persons reportedly attended NGO meetings, compared to 27% and 25%, respectively, of male older persons with disabilities or all male older persons. All other types of meetings were generally reported to have been disproportionately attended by male individuals aged 15 and above, both among persons with and without disabilities (Figure 60).

Figure 60 % of persons with and without disabilities aged 15 and above reportedly having attended community meetings/events in the month prior to data collection, by type of meeting and gender[149]



Drawing from the FGD results, there seemed to be a common perception that treatment as well as to a lesser degree education were required for persons with disabilities to be able to mix with other members of their community. **This likely reflects stigma persons with disabilities face, leading to perceptions of them not being welcome in meetings. Such stigma and related perceptions can therefore be considered barriers that prevent persons with disabilities from participating in meetings.**

Other common barriers reportedly faced by persons with disabilities included inaccessibility of meeting venues, and not being invited to meetings. Specifically, inaccessibility as a barrier was mentioned in all FGDs with adults with disabilities, three of the four FGDs with children with disabilities, and two of the three FGDs with male older persons.

[148] p-value < 0.05
[149] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

> *"There are no people to help me get to the meeting. I want to go to the meeting, but I can't walk."* – FGD with adults with disabilities

> *"I want to go for training, but I can't go, because I can't walk and there are no people to take me in a wheelchair."* – FGD with children with disabilities

As a result, some respondents indicated to only attend meetings that take place close to their shelters. **Thus, while overall persons with disabilities may not be significantly less likely to participate in meetings, they do reportedly often have to overcome additional barriers to be able to participate.**

At the same time, there was a common feeling among adults with disabilities that they could support their community through teaching other people skills in handicraft (reported in four of six adult FGDs), and through teaching in general (three adult FGDs). Moreover, both adults with disabilities and older persons felt that they could contribute by providing advice to the community or to NGOs (reported in five FGDs with older persons, and four adult FGDs), **all of which is indicative of a general desire to be actively involved in community life.**

Means of communication

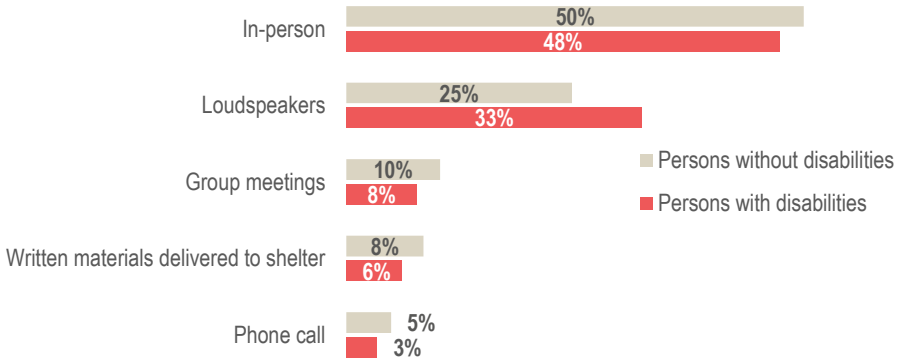
Preferred means of communication to receive information about services in camps did not appear to vary greatly between persons with and without disabilities. Roughly half the individuals in both groups prefer in-person communication, followed by a quarter of persons without disabilities and a third of persons with disabilities reportedly preferring loudspeakers. Any other means of communication were reported as preferred means for a maximum of 10% of individuals (Figure 61).

While generally differences between persons with different types of functional difficulties were not large, a few significant differences were found. Most notably, a significantly larger proportion of persons with difficulties in functioning in the upper body movement domain (17%) than persons with difficulties in functioning not in this domain (5%) reportedly preferred group meetings.[150] Among persons with difficulties in functioning in the hearing domain, a significantly lower proportion (1%) than persons with difficulties in functioning not in this domain (9%) reportedly preferred group meetings.[151] Lastly, only 1% and 0.5%, respectively, of persons with difficulties in functioning in the self-care and vision domains reportedly preferred phone calls, compared to 4% of persons with difficulties in functioning not in those domains.[152] All other results across domains were comparable to the overall results for persons with disabilities.[153]

No considerable differences in preferences between older and not older persons with or without disabilities, or between male and female individuals, were found.

[150] p-value < 0.001
[151] p-value < 0.05
[152] p-value < 0.05
[153] Compare Table 17 in annex 8.

Figure 61 Preferred means of accessing information about services in camps, % of persons with and without disabilities aged 15 and above by reported means of communication (top 5)[154]



Feedback

A slightly lower proportion of persons with disabilities (23%) than persons without disabilities (29%) was reportedly asked for feedback on camp services in the month prior to data collection.[155] The lowest proportions of persons with disabilities reportedly having been asked for feedback were found among persons with difficulties in functioning in the self-care (15%), cognition (18%), upper body movement (21%) and hearing (23%) domains (Figure 62). However, comparing those results to the results for persons with difficulties in functioning not in those domains, the difference is only significant for persons with difficulties in functioning in the self-care domain. Specifically, 15% of persons with difficulties in functioning in the self-care domain had reportedly been asked for feedback, compared to 25% of persons with difficulties in functioning not in this domain.[156]

Among adults aged 18 to 59, 21% of persons with disabilities and 30% of persons without disabilities were reportedly asked for feedback. This difference between persons with and without disabilities was smaller among older persons, with 26% of older persons with disabilities and 31% of older persons without disabilities reportedly having been asked for feedback.

Those reportedly having been asked for feedback were most commonly reported to have been asked for feedback on WASH and health services. The difference between persons with and without disabilities that had been asked to provide feedback on specific services was also largest in relation to WASH. While 76% of persons without disabilities who had been asked for feedback reportedly had been asked to give feedback on WASH, 59% of persons with disabilities who had been asked for feedback reported having been asked for feedback on WASH (this was the only significant difference between persons with and without disabilities across all types of services assessed).[157] At the same time, among those having been asked for feedback, less than a quarter reported or were reported as having been asked for feedback on services other than WASH or health services, including food security, shelter/non-food items (NFI), education and protection (Figure 63).

[154] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[155] p-value < 0.05; The question did not capture the accessibility of feedback mechanisms, i.e. if persons with disabilities were requested to provide feedback in such a way that they were able to provide it.
[156] p-value < 0.05
[157] p-value < 0.01

Figure 62 % of persons with and without disabilities aged 15 and above reportedly having been asked for feedback on camp services in the month prior to data collection, overall and by domain of disability[158]

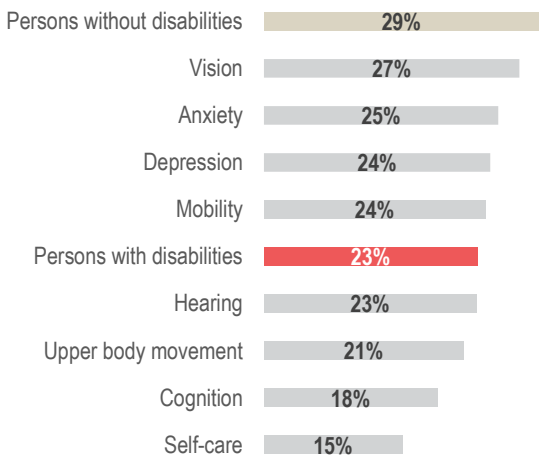
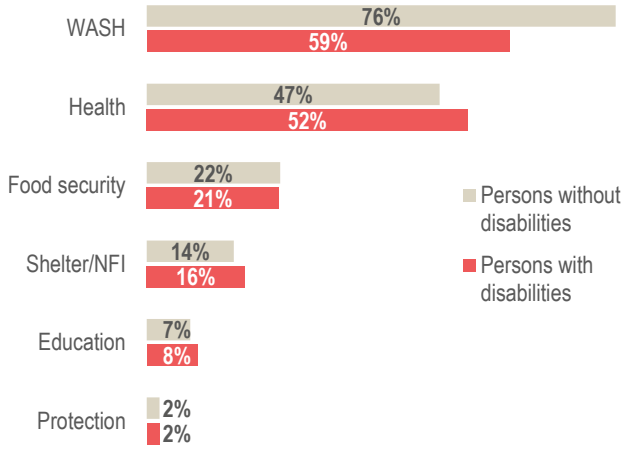
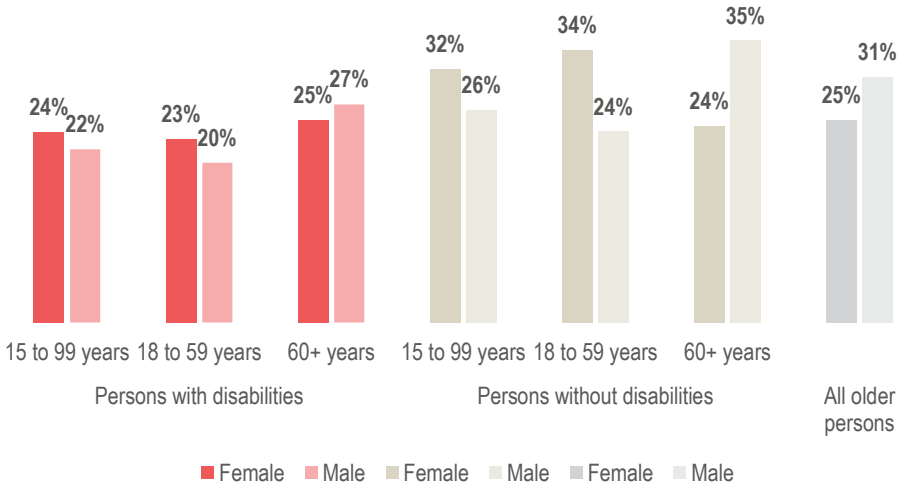


Figure 63 Of those having been asked for feedback, % of persons with and without disabilities by type of service for which they were reportedly asked for feedback[159]



No significant differences in the proportions of individuals reportedly having been asked for feedback were found between age groups. However, among younger age groups, slightly higher proportions of female persons (with and without disabilities) than male persons were reportedly asked for feedback on camp services. In turn, among older persons (with and without disabilities), slightly higher proportions of male individuals were reportedly asked for feedback (Figure 64). This difference is only significant[160], however, for persons without disabilities aged 18 to 59. **Overall, while a person's disability and gender – as opposed to age – may play some role in determining who is providing feedback on camp services, differences between different disability and gender groups were small.**

Figure 64 % of persons with and without disabilities aged 15 and above reportedly having been asked for feedback on camp services in the month prior to data collection, by age group and gender[161]



[158] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[159] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only. Results for persons with disabilities are representative with an 11% margin of error (n = 92). Results for persons without disabilities are representative with a 6% margin of error (n = 351).
[160] p-value < 0.01
[161] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

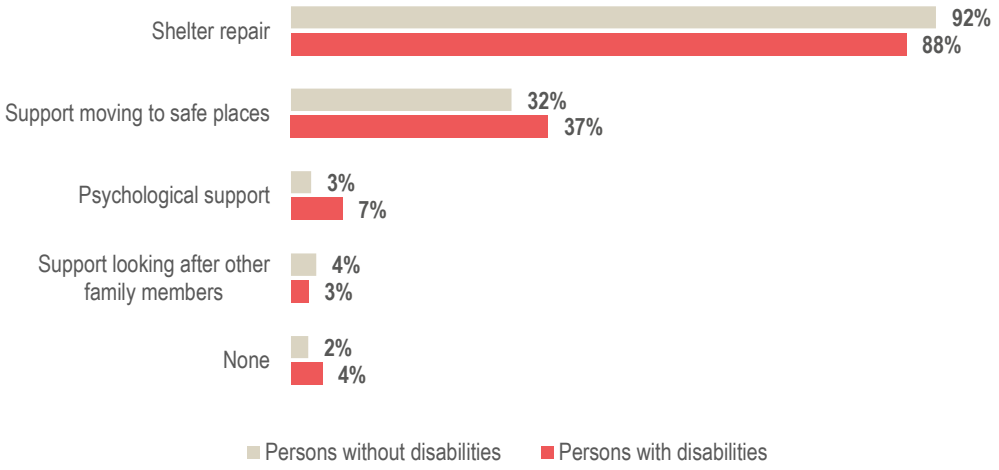
Disaster preparedness[162]

Concerning the types of support persons with and without disabilities would like to receive in the context of disaster preparedness and response, across both groups, a large majority of individuals would reportedly like to be supported with shelter repair. Moreover, roughly two thirds would like to receive support moving to safe places, and between 3% and 7% would like to receive psychological support, or support looking after other family members (Figure 65).

Only in relation to psychological support, the proportion of persons with disabilities reportedly wanting to receive this type of support (7%) was significantly[163] larger than that of persons without disabilities (3%), in particular among persons with difficulties in functioning in the self-care and upper body movement domains. Overall, 14% and 15%, respectively, of persons with difficulties in functioning in the self-care or upper body movement domains would reportedly like to receive this type of support, compared to 6% of persons with difficulties in functioning not in those domains.[164] Moreover, 46% of persons with difficulties in functioning in the vision domain would reportedly like to receive support moving to safe places, compared to 34% of persons with difficulties in functioning not in this domain.

With no significant differences found between age groups, the only significant difference between male and female individuals in terms of support requirements consisted of a significantly[165] larger proportion of male older persons with disabilities (47%) than female older persons with disabilities (28%) reportedly wanting support in moving to safe places. This might possibly be due to other household members, including female and younger household members, being more likely to be physically able to support older female household members with disabilities in moving to safe places than older male household members with disabilities.

Figure 65 % of persons with and without disabilities aged 15 and above reportedly wanting to receive different types of support with regards to natural hazards[166]



Lastly, preferred means of communication to be informed about upcoming hazards did not differ significantly between persons with and without disabilities. Similar to the reported preferred means of

[162] Results in this section are indicative only for persons with difficulties in functioning in the anxiety or depression domains, as well as for persons without disabilities. Overall results for persons with disabilities exclude persons with difficulties in functioning in the anxiety or depression domains only. See "Challenges and limitations" for further explanations.
[163] p-value < 0.001
[164] p-value < 0.01 in both cases
[165] p-value < 0.05
[166] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.

accessing information about camp services (Figure 61), the majority in both groups reportedly prefer loudspeakers, followed by in-person communication – and in the case of natural hazards, warning flags.

Table 8 % of persons with and without disabilities aged 15 and above reporting preferred means of communication to hear about upcoming cyclones or similar hazards, overall and by domain of disability[167]

	Loudspeaker	In-person	Warning flags	Phone call	Radio
Persons with disabilities	**91%**	**62%**	**31%**	**7%**	**4%**
Persons without disabilities	**90%**	**61%**	**29%**	**10%**	**1%**
Vision	91%	54%	30%	6%	4%
Hearing	90%	54%	27%	7%	5%
Walking	90%	64%	29%	7%	5%
Cognition	86%	69%	36%	8%	7%
Self-care	87%	73%	21%	9%	3%
Upper body movement	82%	79%	17%	11%	2%
Anxiety	95%	64%	26%	6%	4%
Depression	91%	65%	23%	7%	4%

Disaggregating results by domain of functional difficulty, however, shows that significantly larger proportions of persons with difficulties in functioning in the self-care and upper body movement domains than persons with difficulties in functioning not in those domains reportedly prefer in-person communication. Among persons with difficulties in functioning in the upper body movement domain, this is also true for phone calls. In turn, significantly lower proportions of persons with difficulties in functioning in those two domains reportedly prefer warning flags, and among persons with difficulties in functioning in the upper body movement domain, this is also true for loudspeakers (Table 8).[168] These findings may be linked to greater barriers faced related to mobility and the relatively high reported proportions of persons with difficulties in functioning in the self-care and upper body movement domains not leaving shelters, and thus being most likely to be reached through in-person communication.

Results between age groups as well as male and female individuals do largely not differ significantly. The only significant difference between male and female individuals was a significantly[169] smaller proportion of female persons with disabilities aged 18 to 59 (24%) reportedly preferring warning flags, compared to 40% of male persons with disabilities of the same age group.

Lastly, phone calls were reportedly preferred by a significantly[170] larger proportion of adults aged 18 to 59 without disabilities (12%), compared to adults aged 18 to 59 with disabilities (7%), as well as compared to older persons without disabilities (4%).

[167] Persons with disabilities exclude those with difficulties in functioning in the anxiety or depression domains only.
[168] Compare Table 18 in annex 8.
[169] p-value < 0.05
[170] Compared with adults aged 18 to 59 with disabilities: p-value < 0.05; compared with older persons without disabilities: p-value < 0.001

CONCLUSION

Over the past four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Since August 2017, an estimated 715,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 860,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.

The equitable consideration and inclusion of individuals across all age groups and persons with disabilities in the humanitarian response has been a key theme in the planning and delivery of the response by national and international organisations alongside the government of Bangladesh. However, while the heightened risk of persons with disabilities and older persons is generally recognized, a lack of data on disability prevalence across camps as well as older persons' and persons with disabilities' needs, barriers and preferences hinders evidence-based inclusive programming.

Against this background, REACH, with support from the ADWG, conducted an Age and Disability Inclusion Needs Assessment, covering all Rohingya refugee populations living in the 34 camps in Ukhiya and Teknaf Upazila. The assessment aimed to support key actors working in Cox's Bazar, including coordination bodies and technical agencies and actors, to consider the nuanced and specific requirements, access to services and assistance, and involvement of persons with disabilities across all age groups, and older persons living in Rohingya camps, within the response programming.

Overall, 12% of individuals were identified as persons with disabilities, with disability prevalence ranging from 2% among 2 to 4 year-olds to 51% among older (aged 60 and above) persons. Differences in reported barriers, requirements and preferences between persons with and without disabilities, persons with different types of functional difficulties, and persons of different ages and genders varied by indicator.

Mobility-related barriers were reported particularly among persons with difficulties in functioning in the self-care, mobility, upper body movement and vision domains. Increasing age further led to higher proportions of individuals reportedly facing challenges moving in shelters and around camps, both among persons with and without disabilities. Especially for persons with difficulties in functioning in the self-care and upper body movement domains as well as to some degree persons with difficulties in functioning in the mobility domain, such barriers may be likely reasons for lower proportions of persons with difficulties in functioning in those domains reportedly having left shelters in the week prior to data collection.

Mobility-related barriers may also in part explain the particularly high proportions of persons with difficulties in functioning in the self-care, upper body movement and mobility domains reportedly facing difficulties with self-care as well as differences in utilisation patterns of different types of WASH infrastructure. Specifically, persons with difficulties in functioning in the self-care or upper body movement domains reportedly used public not accessible latrines and public bathing facilities at significantly lower proportions than persons with difficulties in functioning not in those domains. At the same time, persons with difficulties in functioning in the self-care or upper body movement domains as well as persons with difficulties in functioning in the mobility domain reportedly used private accessible latrines at significantly higher proportions than persons with difficulties in functioning not in those domains. However, overall, the reported use of private or accessible WASH infrastructure was low, possibly indicating access barriers, and a limited impact of this type of infrastructure on facilitating self-care.

Generally, a significantly higher proportion of persons with disabilities than persons without disabilities reportedly faced challenges accessing services. This was particularly the case for persons with difficulties in functioning in the

self-care and mobility domains as well as for female older persons with disabilities. The latter is also reflected in reported gaps in access to assistive devices that – while being large across all age groups and including for older persons without disabilities – were largest for female older persons with disabilities.

Among younger age groups, significantly lower proportions of children with disabilities than children without disabilities were found to have been enrolled in formal or informal learning centres. In particular, high proportions of boys with disabilities were reportedly not attending TLCs before the COVID-19 outbreak. Similarly, the proportions of individuals reportedly not having completed any education were higher among persons with disabilities than persons without disabilities, in particular among younger age groups, and among boys with disabilities compared to girls with disabilities.

With higher proportions of persons with disabilities, in particular those with difficulties in functioning in the anxiety or depression domains, than persons without disabilities reportedly having been engaged in the informal sector pre-COVID, persons with disabilities seem to have experienced loss of access to self-reliance activities more frequently following the COVID-19 outbreak than persons without disabilities. However, no conclusions can be drawn as to whether aggravated barriers for persons with disabilities may have led to a greater drop in access to self-reliance activities, or if COVID-19-related loss of access to self-reliance activities and other services may also have contributed to more prevalent feelings of anxiety or depression at the time of data collection compared to the pre-COVID period. This impacts the comparability of pre- and post-COVID results.

Cognisant of the same limitation, findings indicate a slight possible trend towards children with disabilities having been more likely than children without disabilities to have been engaged in the informal sector pre-COVID. Similarly, households with persons with disabilities appeared more likely than households without persons with disabilities to report at least one child as having been engaged in the informal sector. At the same time, households with persons with disabilities were less likely than households without persons with disabilities to report at least one adult as having been engaged in the informal sector. The former, furthermore, reported lower levels of daily per capita incentives received than the latter, especially among less educated households.

Differences in indicators related to participation between persons with and without disabilities were small. Reported participation in meetings or provision of feedback on camp services was generally low, irrespective of disability, age or gender. Nevertheless, slightly lower proportions of persons with disabilities than persons without disabilities reportedly attended meetings or provided feedback on camp services. In addition, gender gaps were found, in particular among persons without disabilities in relation to participation in meetings, and differing by age group in relation to the provision of feedback.

With regard to support individuals would like to receive in the context of natural hazards, in particular persons with difficulties in functioning in the self-care or upper body movement domains would reportedly like to receive psychological support. Persons with difficulties in functioning in the vision domain as well as male older persons with disabilities were particularly reported as wanting to receive support in moving to safe places.

Lastly, loudspeakers generally emerged as the preferred means of communication to hear about natural hazards. However, possibly linked to their limited ability to move, significantly larger proportions of persons with difficulties in functioning in the self-care or upper body movement domains than persons with difficulties in functioning not in these domains reportedly prefer in-person communication.

These findings show that while certain barriers, requirements and preferences may be widespread across the whole population, persons with (different types of) functional difficulties, persons without disabilities, and individuals of different ages and genders may all face specific barriers, gaps in access to services, and have specific preferences

and requirements. Different factors, such as a person's age, gender and functional difficulties, may compound each other. However, depending on the situation, certain factors may be more or less relevant in shaping lived experiences. As such, the specific barriers, gaps, requirements and preferences of different individuals have to be considered at the most granular level possible to ensure the effective and dignified inclusion of all persons with disabilities and older persons.

In light of the findings and limitations of this assessment, in the future, more comprehensive insights into the specific barriers faced by persons with disabilities towards accessing services and how this varies by age and gender, as well as across and within sectors, may help address those. In this context, it will be important to not only consider physical barriers but also less "visible" ones, such as stigma related to certain perceptions and believes, that potentially hinder persons with disabilities' inclusion.

In addition, in the medium term, further investigation into possible linkages between disability and individuals below the age of 18 engaging in the informal sector as well as enrolment rates into educational facilities could be considered to help address potential adverse impacts on children with disabilities.

Lastly, findings suggest that in the assessed domains, difficulties in functioning in the anxiety and depression domains are the most prevalent forms of functional difficulty among assessed communities. However, there remains a need to better understand the specific barriers, requirements and preferences of persons with difficulties in functioning in the anxiety or depression domains. In light of the apparent difficulties assessing those domains as well as the potentially greater sensitivities involved, this will require a carefully designed approach, in order to do no harm and generate meaningful results.

ANNEXES

Annex 1: Washington Group Questions used

Age group	Washington group domains and questions
Ages 18 to 99	**Vision** Does this household member have difficulty seeing even if wearing glasses?
	Communication Using usual language, does this household member have difficulty communicating (for example understanding or being understood by others)?
	Hearing Does this household member have difficulty hearing even if using a hearing aid?
	Cognition Does this household member have difficulty remembering or concentrating?
	Self-care Does this household member have difficulty with self-care, such as washing all over or dressing?
	Upper body movement Does this household member have difficulty raising a 2 litre bottle of water from waist to eye level? Does this household member have difficulty using their hands and fingers?
	Mobility Does this household member have difficulty walking or climbing stairs?
	Anxiety How often does this household member feel worried, nervous, or anxious? [For those feeling anxious at least a few times a year] Thinking about the last time this household member felt worried, nervous or anxious, how would they describe the level of these feelings?
	Depression How often does this household member feel depressed? [For those feeling depressed at least a few times a year] Thinking about the last time this household member felt depressed, how depressed did they feel?
Ages 5 to 17	**Vision** Does this child wear glasses or contact lenses? [For children wearing glasses or contact lenses] When wearing his/her glasses or contact lenses, does this child have difficulty seeing? [For children not wearing glasses or contact lenses] Does this child have difficulty seeing?
	Hearing Does this child use a hearing aid? [For children using hearing aids] When using his/her hearing aid, does this child have difficulty hearing sounds like peoples' voices or music? [For children not using hearing aids] Does this child have difficulty hearing sounds like peoples' voices or music?
	Mobility Does this child use any equipment or receive assistance for walking? [For children using equipment/receiving assistance walking] Without his/her equipment or assistance, does this child have difficulty walking 100 metres on level ground? That would be about the length of 1 football field. [For children using equipment/receiving assistance walking and not having a lot of difficulty or not being able to walk 100 m on level ground without equipment] Without his/her equipment or assistance, does this child have difficulty walking 500 metres on level ground? That would be about the length of 5 football field [For children using equipment/receiving assistance walking] With his/her equipment or assistance, does this child have difficulty walking 100 metres on level ground? That would be about the length of 1 football field. [For children using equipment/receiving assistance walking and not having a lot of difficulty or not being able to walk 100 m on level ground with equipment] With his/her equipment or assistance, does this child have difficulty walking 500 metres on level ground? That would be about the length of 5 football field

Age group	Washington group domains and questions
	[For children not using equipment/receiving assistance walking] Compared with children of the same age, does this child have difficulty walking 100 metres on level ground? That would be about the length of 1 football field. [For children not using equipment/receiving assistance walking and not having a lot of difficulty or not being able to walk 100 m on level ground] Compared with children of the same age, does this child have difficulty walking 500 metres on level ground? That would be about the length of 5 football field.
	Self-care Does this child have difficulty with self-care such as feeding or dressing him/herself?
	Communication When this child speaks, does he/she have difficulty being understood by people inside of this household? When this child speaks, does he/she have difficulty being understood by people outside of their household?
	Learning Compared with children of the same age, does this child have difficulty learning things?
	Remembering Compared with children of the same age, does this child have difficulty remembering things?
	Concentrating Does this child have difficulty concentrating on an activity that he/she enjoys doing?
	Accepting change Does this child have difficulty accepting changes in his/her routine?
	Behaviour Compared with children of the same age, does this child have difficulty controlling his/her behaviour?
	Making friends Does this child have difficulty making friends?
	Anxiety How often does this child seem very anxious, nervous or worried?
	Depression How often does this child seem very sad or depressed?
Ages 2 to 4	**Vision** Does this child wear glasses? When wearing his/her glasses, does this child have difficulty seeing? Does this child have difficulty seeing?
	Hearing Does this child use a hearing aid? When using his/her hearing aid, does this child have difficulty hearing sounds like peoples' voices or music? Does this child have difficulty hearing sounds like peoples' voices or music?
	Mobility Does this child use any equipment or receive assistance for walking? Without his/her equipment or assistance, does this child have difficulty walking? With his/her equipment or assistance, does this child have difficulty walking? Compared with children of the same age, does this child have difficulty walking?
	Dexterity Compared with children of the same age, does this child have difficulty picking up small objects with his/her hand?
	Communication Does this child have difficulty understanding you? When this child speaks, do you have difficulty understanding him/her?
	Learning Compared with children of the same age, does this child have difficulty learning things?
	Playing Compared with children of the same age, does this child have difficulty playing?
	Behaviour Compared with children of the same age, how much does this child kick, bite or hit other children or adults?

Annex 2: Household surveys completed by camp

Table 9 List of household surveys completed per camp and number of individuals aged 2 and above included in the surveys

Upazila	Camp	Total number of households	Completed number of surveys	Surveyed number of individuals aged 2 and above
Ukhiya	Camp 1E	8,515	70	335
	Camp 1W	8,386	88	349
	Camp 2E	5,939	76	370
	Camp 2W	5,435	79	302
	Camp 3	8,057	74	341
	Camp 4	7,014	75	307
	Camp 4 Extension	1,448	71	307
	Camp 5	5,481	75	308
	Camp 6	4,836	73	378
	Camp 7	8,266	74	337
	Camp 8E	6,188	83	393
	Camp 8W	6,603	73	297
	Camp 9	7,180	74	342
	Camp 10	6,369	75	345
	Camp 11	6,143	75	318
	Camp 12	5,318	75	299
	Camp 13	8,827	62	299
	Camp 14	6,582	74	333
	Camp 15	10,467	73	351
	Camp 16	4,499	66	311
	Camp 17	3,784	69	317
	Camp 18	6,060	76	269
	Camp 19	4,805	110	457
	Camp 20	1,591	73	296
	Camp 20 Extension	1,680	74	303
	Kutupalong RC	3,137	72	305
Teknaf	Camp 21	3,810	75	323
	Camp 22	4,279	67	323
	Camp 23	2,371	74	318
	Camp 24	5,800	71	320
	Camp 25	1,487	71	314
	Camp 26	9,123	68	319
	Camp 27	3,234	72	326
	Nayapara RC	4,906	73	375
Total		**187,620**	**2,530**	**11,187**

Annex 3: Focus group discussions completed by camp and participant profiles

Table 10 List of FGDs completed per camp, by type of FGD and gender of participants

Upazila	Camp	Type of FGD (female)	Type of FGD (male)	Total
Ukhiya	Camp 1W	Older persons; Children with disabilities		2
	Camp 5		Adults with disabilities	1
	Camp 6		Older persons	1
	Camp 8E		Adults with disabilities	1
	Camp 13	Caregivers of children; Adults with disabilities		2
	Camp 14		Older persons	1
	Camp 15		Caregivers of children	1
	Camp 17		Older persons	1
	Camp 19	Adults with disabilities		1
	Kutupalong RC		Children with disabilities	1
Teknaf	Camp 21	Caregivers of children		1
	Camp 24		Caregivers of children	1
	Camp 26	Older persons	Adults with disabilities	2
	Camp 27	Older persons		1
	Nayapara RC	Children with disabilities; Adults with disabilities	Children with disabilities	3
Total		**10**	**10**	**20**

Table 11 Number of FGD participants by gender, type of disability and overall[171]

Type of FGD	Gender of participants	Physical disability	Mental disability	Speech impairment	Sensory disability	Intellectual	Cerebral palsy	Not identified	None	Total
Older persons	Female	-	-	-	-	-	-	-	6	6
		-	-	-	-	-	-	-	6	6
		2	-	-	1	-	-	2	1	5
	Male	-	-	-	-	-	-	-	7	7
		5	1	-	2	-	-	-	-	6
		5	-	-	1	-	-	-	-	6
Adults with disabilities	Female	4	-	-	1	-	-	-	-	5
		4	1	-	-	-	-	-	-	4
		5	-	-	5	-	-	-	-	6
	Male	3	-	-	2	-	-	-	-	4
		3	-	1	1	-	-	-	-	5
		2	-	1	-	-	-	-	-	3
Children with disabilities	Female	3	-	-	2	1	-	-	-	6
		4	-	-	1	-	-	1	-	6
	Male	2	-	-	1	2	1	-	-	6
		1	-	-	1	2	-	3	-	7
Caregivers of children with disabilities[172]	Female	3	1	-	1	-	-	1	-	6
		7	1	-	5	-	-	-	-	7
	Male	3	1	6	-	-	-	-	-	7
		4	-	1	-	-	-	-	-	4
Total		**64**	**5**	**9**	**26**	**5**	**1**	**7**	**20**	**112**

[171] Some individuals were identified as having multiple types of disabilities. The total number of participants does therefore not equal the sum of participants across types of disability.
[172] The table indicates the participants' gender and the children's disability profiles.

Annex 4: Household survey training agenda

AGENDA

Age and Disability Inclusivity Assessment Training for REACH and NPM enumerators, November 2020 (facilitated by REACH and ADWG)

Purpose/Overall aim –

To enable, strengthen and improve the skills and capacity of enumerators to be able to conduct data collection for Age and Disability assessment to a high quality and ethical standard.

Learning outcomes –

- Understanding of the, objectives and purpose of the Age and Disability assessment
- Knowledge and understanding of research ethics (confidentiality, informed consent, do no harm)
- In-depth understanding of questionnaires

Timing –

- Please note that the timing will be: **8:30 am start** and **5:00 pm finish**.
- Two 15-minute breaks and one (1 hour) lunch break will be given across the day.
- Agenda time is a guide only. **Training venue**- Sea Palace

Date &Time	Session	Objectives	Facilitator
Training Day 1 – **Group B**, 8 November, 2020 (Sunday) / Training Day 2 – **Group A**, 9 November, 2020 (Monday)			
8:30-9:00 am	Registration		
9:00-9:15 am	Welcome & Introduction, learning objectives, Learning Agreement for the day	Understand purpose, objectives and agenda of the training Establish a learning agreement	REACH
9:15-10:00 am	Data collection instructions	Summarize the outline of core research principles (including AAP, PSEA, referrals)	REACH
10:00-11:00 am	Overview of research objectives and scope	Understanding basic research principles, random sampling	REACH
11:00-11:15 am	Morning break		
11:00-11.30 am	Research ethics and code of conduct	Identify challenges in surveying over the field and positive communication that supports a safe and comfortable interview	REACH
11:30-12.00 pm	Refresher on methodology	Opening part of the questionnaire (informed consent, basic information of caregiver/teacher)	REACH
12.00 pm – 1:00 pm	Introduction to questionnaire (Hard copy)	Question-by-question review of questionnaire, clarification of any issues	REACH
1:00-2:00 pm	Lunch break		
2:00-3:30 pm	Continuation of the questionnaire (Hard copy)	Question-by-question review of questionnaire, clarification of any issues	REACH

Date &Time	Session	Objectives	Facilitator
3:30 – 3:45 pm	Open questions	Clarification of any open questions	REACH
3:45-4:00 pm	Tea break		
4:00–4:45 pm	Continuation of the questionnaire (Hard copy)	Question-by-question review of questionnaire, clarification of any issues	REACH
4:45-5:00 pm	Open platform for questions	Clarification of any open questions	REACH
End of Day			
Training Day 2 – **Group B**, 8 November, 2020 (Monday) / Training Day 1 – **Group A**, 9 November, 2020 (Sunday)			
8:30-9:00 am	Registration		REACH
9:00-9:15 am	Learning objectives, Learning Agreement for the day	Develop clear participant expectations Establish a learning agreement	REACH
9:15 – 10:00 am	Review of day 1 learning		REACH
10:00-10:30 am	Welcome, intro, objectives	Ice breaking	CDD
10:30-11:00 am	Disability definition and types	Discussion	CDD
11:00-11:15 am	Morning break		
11:15-12:15 am	Inclusive communication, disability etiquette, inclusive facilitation	Group work	CDD
12:15-1:00pm	Questionnaire (WGSS-Enhanced+CFM), methods		CDD
1:00-2:00 pm	Lunch break		
2:00-3:30 pm	Mock FGDs & using tools with invited people with disabilities + findings Pictorial presentation of commonly used ADs		CDD
3:30–3:45 pm	Conclusion		All
3:45-4:00pm	Tea break		
4:00-5:00pm	Review of learning		REACH
End of day			
Training Day 3 – **Group A** 10 November, 2020 (Tuesday)			
8:30-9:00 am	Registration		
9:00-9:15 am	Learning objectives, Learning Agreement for the day	Develop clear participant expectations Establish a learning agreement	REACH
9:15-11:00 am	Questionnaire review using Kobo tool	KOBO form review	REACH
10:45-11:00 pm	Tea break		
11:00-1:00 pm	Mock interview session (small group between enumerators with team leader feedback within their small groups)	Exercise questionnaire with Kobo form	REACH
1:00-2:00 pm	Lunch break		
2:00-3:45 pm	HR / Security	HR and Security overview	REACH
3:45- 4.00 pm	Tea break		
4:00- 4.45 pm	Continuation of mock session	Exercise questionnaire with Kobo form	REACH

Date &Time	Session	Objectives	Facilitator
4.45 pm – 5.00 PM	Review (Day 1 & Day 2)	Refreshed memory on day 1 and day 2	REACH
End of day			
Training Day 3 – **Group B** 10 November, 2020 (Tuesday)			
8:30-9:00 am	Registration		
9:00-9:15 am	Learning objectives, Learning Agreement for the day	Develop clear participant expectations Establish a learning agreement	REACH
9:15-11:00 am	HR / Security	KOBO form review	REACH
10:45-11:00 pm	Tea break		
11:00-1:00 pm	Questionnaire review using Kobo tool	KOBO form review	REACH
1:00-2:00 pm	Lunch break		
2:00-3:45 pm	Mock interview session (small group between enumerators with team leader feedback within their small groups)	Exercise questionnaire with Kobo form	REACH
3:45- 4.00 pm	Tea break		
4:00-4.45 pm	Continuation of mock session	Exercise questionnaire with Kobo form	REACH
4.45–5.00 pm	Review (Day 1 & Day 2)	Refreshed memory on day 1 and day 2	REACH
End of day			

Annex 5: Focus group discussion training agenda

AGENDA

Age & Disability Assessment Focus Group Discussions Training – 26 and 27 January 2021

(jointly facilitated by ADWG/REACH)

Purpose/Overall aim

To strengthen the skills of enumerators to conduct data collection for the age and disability assessment focus group discussion (FGD) component adhering to high quality and ethical standards.

Learning outcomes

- Understanding the objectives and purpose of the age and disability assessment and in particular the FGD component
- Knowledge and understanding of key principles and research ethics: confidentiality, informed consent, do no harm and best interest of the child
- Refreshed memory on the good practice on communicating effectively with adults, children and elderly with disability, as well as elderly people in general and caregivers of children with disability

Timing

- Please note that the timing will be: **9:30 am start** and **4:30 pm finish**
- Two 15 minute breaks and one (1 hour) lunch break will be given across the day
- Agenda time is a guide only

Venue

- ISCG Coordination Hub, Ukhiya

Time	Session	Objectives	Facilitator
DAY 1			
09:30	Sign in	Sign in sheet	REACH
Session 1 – Welcome and introduction			
09:30 – 09:45 am	• Formal opening/ introductions • Objectives and expectations • Learning agreement	• Understanding of purpose, objectives and agenda of training • Understanding of participants' expectations • Establishing a learning agreement	REACH
Session 2 – Assessment objectives, roles and responsibilities, practical considerations			
09:45 – 10:15 am	• Introduction to the assessment • Introduction to the FGD component	• Understanding of assessment objectives • Understanding of the purpose of the FGD component	REACH
Tea break (10:15– 10:30 am)			
10:30 – 11:00 am	• Roles and responsibilities	• Clarification of REACH and partner roles and responsibilities • Clarification of lines of communication	REACH
11:00 – 11:30 am	• Schedule of FGDs • Logistics • Daily debriefing sessions	• Common understanding of data collection plan • Common understanding of logistical procedures	REACH

Time	Session	Objectives	Facilitator
		• Understanding purpose of and process of daily debriefing sessions, especially the outputs to be provided	
Session 3 – Basics of FGDs			
11:30 – 12:00 am	• Introduction to FGDs	• Understanding purpose of FGDs • Understanding basic requirements, and roles and responsibilities before, during and after FGDs	REACH
Session 4 – Introduction to the tool and simulation			
12:00 – 1:00 pm	• Introduction to the tool	• Understanding the intent and wording of all questions and probes for all types of FGDs	REACH
Lunch (1:00– 2:00 pm)			
2:00 – 2:30 pm	• Introduction to the tool (con't)	• Understanding the intent and wording of all questions and probes for all types of FGDs	REACH
2:30 – 4:00 pm	• Simulation • Feedback	• Tool testing • Identification of any issues to be corrected before data collection	REACH
4:00 – 4:30pm	• Wrap-up	• Clarification of any open questions • Wrap-up and feedback on the first day	REACH
DAY 2			
09:30	Sign in	Sign in sheet	REACH
Session 1 – Ethical considerations and communication with people with disability/elderly			
10:00 – 12:00 pm	• Disability definition and types • Communication etiquette & inclusive facilitation • Age & Disability Service Matrix	• Improved understanding on disability so that participants can contribute better in the FGD • To better communicate and engage with the Persons with Disabilities • Referral beneficiaries with disability to appropriate rehabilitation services	CDD & CBM
12:00 – 1:00pm	• Ethical consideration • Confidentiality • Informed Consent • Do no harm • Preparation, do's and don'ts during the interviews	• Understanding of necessary steps to ensure confidentiality • Understanding informed consent as well as informed assent for children and how to seek it • Understanding of risks and strategies to ensure do no harm, including safety, privacy, when to withdraw, potential for harm, stigmatisation, etc • Understanding steps to ensure participants are safe and comfortable during the FGD	HI
Lunch (1:00-2:00 pm)			
Session 2 – Simulation			
2:00 – 4:00 pm	• Mock session (small group between participants with person with disabilities) • Feedback	• Exercise FGD questionnaire • Identification of any issues to be corrected before data collection	CDD & CBM, SHG members
4:00 – 4:30pm	• Wrap-up	• Clarification of any open questions • Wrap-up and feedback on training	REACH/HI

Annex 6: Co-occurrence of functional difficulties across major domains

The assessment found an overlap between domains, such that one person was sometimes reported as having difficulties in functioning in several domains at the same time. Table 12 below shows the degree of overlap for the main domains – those for which representative results were achieved – presented throughout the report. For instance, 5% of persons with difficulties in functioning in the vision domain were also reported as having difficulties in functioning in the hearing domain; 52% of persons with difficulties in functioning in the vision domain were also reported as having difficulties in functioning in the mobility domain, etc. In turn, 9% and 16% of persons with difficulties in functioning in the hearing and mobility domains, respectively, were also reported as having difficulties in functioning in the vision domain.

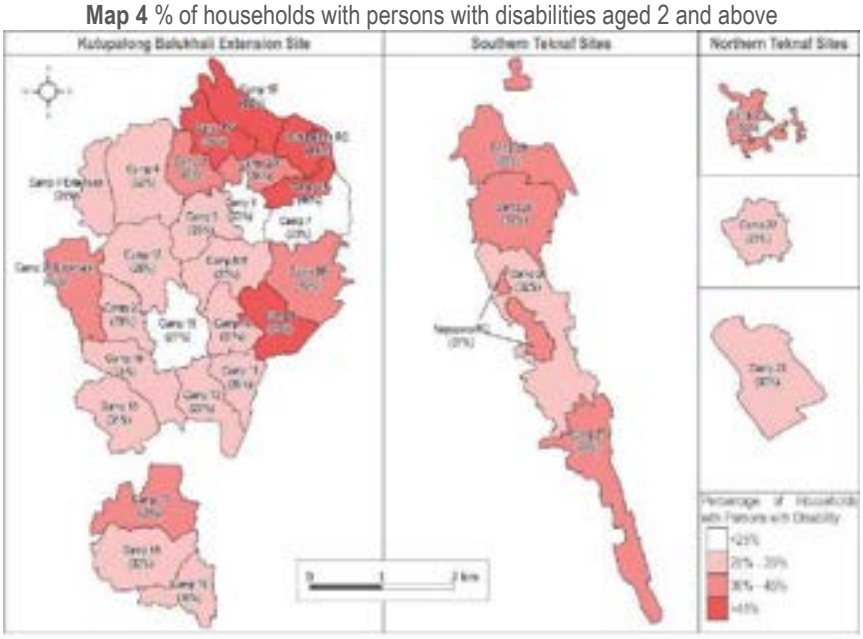
Table 12 % of persons with difficulties in functioning in one domain also reporting difficulties in functioning in other domains, by type of functional difficulty

			Of persons with difficulties in functioning in this domain…							
			Ages 2-99			Ages 5-99			Ages 18-99	
			Vision	Hearing	Mobility	Self-care	Anxiety	Depression	Upper body movement	Cognition
… % of individuals also in this domain	Ages 2-99	Vision		9%	16%	13%	4%	6%	20%	16%
		Hearing	5%		5%	8%	2%	3%	5%	15%
		Mobility	52%	25%		79%	14%	20%	80%	58%
	Ages 5-99	Self-care	16%	16%	28%		6%	9%	52%	32%
		Anxiety	37%	32%	41%	51%		81%	46%	40%
		Depression	37%	37%	37%	49%	52%		48%	53%
	Ages 18-99	Upper body movement	21%	12%	25%	51%	5%	8%		22%
		Cognition	15%	29%	15%	26%	4%	7%	19%	

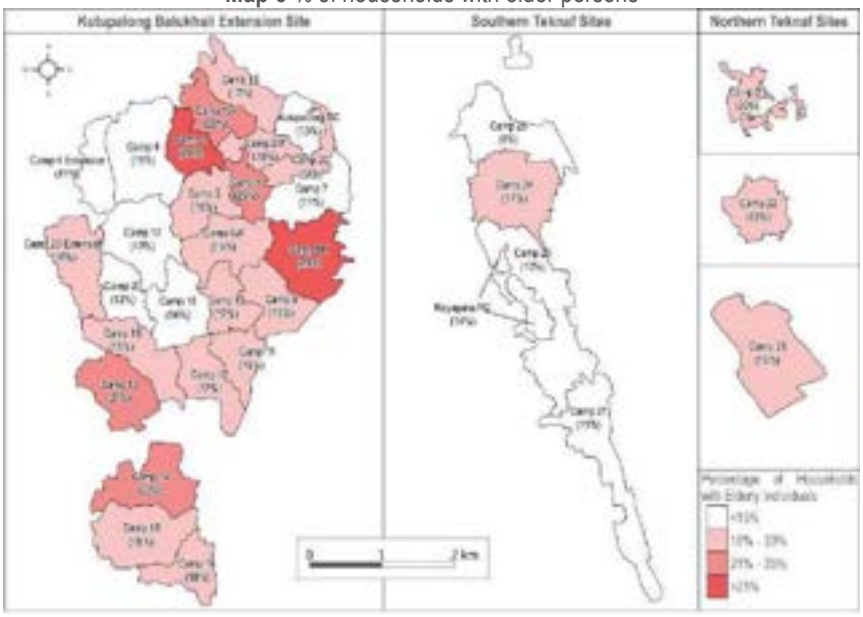
Annex 7: Prevalence of persons with disabilities and older persons at the household level (maps)

Disability prevalence maps can be found in A4-format online.

Map 4 % of households with persons with disabilities aged 2 and above



Map 5 % of households with older persons



Annex 8: Additional significance testing results by domain of functional difficulty

The assessment found an overlap between domains (compare Table 12 in annex 6), such that one person was sometimes reported as having difficulties in functioning in several domains at the same time. Therefore, reported barriers may often be related to a combination of functional difficulties rather than being attributable to one functional difficulty. For instance, if 50% of persons with difficulties in functioning in the mobility domain were reported as facing a specific barrier, this barrier could be interpreted as affecting in particular persons with difficulties in functioning in the mobility domain. However, it may also be that many of those 50% also faced other difficulties in functioning and the reported barrier was rather related to those. Therefore, in order to still be able to analyse the relationship between reported barriers and domains of functional difficulty, results for persons with difficulties in functioning in a specific domain were compared to results for persons with difficulties in functioning in any domain, i.e. persons with disabilities, but no difficulties in functioning in this specific domain. If persons with difficulties in functioning in the specific domain under consideration were particularly affected by the reported barrier, a statistically significant difference in results between those two groups would be expected. If they were not particularly affected, no significant difference between the two groups would be expected.

The p-values reported below indicate cases for which significant differences were found and a relationship between the reported barrier and the specific functional difficulty may therefore exist. Persons with difficulties in functioning in the anxiety or depression domains only were excluded from this analysis. Moreover, due to the non-representativeness of the samples of persons with difficulties in functioning in the anxiety or depression domains, no significance testing was conducted for those groups (see "Challenges and limitations" for further explanation). Neither were significance tests conducted for persons with difficulties in functioning in other domains with insufficient sample sizes to achieve representative results.

Table 13 % of persons with disabilities aged 2 and above reportedly facing difficulties moving inside shelters without support from others by reason, by inclusion in specific domains of disability[173]

Domain	Functional difficulty in this domain	Door openings too small	Thres-holds between rooms	Floor not level	Lack of handrail	Not enough space to turn around	Any challenge
Upper body movement	No (n = 302)	**6%****	8%	9%	33%	34%	**53%****
	Yes (n = 89)	**16%****	11%	16%	35%	46%	**70%****
Self-care	No (n = 358)	**4%******	**6%***	**8%***	**26%******	**30%******	**45%******
	Yes (n = 107)	**19%******	**13%***	**16%***	**49%******	**53%******	**79%******
Mobility	No (n = 185)	**1%******	**1%******	**4%****	**12%******	**17%******	**26%******
	Yes (n = 302)	**11%******	**12%******	**12%****	**42%******	**44%******	**67%******
Vision	No (n = 385)	8%	7%	10%	**27%****	**32%***	50%
	Yes (n = 97)	5%	10%	6%	**42%****	**45%***	59%
Cognition	No (n = 320)	8%	9%	12%	34%	38%	59%
	Yes (n = 72)	7%	8%	5%	32%	32%	50%
Hearing	No (n = 419)	7%	9%*	9%	32%**	35%	53%*

[173] Results for domains of disability for which significant differences were found are shown. Levels of confidence are denoted as follows: p-value < 0.05 (*), p-value < 0.01 (**), p-value < 0.001 (***), and p-value < 0.0001 (****). Sample sizes n are indicated in parentheses below the results.

Domain	Functional difficulty in this domain	Door openings too small	Thres-holds between rooms	Floor not level	Lack of handrail	Not enough space to turn around	Any challenge
	Yes (n = 61)	10%	2%*	6%	15%**	26%	36%*
Learning	No (n = 48)	4%	0%*	2%	21%	25%	34%
	Yes (n = 48)	7%	9%*	2%	17%	21%	28%
Communication	No (n = 436)	8%	8%	9%	33%*	36%	54%*
	Yes (n = 52)	7%	2%	6%	17%*	26%	34%*

Table 14 % of persons with disabilities aged 15 and above reportedly facing difficulties moving around camps by reason, by inclusion in specific domains of disability[174]

Domain	Functional difficulty in this domain	Paths unstable/ uneven	Difficulty crossing roads	Surfaces slippery/ uneven	Stairs too steep	Pathways too steep	Any challenge
Self-care	No (n = 321)	**19%****	**18%*****	33%	53%	52%	**74%***
	Yes (n = 90)	**33%****	**42%*****	44%	51%	63%	**85%*****
Mobility	No (n = 131)	**12%****	**14%***	**27%***	**28%*****	**27%*****	**51%*****
	Yes (n = 280)	**26%****	**27%***	**40%***	**63%*****	**66%*****	**87%*****
Upper body movement	No (n = 302)	22%	23%	39%	54%	56%	79%
	Yes (n = 89)	23%	26%	33%	51%	54%	76%
Vision	No (n = 317)	22%	22%	34%	51%	53%	75%
	Yes (n = 87)	22%	31%	45%	53%	57%	80%
Cognition	No (n = 320)	23%	23%	39%	56%*	59%*	80%*
	Yes (n = 72)	18%	27%	29%	40%*	42%*	68%*
Hearing	No (n = 361)	23%	24%	37%	55%**	57%**	78%**
	Yes (n = 48)	15%	20%	29%	30%**	30%**	58%**

Table 15 % of persons with disabilities aged 2 and above reportedly unable to use latrines or shower without support from others, by inclusion in specific domains of disability[174]

Domain	Functional difficulty in this domain	Unable to use latrines	Unable to shower
Upper body movement	No (n = 302)	**25%*****	**26%*****
	Yes (n = 89)	**49%*****	**59%*****
Self-care	No (n = 358)	**17%*****	**20%*****
	Yes (n = 107)	**68%*****	**77%*****

[174] Results for domains of disability for which significant differences were found are shown. Levels of confidence are denoted as follows: p-value < 0.05 (*), p-value < 0.01 (**), p-value < 0.001 (***), and p-value < 0.0001 (****). Sample sizes n are indicated in parentheses below the results.

Domain	Functional difficulty in this domain	Unable to use latrines	Unable to shower
Mobility	No (n = 184)	**13%******	**20%******
	Yes (n = 302)	**40%******	**43%******
Vision	No (n = 385)	31%	35%
	Yes (n = 97)	27%	30%
Cognition	No (n = 320)	30%	34%
	Yes (n = 72)	30%	33%
Hearing	No (n = 419)	32%*	35%
	Yes (n = 61)	16%*	23%
Learning	No (n = 48)	27%	31%
	Yes (n = 48)	36%	43%
Communication	No (n = 436)	31%	35%
	Yes (n = 52)	25%	34%

Table 16 % of persons with disabilities aged 15 and above reportedly having accessed different WASH services in the month prior to data collection, by inclusion in specific domains of disability[175]

Domain	Functional difficulty in this domain	Not accessible latrine		Accessible latrine		Bathing facilities
		Public	Private	Public	Private	Public
Upper body movement	No (n = 302)	**85%****	12%	0.4%	**1%*****	**35%****
	Yes (n = 89)	**71%****	20%	1%	**7%*****	**17%****
Self-care	No (n = 321)	**88%******	**11%****	**0%****	**1%******	**35%****
	Yes (n = 90)	**65%******	**23%****	**2%****	**7%******	**19%****
Mobility	No (n = 131)	87%	12%	5%	**0%***	35%
	Yes (n = 280)	80%	15%	5%	**3%***	30%
Vision	No (n = 317)	81%*	15%	1%	3%	32%
	Yes (n = 87)	91%*	8%	0%	0%	27%
Cognition	No (n = 320)	80%*	16%	1%	3%	31%
	Yes (n = 72)	93%*	6%	0%	1%	31%
Hearing	No (n = 361)	81%*	15%	1%	3%	30%
	Yes (n = 48)	93%*	6%	0%	0%	41%

[175] Results for domains of disability for which significant differences were found are shown. Levels of confidence are denoted as follows: p-value < 0.05 (*), p-value < 0.01 (**), p-value < 0.001 (***), and p-value < 0.0001 (****). Sample sizes n are indicated in parentheses below the results.

Table 17 % of persons with disabilities aged 15 and above reporting preferred means of accessing information about services in camps, by inclusion in specific domains of disability[176]

Domain	Functional difficulty in this domain	In-person	Group meetings	Loud-speakers	Written materials	Phone call
Upper body movement	No (n = 302)	49%	**5%*****	36%	6%	3%
	Yes (n = 89)	47%	**17%*****	27%	5%	2%
Self-care	No (n = 321)	48%	7%	31%	7%	**4%***
	Yes (n = 90)	46%	9%	37%	4%	**1%***
Hearing	No (n = 361)	49%	**9%****	31%	7%	3%
	Yes (n = 48)	47%	**1%****	43%	2%	4%
Vision	No (n = 317)	49%	8%	30%	7%	**4%***
	Yes (n = 87)	47%	7%	41%	3%	**0.5%***
Cognition	No (n = 320)	48%	8%	33%	6%	2%
	Yes (n = 72)	48%	8%	37%	3%	4%
Mobility	No (n = 131)	49%	9%	33%	5%	2%
	Yes (n = 280)	47%	7%	32%	6%	4%

Table 18 % of persons with disabilities aged 15 and above reporting preferred means of communication to hear about upcoming cyclones or similar hazards, by inclusion in specific domains of disability[176]

Domain	Functional difficulty in this domain	Loudspeaker	In-person	Warning flags	Phone call
Upper body movement	No (n = 302)	**94%*****	**59%****	**34%****	**5%***
	Yes (n = 89)	**82%*****	**79%****	**17%****	**11%***
Self-care	No (n = 321)	92%	**59%***	**34%***	7%
	Yes (n = 90)	87%	**73%***	**21%***	9%
Mobility	No (n = 131)	93%	57%		7%
	Yes (n = 280)	90%	64%		7%
Vision	No (n = 317)	91%	65%		7%
	Yes (n = 87)	91%	54%		6%
Cognition	No (n = 320)	92%	62%		6%
	Yes (n = 72)	86%	69%		8%
Hearing	No (n = 361)	91%	64%		7%
	Yes (n = 48)	90%	54%		7%

[176] Results for domains of disability for which significant differences were found are shown. Levels of confidence are denoted as follows: p-value < 0.05 (*), p-value < 0.01 (**), p-value < 0.001 (***), and p-value < 0.0001 (****). Sample sizes n are indicated in parentheses below the results.