Cox's Bazar

Settlement and Protection Profiling: Round 5

Report

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About REACH

REACH Initiative 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). As part of Alliance 2015, REACH Initiative is hosted in Bangladesh as a technical partner of Helvetas Swiss Intercooperation Bangladesh. 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.

CONTENTS

List of Acronyms

CiC	Camp in Charge
IOM-NPM	International Organization for Migration-Needs and Population Monitoring
ISCG	Inter-Sector Coordination Group
MSNA	Multi-sector needs assessment
NFIs	Non-food items
NGO	Non-governmental organisation
ODI	Overseas Development Institute
RC	Registered camp
REVA	Refugee influx Emergency Vulnerability Assessment
SPP	Settlement and Protection Profiling
TWB	Translators Without Borders
UNHCR	The UN Refugee Agency
UNOSAT	United Nations Operational Satellite Applications Programme
WASH	Water, sanitation and hygiene
WGSS	Washington Group short set of questions on disability

List of Figures and Maps

SUMMARY AND INTRODUCTION

Since August 2017, an estimated 741,000 Rohingya refugees have fled from Myanmar into Cox's Bazar, Bangladesh, increasing the total number of refugees to around 910,000.[1] The majority are reliant on overstretched humanitarian assistance, services, and resources including shelter, food, clean water, and sanitation. Information on Rohingya households, particularly in relation to protection and services, is in need of regular updating due to the variation in service provision across settlements, challenges presented by the monsoon and cyclone seasons, and the evolving social and contextual dynamics within each settlement.

REACH, in partnership with the Office of the United Nations High Commissioner for Refugees (UNHCR), conducts Settlement and Protection Profiling (SPP) assessments to support evidence-based monitoring and analysis of cross-cutting protection issues in Rohingya refugee settlements. The current round of assessment (round 5) focused on household-reported quality of life and safety in the camps, as well as vulnerabilities, demographics, and access to key services. This report compiles and summarises the key findings of SPP Round 5 and, whenever data allows, provides a comparative analysis with data from SPP round 4 in December 2018, to analyse trends over time. Please note that the assessment is not a tool for identification or monitoring of individual protection cases.

The fifth round of SPP was conducted in 33 out of 34 camps in Cox's Bazar District from 25 June - 5 August, 2019, with Kutupalong Registered Camp (RC) being the only exception due to security considerations at that time. Surveys were conducted with households selected through simple random sampling of shelter footprints. Findings for this report are generalisable to the refugee population living in all 33 accessible camps at a 95% confidence level and a 2% margin of error, based on interviews with 3,335 households.

Key Findings

Feelings of safety and security in the community

Findings point to persistent trends in perception of risk among the overall population and protection concerns affecting specific vulnerable groups. Households' reported perception of risk for adults has decreased since the previous round and was comparatively low, relative to reported perception of risk for boys and girls. For boys and girls, the fear of kidnapping was cited by roughly half of households. Reported prevalence of family separation was relatively low, inclusive of separated and unaccompanied minors, missing family members, or family members in detention, but was likely underreported when compared with larger numbers suggested by new cases of separated children as captured by child protection case workers. Reported rates of current or planned early marriage of children under 18 were consistent with the previous round of assessment (7% of households), and findings on justifications for early marriage suggest that this practice may be exacerbated by the challenges of displacement. Findings indicate a high prevalence of signs of distress among the population, reportedly affecting over half of households and disproportionately affecting adult women.

Majhis[2] continued to be the most frequently cited first port of call for reporting safety and security incidents, including general safety concerns, violence against children, and gender-based violence. Findings indicate that the proportion of households citing *majhis* as first port of call for reporting disputes and security incidents is largely consistent with the previous round. Awareness of alternative community level protection, or community watch groups operating during the day, decreased since the previous round.

The assessment highlights areas in which camp structures and facilities directly impacted feelings of safety and security in the camps. Improved roads and paths were the most cited necessary intervention to improve safety and security in the camp. Moreover, a lack of lighting in the camps was found to be preventing universally safe access to camp facilities. Lack of lighting at latrines in particular was a protection concern for a majority of households. This is supported by over half of households citing solar lighting as their most urgent priority need, increasing significantly since the previous round. A majority of the 11% of households that reported paying rent were worried about meeting

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[1] UNHCR, "Population data and key demographical indicator (Block Level), 31 August 2019" (accessed 24 September 2019).

[2] *Majhis* are Rohingya refugees appointed by the Bangladeshi Army to support camp management authorities and the police in maintaining order in the camps, and acting as focal points for camp management activities at the block level. These individuals were selected rapidly after the onset of the crisis without any formal process. See ACAPS, *Rohingya Crisis Governance and community participation* (Cox's Bazar, June 2018) p. 2-3 (accessed 17 November 2019).

rent payments, and roughly one third were concerned about the threat of physical harm as a result of being unable to pay rent to host communities. Findings indicate little improvement on reported rates of shelter locks. Declining use of firewood in favour of fuel has likely mitigated the risks associated with firewood collection.

Gaps in meaningful access to services

The assessment aimed to further understand household access to a wide range of basic services, in order to highlight potential barriers to equitable and dignified service provision for all. A large majority of households reported access barriers to camp healthcare facilities, widely reporting overcrowding, excessive distances to facilities, and an unavailability of medicine and medical supplies. Half of households were reportedly unable to access the treatment they needed in the 30 days prior to data collection. Consistent with the previous round, many households incurred costs to supplement treatment in response to gaps in access to healthcare facilities, and households in many cases did not receive the treatment that they felt they needed. Over half of households reported concerns about receiving insufficient food or having insufficient funds to buy food, even though food distribution coverage was reported at 96%. Concerns about inadequate nutrition and limited variety in food distributions have decreased since the previous round, but remained pertinent nonetheless. Households tended to rely on borrowing food or limiting food consumption as coping mechanisms, which is consistent with the previous round.

The ability of all groups to access basic services was examined by the assessment, with findings indicating specific challenges to service access faced by women and children. Households were widely concerned about limitations to education curriculum, and reported a lack of appropriate educational programming for older students, with attendance rates for boys from 6-14 years old reported at a higher rate than for girls. The knock-on effect of poor educational opportunities for children on their future prospects and job opportunities was a wide concern among households, consistent with the previous round. More than half of men and women reported facing problems accessing latrines, with overcrowding reported as the primary barrier to access for over half the population. Latrines being full affected more than a third of households, and lack of gender separation at latrines disproportionately affected females. Lack of gender separation at bathing facilities was linked to female household members predominantly bathing inside their shelters.

Concerns for specific sub-groups

Households with elderly individuals: While elderly individuals are a small proportion of the population, they face barriers to accessing services and have comparatively aggravated wellbeing considerations. Roughly half of elderly individuals faced challenges with mobility, and were twice as likely to require medical treatment than the general population, with elderly women disproportionately affected. Elderly individuals were also more likely to suffer from diarrhoea and incontinence. Insufficient consideration for this particularly vulnerable group in service design, and uneven camp terrain likely contributed to barriers in accessing healthcare, WASH and education services for elderly individuals.

Households with members with a disability: Findings indicated that one tenth of households included members with disabilities, which was likely under reported since the Washington Group Questions on disability were answered by proxy from the chosen respondent, and were not asked about each individual household member. Households reporting the presence of at least one individual living with a disability were more likely to report health services and medicine as a priority need, and individuals with disabilities were reported to be more likely to face challenges in accessing and using WASH services, including latrines, water points and bathing facilities, as well as being more likely to suffer from diarrhoea than the general population.

Children: School attendance rates for children aged 6-14 were found to drop off after the age of 11, with girls disproportionately affected, in part due to cultural norms. Lack of age appropriate curricula was a reported barrier to education for both boys and girls. There was no change in reported rates of children under 5 being ill with diarrhoea in the 2 weeks preceding data collection when compared with the previous round, with one fifth of children under 5 affected.

Gender: Additional findings highlighting responses disaggregated by gender can be found here: https://data2.unhcr.org/en/documents/download/71873
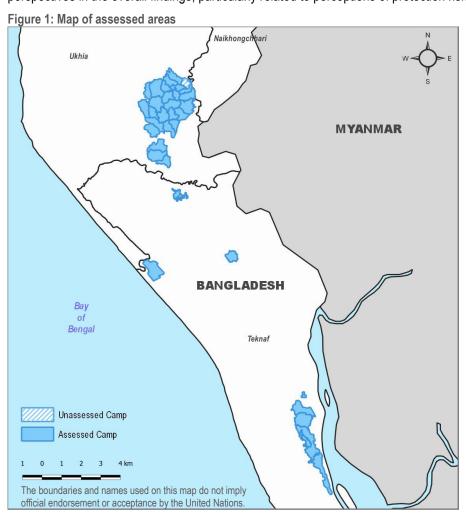
METHODOLOGY

Indicators and tool design

Research questions and indicators included in this latest round of assessment were drawn from the previous round of the assessment and refined in collaboration with UNHCR and Protection Working Group partners. Following review and validation by REACH technical staff in Geneva, tools were translated into Rohingya with support from Translators Without Borders (TWB).

Household survey sampling and methodology

REACH collected primary data using a quantitative household survey in 33 Rohingya refugee settlements. Household data collection took place from 25 June - 5 August 2019, covering 3,335 households (see Map 1 for an overview of camps covered by the assessment). Enumerator teams consisted of 50% male and 50% female enumerators to allow for equal numbers of respondents by gender and to capture male and female refugee perspectives in the overall findings, particularly related to perceptions of protection risks and concerns.

Figure 1: Map of assessed areas

The selection of households was conducted through a stratified random sample approach to collect data on the population of interest. REACH overlaid ISCG camp boundaries onto REACH/UNOSAT shelter footprint data[3] to identify camps and generate random distribution of GPS points, with each point indicating a shelter to be surveyed. Enumerators navigated to the GPS points to interview a consenting adult household member of their own gender most knowledgeable about household affairs who could answer on behalf of the household. An estimated 25% non-eligibility rate was factored into sample size estimates to account for instances where eligible respondents might be absent from the household, or where GPS points might fall on structures other than shelters (mosques, schools etc.).

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[3] Available at https://data.humdata.org/dataset/bangladesh-refugee-camp-infrastructure-foot-print-january-2019 (accessed 18 September 2019).

Findings are representative at the settlement level, and are aggregated within this report to be generalisable for all Rohingya refugees living within the 33 assessed camps with a 95% confidence level and 2% margin of error.

Data cleaning and analysis

Data checking and cleaning was carried out on a daily basis according to a pre-determined set of data cleaning standard operating procedures. Cleaning included the removal of identifying data, outlier checks, correct categorisation of "other" responses and the identification and removal of incomplete or inaccurate records. Changes were documented in a data cleaning log and cleaned and raw data was validated by technical specialists at REACH's Geneva-based Research Department.

Following the finalisation of tools and feedback from UNHCR, a data analysis plan for the assessment was developed, ensuring linkages between questionnaire responses and the indicators measured to address research questions. Data analysis was conducted accordingly using RStudio software, developed in the field and validated in Geneva.

Challenges and Limitations

There are several limitations on the collected data which should be considered in interpreting and applying findings to decision-making or response planning:

Sampling

- **Coverage:** Kutupalong registered camp (RC) was not included in the study, due to concerns around security of enumerator teams related to community hostility toward aid providers in this camp. Aggregate findings therefore cannot be extrapolated to the population of this camp.
- **Confidence levels and precision of findings:** Questions that were only asked to a sub-set of the population, such as households with elderly individuals or school-aged children, have a smaller sample size and thus will have a higher margin of error. All questions asked to a sub-set of the population are referenced accordingly throughout this report.
- **Sampling bias:** The sampling approach used could have skewed the probability of some households being selected for interview relative to others, such as households who do not have any shelter, child-headed households, or households with eligible members likely to be out of the home due to work. These households would not be identified by shelter footprint data or would not be eligible for interview, which could account for some small differences in results.

Data collection

- **Proxy reporting:** As the household survey required data on individuals to be collected by proxy from the chosen respondent and not directly from household members themselves, biased or inaccurate reporting on individuals by their proxies may have occurred.
- **Questions on perception**: Questions on household perceptions do not directly reflect the realities of service provision or security conditions within the camps, but rather indicate the respondent's perceptions of them.
- **Sensitive topics:** Further to the limitations regarding perception-based questions, respondents may have been uncomfortable or unwilling to answer questions relating to sensitive topics such as feelings of safety, and perceived risks for individuals. As such, findings may be an under-estimation of household perceptions of risks.
- **Respondent bias:** Some indicators may be over-reported or under-reported due to perceptions of respondents, such as social desirability bias (perceived pressure to give the "right" answer to a question). This is likely to have influenced the responses to key questions, such as those determining priority needs.

It is worth noting that while quantitative instruments are valuable in determining types of issues being reported, relative scale of reporting of issues and changes over time, they are inherently limited in capturing complex, nuanced data that focuses on how and why things occur, or sensitive information that might require building rapport with participants to discuss. As a consequence, perception-based results in particular should be triangulated with alternative, qualitative data sources.

FINDINGS

This section presents the main findings of round 5 of the SPP assessment. First, it outlines key findings for protection-related indicators. It then moves on to examine access to key services through a protection mainstreaming lens, including health, shelter and non-food items (NFI), food security, education, water, sanitation and hygiene (WASH), and communication with communities in support. Where relevant, this section presents comparative analysis of findings with the previously conducted SPP Round 4, for which data collection was completed in November – December 2018. Wherever possible, findings are triangulated and compared with secondary data sources.

Protection

Perceptions of safety and security

The study collected information on household-reported safety and perceived risks to establish common protection concerns within the refugee community. The quantitative instrument employed for this survey indicates distinct types of protection issues being reported, and their variation over time, but likely resulted in under-reporting of protection concerns and over-reporting of satisfaction or "no issues". When households were asked direct questions about feelings of safety, findings tended toward high reported levels of safety, with 90% of households reportedly feeling safe in their place of residence. However, further questioning on perceived security and risks revealed trends in safety concerns among the population.

Reported perception of risk for adults was relatively low, with no perceived issues reported for adult men by 38% of households, and for adult women by 48% of households, largely unchanged when compared with the previous round of assessment. The trend of high reported levels of safety for adults is further illustrated by a lower percentage of households reporting the risk of recruitment by armed elements[4], particularly for men (decreased from 19% to 9% this round), and reported rates of violence within the home for women, decreasing from 21% to 6% since the previous round. This trend was similarly pronounced in the lower percentage of households that cited fear of kidnapping[4] as a concern for both adult men (decreased from 39% to 33%) and adult women (decreased from 34% to 24%), compared to the previous round in December 2018. These data are supported by findings from a household survey conducted by Ground Truth Solutions in April 2019, in which respondents reported that safety within shelters and camps has improved since August 2018, and commonly reported no perceived safety issues for adults.[5] When reporting on risks for adults, male respondents were somewhat more likely to cite issues such as risk of recruitment by armed elements, risk of trafficking, and risk of detention as risks for both genders[4]. Female respondents were more likely to cite general "violence in the community" which could be a reflection of the differing exposure of males and females and the spaces that they occupy.

Perceptions of risk were more commonly reported for boys and girls relative to adults, with kidnapping followed by trafficking cited as primary safety concerns. Nearly half of all households reported kidnapping in the camps as a risk for boys (48%), and to a slightly lesser extent for girls (44%). Reported fear of trafficking was less pronounced, but remained a considerable perceived risk for children under 18, reported as a concern for boys by 28% of households, and for girls by 23%. This finding is consistent with the findings of the January 2019 UNHCR/REACH multi-sector needs assessment (MSNA II), which similarly cited kidnapping as the primary safety concern for children under 18, (66% for boys, 52% for girls).[6] Of households reporting kidnapping as a concern for adults or children, more than half of the respondents suspected that perpetrators might come from outside of the camps.[7] In keeping with overall trends, responses similarly varied significantly by gender of respondent, with male respondents much more likely to report trafficking or kidnapping as potential risks for children of both sexes, while female respondents were more likely to report no perceived risks or issues whatsoever.

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[4] These results are based on the respondent's subjective perception of risks in the camp, and not the actual number of security incidents.

[5] It is noted that the results of these surveys are not generalisable to the overall refugee population and therefore no direct comparison between findings can be drawn. Ground Truth Solutions, *Rohingya Bulletin, Safety and Outlook* (Cox's Bazar, April 2019), p.2 (accessed 17 November 2019).

[6] UNHCR/REACH Initiative, *Multi-Sector Needs Assessment II*, (Cox's Bazar, January 2019), p. 2.

[7] This question was asked to households that identified "kidnapping" as a risk for individuals in the camp (n=2,111), with more than one response possible. Findings are representative at 95% confidence level and 12% margin of error.

Other risks for children were reported by a lower proportion of households overall, including risks of sexual assault for girls (11%), recruitment by armed elements for boys (4%), and violence in the camps in general (13%).[8] By contrast, the findings of the MSNA II, show that 47% of the population were concerned about sexual violence for girls, 35% were concerned about recruitment by armed elements for boys, and violence in the community was a broad concern for both sexes, disproportionately affecting young males (52% for boys, 31% for girls).[9] This suggests a potential downward trend in prevalence of these safety concerns among the population.

Findings suggest that male respondents were much more likely than female respondents to report on more types of risks for both genders, and reported risk at a higher rate. Male respondents were significantly more likely than female respondents to report sexual assault as a perceived issue for girls, (reported by 17% of male respondents and 3% of females) and for adult women (reported by 28% of male respondents and 4% females). The data do not offer any insight into why this difference occurs, but findings are largely contradictory when compared to a recent qualitative survey conducted by BBC Media Action on violence against women within the Rohingya community, which finds that Rohingya men perceived no risk of sexual abuse inside the camps, while women report sexual harassment from men in their own community.[10] Contradictory findings suggest that more in-depth qualitative research may be necessary to better understand attitudes toward and dynamics of gender-based violence in the Rohingya community.
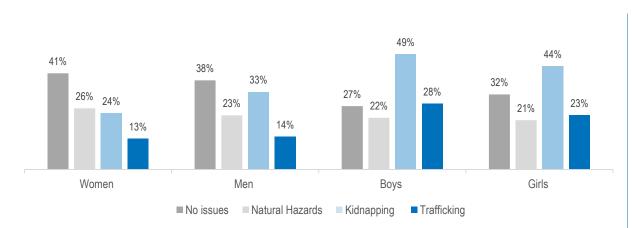
Figure 2: % of households reporting perceived risks faced by individuals in the camp

Individual and collective responses to safety issues

When presented with a series of hypothetical security incidents, households generally said that they would report these incidents, with *majhis* almost unanimously reported as the first port of call for assistance. Similar trends in reporting practices were found for varying types of security incidents, including serious disputes with someone inside or outside of the camp, and in the event that a household member witnessed a serious incident, such as a robbery or fight.[11] Findings from this round of assessment are largely consistent with December 2018 SPP Round 4 data, in which rates of reporting disputes inside the camps were identical, with 94% identifying *majhis* as preferred focal points for reporting, and 54% identifying government Camp in Charges (CiCs). Overall trends in reporting security incidents to the *majhis* and CiCs were also broadly similar. Consistent with key informant findings from the International Organization for Migration-Needs and Population Monitoring (IOM-NPM) Site Assessments conducted in June and MSNA II, households were most likely to report their issues and concerns to *majhis* (86%), though a higher proportion of households in this recent round cited the CiCs for serious incidents (63%), compared to MSNA II findings from January 2019 (29%). When assessing gender disaggregated data, the trend of reporting to *majhi* as first port of call was evident for both male and female respondents. However, it should be noted that male respondents were more likely to cite more points of contact than female respondents, which may indicate a higher awareness of overall available support and resources among men.

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[8] These results are based on the respondent's subjective perception of risks in the camp, and not the actual number of security incidents.
[9] UNHCR/REACH, *MSNA II*, p. 2.
[10] BBC Media Action, *Violence against women within the Rohingya community* (Cox's Bazar, November 2018), p. 12 (accessed 17 November 2019).
[11] International Organization for Migration-Needs and Population Monitoring (IOM-NPM), *Site Assessment: Round 15* (Cox's Bazar, June 2019), p.15 (accessed 24 September 2019).

Across all camps, three out of four people indicated that they would report to someone if they knew a child in their area was experiencing violence, abuse or neglect. Of these, an overwhelming majority reported that they would go to *majhis* (95%), followed by CiCs (38%), as their first port of call.[12] Of the 38% of the overall population that would not report an incidence of violence against children, a large majority of households reported the reason being that they would try to intervene first (79%).[13] Furthermore, J-MSNA data collected in August 2019, show that a large majority of households would go to the *majhi* as their preferred point of contact if they needed to refer a friend who was sexually assaulted for care and support.[14] Appointed by the Bangladeshi authorities after the onset of the crisis, *majhis* are a critical focus of block-level governance and decision-making, as they represent one of the key forms of representation for Rohingya. However, refugee reliance on them as suggested by survey findings, could present concern in some cases, given that other data sources suggest that the *majhi* system does not meet minimum standards of representation and impartiality.[15] Protection sector assessments of the *majhi* system observe that it does not accurately reflect the composition of age, gender and diversity of the refugee population.[16] Considering the high likelihood of refugees reporting issues relating to child protection and gender-based violence to *majhi*, gender imbalances within this governance structure, as well as reported issues relating to confidentiality and prioritisation of mediation over protection in some cases, could present problems.

Community-based protection

Households were assessed on their awareness of community groups organising to watch the neighbourhood, findings indicated that only 18% of households were aware of community groups active during the day, and 50% were aware of those active at night, with significant geographic variation across camps. Of households that reported being aware of community watch groups operating in their area of the camps, a large majority (95%) of households were satisfied or very satisfied with their presence.[17] Findings show a marked decrease in awareness of community watch groups since the previous round of assessment in late 2018, where 34% of households reported the presence of watch groups during the day.

Family separation

Only a small number of households reported issues of family separation, with 3% reporting the presence of separated children, extrapolated to 1% of children overall.[18] These data are likely underreported, given that Child Protection sub sector findings suggest a larger number of documented child separation cases.[19] The approximate number of new cases of separated children as captured by case workers from January to October 2019 was 1,662, which when extrapolated to the wider population suggests a much larger percentage of the overall population than is reported in SPP Round 5. It is unclear why these findings are underreported, however findings could be the result of limitations of the survey tool design, or of respondent reluctance to report accurately on a potentially sensitive issue. No households reported the presence of unaccompanied children, and only 1% of households reported both that a family member had gone missing since arriving in Bangladesh, and that any household members were presently in detention in Bangladesh. Reported rates of early marriage were consistent across assessment rounds, reported at 9% in December 2018, and 7% in this round. Furthermore, reported justifications for child marriage are similarly consistent across rounds, with roughly half of households that reported the practice of child marriage in their family, citing tradition as the reason behind this decision. Child marriage as a protection measure for the individual getting married, and as an economic necessity to reduce family burden, were both cited by one third of households as reasons for early marriage, implying that displacement might be exacerbating child marriage practices.

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[12] This question was asked to households that would report an incident of violence, exploitation or neglect against children (n=2,250), with more than one response possible. Findings are representative at 95% confidence level and 12% margin of error only.

[13] This question was asked to households that would not report an incident of violence, exploitation or neglect against children (n=785).

[14] Inter Sector Coordination Group, *Joint Multi-Sector Needs Assessment (J-MSNA)* (Bangladesh, August 2019) (accessed 20 November 2019).

[15] Protection Sector Working Group, *Protection considerations of the Majhi system* (Cox Bazar, 2018) (accessed 6 November, 2019).

[16] International Rescue Committee, *Access to Justice for Rohingya and Host community in Cox's Bazar* (New York, NY, 2019), p. 16 (accessed 6 November, 2019).

[17] This question was asked to households that reported the presence of watch groups during the day OR during the night (n=1,761). Findings are representative at 95% confidence level and 12% margin of error only.

[18] Respondents were asked to report information for each individual in their household. Individuals were classified as separated children if they were reported as joining the household since arriving in Bangladesh, excluding those who were born into the household.

[19] Strategic Executive Group, *2019 Joint Response Plan for Rohingya Humanitarian Crisis* (Dhaka, 2019), p.16 (accessed 17 November 2019) states that over 6,100 children have been separated from their primary caregiver as a result of the crisis.
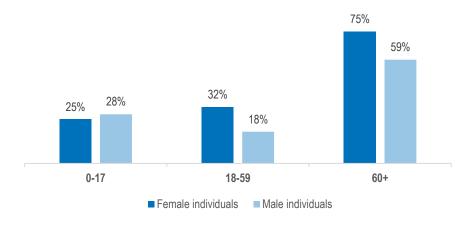
Prevalence of distress signs

Half of all households reported signs of distress[20] in household members within the last month, with a higher proportion of female respondents than male respondents reporting signs of distress among their household members. The specific household member profile reported to exhibit such signs of distress was also skewed toward female members; of the 52% of households reporting signs of distress in household members, 63% of households reported that adult women exhibited these signs, compared to 50% reporting that adult males exhibited signs of distress. Households were less likely to report that children exhibited signs of distress when compared with adults, with boys under the age of 18 more likely to be reported as exhibiting signs of distress (17%), when compared with girls under the age of 18 (reported by 13% of households).

Households with Elderly Members

Data from this household survey and other REACH assessments suggests that while elderly individuals, defined as any individual aged 60 years and older, form a very small proportion of the overall population (3%),[21] elderly people and their households face barriers to access multiple services in part due to their mobility issues, and have comparatively more aggravated wellbeing considerations.

Roughly half of elderly individuals (45%), were reported to have difficulty moving around the home without any help, with elderly females marginally more affected than elderly males[22] (50% compared to 42%). At the individual level, information was collected on individuals who were reported to have an illness serious enough to require medical treatment in the 30 days prior to collection. Elderly individuals were roughly twice as likely to have required medical treatment than the general population, with elderly women affected at a disproportionately high rate (75% women, 59% men). Findings from the most recent household survey on water, sanitation, and hygiene (WASH) needs finds that elderly people of both genders were reported to be more likely to have suffered from diarrhoea in the two weeks prior to data collection, when compared with adults aged 18-59. Furthermore, elderly women in particular had a higher likelihood of facing problems getting to the toilet on time, used as a proxy measure for incontinence,[23] when compared with adult women.[24]

Figure 3: % of individuals of each age group and gender demographic reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection

Elderly individuals are likely to face barriers in accessing the most fundamental aspects of humanitarian assistance, largely resulting from the physical terrain of the camps as well as lack of regard for accessibility for elderly individuals in service design and provision.[25] Findings indicate that elderly individuals are particularly vulnerable with regards to

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[20] Signs of distress measured by the survey included being socially withdrawn, increase or decrease in appetite, increase or decrease in sleep pattern, bedwetting (for children), sad mood or crying, angry or aggressive behaviour and multiple unexplained physical complaints.

[21] This is equivalent to 537 individuals over the age of 59 in the dataset. This figure is consistent with UNHCR Demographic Indicators and SPP Round 4 data.

[22] Respondents were asked to report information for individuals in their household aged 60 and over. Findings are representative at the overall level only. The sample size of elderly females was 225 and the sample size of elderly males was 415.

[23] A cautionary note that this proxy measurement could have been affected by challenges with mobility common to elderly individuals.

[24] REACH Initiative, *Water, Sanitation, and Hygiene Assessment: Dry Season Follow-Up* (Cox's Bazar, 2019), p. 5 (accessed 17 November 2019).

[25] Ground Truth Solutions. *Rohingya Bulletin, Needs and Services* (Cox's Bazar, April 2019) (accessed 17 November 2019).

accessing healthcare services, aligned with block-level key informant findings from IOM-NPM Site Assessments.[26] While inability to access or pay for medical treatment was reported by half of the population, this figure increased to 60% for households with elderly members.[27] In addition, households with elderly members were marginally more likely than the general population to take out a loan in order to bear the cost of paying for medical treatment (22% compared with 17%). Across the multiple questions asking about priority needs, findings indicate a slight skew toward households with elderly members citing access to health services and medicine as a top priority. Recent data from Amnesty International on the impacts of displacement on elderly people, found that a common concern among the elderly was non availability of medication and other services in health clinics to treat chronic conditions that disproportionately affect older people. Furthermore, the centre-based approach of the health response was found to restrict access to clinics for elderly men and women with limited or no mobility, due to excessive distances to health clinics and the hilly terrain of the camps.[28]

These findings are triangulated by data from recent REACH Education and WASH assessments, that elderly individuals may face specific vulnerabilities and challenges that differ from those of the general population. The recent Education Needs Assessment found that four percent of primary caregivers were aged 60 and above, and that serving as primary caregiver would likely compound and intersect other specific challenges that elderly individuals face living in the camps. This is reflected in the finding that the presence of an elderly caregiver had a clear link with lower school attendance rates for dependent children, with children aged 3-14 less likely to be reported as attending learning centres if their caregiver was 60 or older.[29]

Furthermore, findings from the May 2019 REACH/WASH Sector household survey reaffirm that elderly individuals face service access issues at disproportionately high rates, particularly elderly women. Notably, elderly people were somewhat more likely to be reported as facing problems accessing latrines, compared with adults aged 18-59, and elderly women in particular had a higher likelihood of facing problems accessing or using bathing facilities, when compared with adult women.[30] Amnesty International data similarly finds that the design of latrines and bathing facilities excluded elderly individuals and that even those with moderate mobility were unable to access the closest latrine as a result of uneven terrain.[31] Overall findings suggest that the needs of elderly individuals are not sufficiently addressed by the current scope and coverage of humanitarian programming in the camps, and that further in-depth and targeted information regarding challenges, barriers to accessing services and priority needs of elderly individuals is required to adequately inform humanitarian planning.

The overall prevalence of households reporting the presence of members with a disability[32] was 9%, with the Washington Group short set (WGSS) of questions on disabilities asked once for the household as a whole.[33] A higher proportion (14%) of households reported the presence of at least one member with a disability in the May 2019 REACH/WASH sector household survey, when the WGSS were asked successively for each household member, which suggests that prevalence of disability in SPP round 5 may have been underreported.[34] Households with a member with a disability were more likely to report access to health services and or medicine as among their top three priority household needs, when compared with the overall population. Findings are supported by REACH/WASH Sector household survey data, which found that individuals with disabilities were more likely to face challenges accessing and using services, such as latrines, water points and bathing facilities, and were significantly more likely to report suffering from diarrhoea than the general population.[35]

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[26] IOM-NPM, *Site Assessment: Round 15*, p. 15.

[27] This question was asked to households reporting the presence of members aged 60 and over (n=537).

[28] Amnesty International, *"Fleeing my whole life": Older people's experience of conflict and displacement in Myanmar* (London, 2019), p. 35-59 (accessed 17 November 2019).

[29] REACH Initiative, *Education Needs Assessment, Rohingya Refugee Response* (Geneva, 2019), p. 28 (accessed 17 November 2019).

[30] REACH Initiative, *Water, Sanitation, and Hygiene Assessment*, p. 5

[31] Amnesty International, *"Fleeing my whole life"*, p. 35-59.

[32] For this round of data collection, disability was measured at the household level using the WGSS of questions on disability. According to this methodology, "disability" is determined as anyone in the household having at least "a lot of difficulty" following six domains: walking, seeing, hearing, cognition, self-care, and communication. However, this study does not employ the recommended approach of Washington Group – which asks for collection of data at individual level by proxy if necessary and ideally directly. Instead, respondents were asked if any household members had difficulty in each of the 6 domains. As a consequence, it is likely to result in under-reporting. Ideally questions should be asked to individuals directly to prevent under-reporting.

[33] While MSNA II reported that only 5% of households reported the presence of a member with a disability, it is not directly comparable with SPP round 5 because "disability" was not defined according to the Washington Group questions, but rather was determined by asking respondents to report on each household member with the question, "does this individual have a disability or chronic illness that affects their ability to do everyday tasks?"

[34] REACH Initiative, *Water, Sanitation, and Hygiene Assessment*, p. 5.

[35] Ibid., p. 49.

Health

Healthcare needs and barriers to accessing healthcare

Consistent with data from SPP Round 4 and MSNA II, this study found that roughly one third of the population (29%) had an illness serious enough to require medical treatment in the 30 days prior to data collection, of whom 86% reported accessing treatment at a camp healthcare facility (previously 90% in SPP round 4).[36] While households generally reported seeking treatment when feeling ill, they indicated that there are access barriers to doing so, with 78% of households reporting at least one access barrier. The most commonly reported barriers to accessing healthcare services were overcrowding (59%), followed by unavailable drugs or supplies (37%) and distance to healthcare facilities (27%).[37]

Findings suggest that households are not necessarily getting the treatment that they feel they need, indicated by the 50% of households that reported being unable to access or pay for medical treatment in the month prior to data collection. Inability to access adequate healthcare services led many households to incur costs in order to supplement treatment, with 23% of households reporting that they used private clinics, 18% borrowing money from family, friends or neighbours, and 17% of households taking out a loan to cover the cost of medical expenses. Findings were largely consistent with the previous round of assessment in 2018, where 47% of households reported being unable to pay for or access treatment, and rates of incurring costs as a strategy for coping with insufficient healthcare were similar when compared with this round of assessment. These data are largely supported by reports of growing concern about the quality of health care and the availability of medical supplies in the camp,[38] with insufficient health facilities and long distances to facilities cited as key barriers to accessing healthcare.[39] Continued illness after treatment and wanting a treatment other than what was provided at camp healthcare facilities were cited as reasons for paying for treatment by over two thirds of households that reported recurring health expenses in the previous round of assessment.

Shelter and Non-Food Items

Data on shelter and non-food items (NFIs) from this assessment suggests that a lack of lighting in the camps is a barrier to households' perceived safe access to camp facilities; that the decline in the use of firewood in favour of widespread use of fuel has mitigated the risks associated with collecting firewood for households; and that the challenges associated with rent and security of tenure for some households has implications for household movement intentions and perceptions of safety and security. Furthermore, there has been little improvement in the reported rates of households having a lock on their shelter since the previous round, with one quarter of households reportedly not having a lock.

Lack of adequate lighting in shelters was a key shelter concern for households, and remains one of the primary reasons why people feel unsafe in camps and shelters,[40] with 60% of households now citing solar light as their primary shelter need, compared with only 8% of households in 2018. These data are largely supported by the fact that only 23% of households reported that there was enough light in their area at night for household members to safely access latrines. Findings are consistent with MSNA II, which show that 40% of households reported not having functioning portable lights, and found that solar lights were the most commonly reported urgently needed NFIs.[41] Data from this round of assessment is triangulated by IOM-NPM Site Assessments, which found that a lack of adequate lighting in shelters is a priority shelter safety concern across camps, and that torches and solar lamps are widely reported as urgent needs.[42]

Firewood as the main source of fuel used by households has declined significantly since the previous round, from 64% of households using self-collected or purchased firewood as their main source of fuel in SPP round 4, to only 12% of households using firewood in this round. Bypassing regular collection of firewood, which puts household

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[36] This question was asked about individuals who were reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection (n=5,361).

[37] This finding is supported by MSNA II which similarly finds unavailability of drugs followed by over-crowding and distance to services to be the top 3 most commonly reported barriers to accessing healthcare.

[38] Ground Truth Solutions, *Needs and Services*, p. 3.

[39] IOM-NPM, Site Assessment Round 15, p. 11.

[40] Ground Truth Solutions, *Safety and Outlook*, p. 2.

[41] UNHCR/REACH, *MSNA II*.

[42] IOM-NPM, *Site Assessment Round 15*, p. 5.
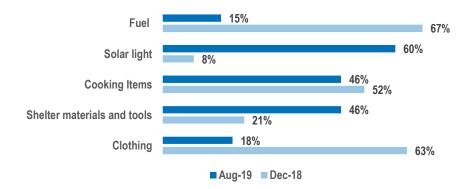
members, and particularly women and children, at risk of abuse, has positive implications for household protection. SPP round 5 findings show that a large majority of households now use cooking gas cylinders as their primary source of fuel (88%), and a significantly smaller proportion of the population are facing safety implications as a result of collecting firewood from surrounding forests.[43]

Several other survey findings bring to light concerns about paying rent and security of tenure among households, particularly those living close to host communities. A significant number of households, largely concentrated in camps 23-27, reported paying rent to live in their shelter (11%), of whom 89% reported paying rent to host communities. A large majority (82%) of the households paying rent reported concerns, the most common of which was having insufficient funds to cover the cost of rent (76%). The issue of paying rent had implications for household perceptions of security, with a third of households reporting that they feared the threat of physical harm if they missed rent payments. A third of households also cited unfair increases in rent as a key concern. This finding is triangulated by ODI qualitative data, which finds that in certain camps, having to pay rent to Bangladeshi owners of land was a pressing concern for interviewees, and that in some cases inability to pay rent has led some refugees to consider moving, or even returning to Myanmar.[44]

Comparative analysis with the previous round of assessment shows that households were far more likely to report being in urgent need of shelter materials and tools, which were not among urgent forms of assistance needed in 2018, during this round (50%), likely due in part to the fact that data collection was conducted in July, during the heaviest period of rain of the monsoon season, while SPP round 4 data collection was conducted in December. Cooking items have consistently been reported as an urgently needed form of assistance by roughly half of households, in line with in-depth MSNA findings. Fewer households in this round of assessment reported fuel and clothing as priority needs. Reporting of fuel as a priority need likely decreased this round because fuel is being widely provided across camps. Furthermore, household need for both fuel and clothing are likely to decrease during the summer months, which likely accounts for this difference between rounds of assessment. It is noted that findings vary widely by geographical location.

Figure 4: % of households reporting the most important forms of assistance the family most urgently needs to address shelter needs

Legend: ■ Aug-19 ■ Dec-18

Category	Aug-19	Dec-18
Fuel	15%	67%
Solar light	60%	8%
Cooking Items	46%	52%
Shelter materials and tools	46%	21%
Clothing	18%	63%

Food Security and Nutrition

Data was collected on household access to food and nutrition services, coping mechanisms, and associated food security concerns. Overall, 96% of households reported receiving food assistance in the month prior to data collection, yet almost all households (99%) reported some expenditure on food, consistent with data from SPP round 4. MSNA II mirrored these findings, reporting identical rates of households receiving food assistance. Despite wide access to food distributions among the population, over half of households reported concerns about receiving insufficient food at distributions and having insufficient funds to purchase food, consistent with SPP round 4 findings. Concerns about food assistance lacking in nutritional value or variety, despite having decreased significantly since 2018, remained a key trend. Consistent with these data, the WFP refugee influx emergency vulnerability assessment (REVA II) conducted in November 2018, found that roughly half of households had acceptable food consumption

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[43] SEG, *2019 Joint Response Plan,* p.16.
[44] Wake, Barbelet and Skinner, *Uncertain Futures,* p. 10-11.

scores, while the remaining 44% of households' food consumption scores were unacceptable, with 8% having poor consumption scores, reflecting a diet of poor quality and quantity. Around 10% of Rohingya refugees were reported to have unacceptable dietary diversity, which echoes reported concerns about a lack of nutrition and variety in existing food assistance.[45] According to REVA data, deterioration of food consumption and dietary diversity may well be driven by a reduced consumption of pulses, linked to the resale of lentils to purchase fish.

SPP round 5 found that more than half of all households reported not having enough food or money to buy food at least once in the 7 days preceding data collection. The most commonly reported top three coping strategies for food insecurity have remained consistent since SPP round 4. Across both rounds, reported rates of borrowing food or relying on help from friends or relatives were nearly identical (43% in SPP round 5; 42% in SPP round 4). A third of households also reported consuming less preferred or inexpensive food, and 18% reported limiting portion sizes at mealtimes to cope with food insecurity in this round. Findings are triangulated by the REVA II, which reported the same three most common coping mechanisms for lack of access to food.[46]

Education

Attendance rates and barriers

Survey findings indicate that while a majority of children aged 6-14 were accessing some type of education, attendance rates declined after the age of 11, disproportionately affecting girls. This decline in school attendance rates was likely due to a lack of age-appropriate curricula. While households largely reported satisfaction with education, findings indicate that households are widely concerned about limitations of the educational system, and worried about the affect this will have on their children's future livelihoods and opportunities.

Identical to SPP Round 4, 81% of children aged 6-14 were reported as attending madrassas and 74% were reported as attending NGO-run learning centres. Sixteen per cent (16%) of children aged 6-14 were reported as attending other learning centres, up from 2% in 2018. Across multiple forms of educational opportunities, the reported attendance rates for boys in this age range was higher than that of girls, which is largely supported by IOM-NPM assessment reports indicating that, from the ages of 6-18, girls faced more barriers to accessing education than boys. The primary reasons identified by IOM-NPM surveys for girls not attending learning centres were cultural reasons, reported by over half of households, followed by a lack of age appropriate education, and attendance at madrassa.[47] This finding is triangulated by March 2019 REACH Education Needs Assessment data, which observed that from the age of 11 onwards, attendance rates were found to fall off rapidly for girls, and more steadily for boys.[48] Non-attendance rates for girls could be further explained by cultural norms, including gender segregation linked to reaching the age of puberty and restriction to home-based work.[49]

Education at NGO-run learning centres was reported to be largely free, whereas households reported paying tuition for madrassas (81% of children attending reportedly paid) and other learning spaces (83% of children attending reportedly paid). These findings show a slight increase since SPP Round 4, where roughly three quarters of children that attended madrassas and other learning centres reportedly paid tuition, although a very low percentage of children were reported to be accessing other learning opportunities, therefore findings on reported rate of tuition are less generalisable.

Satisfaction with education

The survey finds that a large majority of households reported that they were either very satisfied or satisfied with education in the camps (95%), a significant increase when compared with SPP round 4, which reported satisfaction rates at 80%.[50] However, this finding is largely contradicted by qualitative research undertaken as part of the March 2019 REACH Education Needs Assessment, suggesting that populations are widely concerned about limitations on the existing curriculum for older and more advanced learners as well as the lack of a structured curricula and grade progressions. Leaving older or more advanced learners out of the education curriculum is cited as a key cause for low educational attendance rates among older students.[51] Research by BBC Media Action reinforces that the majority

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[45] World Food Programme, *Refugee influx Emergency Vulnerability Assessment* (REVA II) (Cox's Bazar, May 2019) (accessed 24 September 2019).

[46] Ibid., p. 49

[47] IOM-NPM, Site Assessment Round 15, p. 15. IOM-NPM did not consider madrassas in these figures.

[48] REACH Initiative, *Education Needs Assessment, Rohingya Refugee Response* (Geneva, 2019), p. 5.

[49] BBC Media Action, *CXB Foresight, Community Feedback Bulletin: Education* (Cox's Bazar, 2019) (accessed 24 September 2019).

[50] This question was asked to households reporting the presence of members aged under 18 (n=3,028).

[51] REACH Initiative, *Education Needs Assessment*, p. 5.

of adolescent children living in the camps are not accessing any education or vocational training at all, similarly citing a lack of appropriate educational programming, as well as under-qualified and under-prepared teachers as the main barriers to education for all ages.[52] Ascertaining levels of satisfaction via a household survey does pose some limitations in interpreting findings however, as the quantitative instrument does not allow for deeper investigation into household attitudes toward education. Furthermore, social desirability bias could have affected household responses to questions determining satisfaction.

The population was widely concerned about limited future prospects or job opportunities for their children, with roughly half of households reporting being concerned that their children would have no hope or future, and roughly a third of households worrying that their children would not be able to compete in the job market, and would have a low quality of education. These concerns were consistent under SPP round 4, and are supported by qualitative data from BBC Media Action, reporting that young people and parents are frustrated by the lack of education services available to them, and are concerned about their future and how they will catch up on the formal education that they are missing out on.

WASH: Water, Sanitation and Hygiene

The study collected data on water, sanitation and hygiene (WASH) practices to establish key protection concerns. Overall, the most commonly reported main facility used by households for defecation was communal/public latrines, reported by 60% of households, followed by shared family latrines (37%) and single family latrines (5%). When compared with SPP round 4, this trend represents a decrease in use of communal/public latrines (previously 74%) and an increase in the use of shared family latrines (previously 26%). Findings represent the opposite trend to REACH/WASH Sector household survey data, which indicates an increase in the use of communal latrines and decrease in the use of shared latrines between October 2018 and May 2019. Differences in findings could be a result of differences in the way this question was asked between surveys, with households reporting on the "main facility used for defecation" in SPP, and households reporting "at least one member defecating in different spaces" in the WASH household survey.[53]

Households reported that 54% of men and 58% of women faced problems accessing latrines, which represents little to no change when compared to SPP round 4. Also consistent with SPP round 4, overcrowding at latrines was reported as an issue for male members by 36% of households, while 37% of households reported overcrowding as an issue for female members.[54] These findings also correspond to the 2019 REACH/WASH Sector household survey findings, which indicated that "too many people using latrines" was the most widely reported problem for both men and women.[55] Consistent with data from the previous round, latrines being full was reported as an issue for males by 21% of households, and for females by 20% of households. Lack of gender separation at latrines was reported as a key barrier to accessing latrines primarily for women, although reported by a higher percentage of male respondents (27%), than female respondents (18%), while female respondents were more likely to report latrines being full as an issue for women (34%).[56] This finding is largely consistent with findings of SPP round 4, as well as IOM-NPM findings, suggesting that a lack of gender separation at latrines was a widely reported problem among the overall population.[57]

Several other survey findings identified protection issues related to latrine access. Lack of safety on the way to latrines, was reported as an access problem for men by 14% of households, and for women by 16% of households. Lack of safety at latrine facilities was considered to be a problem for both men and women, with male respondents twice as likely to report this as an issue in both cases. Lack of lighting at latrines was a key barrier to accessing latrines, reported as an access issue for males by 11% of households, and for females by 13% of households, with male respondents more likely than female respondents to report lack of lighting as an access barrier for males and females. Insufficient lighting at night was a concern for a majority of households, with 77% reporting that they did not have enough light at night for household members to safely access latrines in their area. Access to solar lighting was also a broad concern, which would likely improve safe access to latrines during the night, and was cited as an urgent

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[52] BBC Media Action, *Community Feedback Bulletin: Education*.

[53] REACH Initiative, *Water, Sanitation, and Hygiene Assessment*, p. 5.

[54] These questions were asked to all households containing a male family member over 5 years that reported male members facing problems accessing latrines (n=1,668), and all households containing a female family member aged over 5 years that reported female members facing problems accessing latrines (n=1,850). Findings are representative at the camp level at 95% confidence level and 14% margin of error only.

[55] REACH Initiative, *Water, Sanitation, and Hygiene Assessment*, p. 5.

[56] Perception questions in this assessment were asked by proxy to male and female respondents, who answered on behalf of the household.

[57] IOM-NPM, Site Assessment Round 15, p.6.

form of assistance needed to address shelter needs by 60% of households. Lack of privacy at latrines was not considered to be a primary access issue, reported as a problem for males by only 2% of households and for females by 1% of households.

Types of bathing facilities used by family members were found to be strongly dependent on the gender of the individuals, with female family members far more likely to be reported to bathe in a makeshift space within their shelter (78%), while male family members were significantly more likely to be reported to bathe at tubewell platforms (68%). Findings are triangulated by REACH/WASH Sector household survey data, which indicates that bathing practices vary significantly based on gender, with females aged 5 and over most commonly reported as bathing inside the household, while males aged 5 and over were most commonly reported as using tubewells.[58] Consistent with data from December 2018, 19% of children under 5 were reported to have been ill with diarrhoea in the 2 weeks preceding data collection, similar to the 17% reported in SPP round 4.[59]

Communication with Communities & Priority Needs

Communication

All households reported that Rohingya is the primary language spoken at home. Almost half of the population (41%) does not speak or understand any other language, while smaller proportions of the population spoke or understood a second language, most notably Burmese (18%), Bangla (9%) and Chittagonian (6%). Nearly half of households (44%) reportedly could not read or understand another language, while 16% read Burmese and 5% read Bangla.

The most preferred method of receiving information in the camps is by face-to-face communication, supported by reports that Rohingya refugees largely exchange information by word of mouth.[60] Roughly similar to the findings of SPP round 4, 88% of households reported preferring face-to-face communication, 72% reported preferring loudspeakers, and 41% reported phone calls as preferred methods of communication.

A large majority of households (82%) felt that assistance providers listened to their opinions. This is supported by light MSNA findings, which highlighted that over half of households reported having been consulted in the past 6 months about the type of aid or support that they most needed.[61] These findings are further triangulated by Ground Truth Solutions survey findings reporting that a majority of Rohingya refugees reported feeling that humanitarian organisations take their opinions into account when providing aid and services, and a large majority reported feeling treated with respect by aid providers.[62]

Priority Needs

Similar to SPP round 4, access to food was the most commonly reported first priority need for the overall population. Male respondents were more likely to list shelter materials or upgrades as their second priority need (25%), whereas female respondents were more likely to report needing access to solar light (16%). The most commonly reported third priority need irrespective of gender, was solar lighting. When compared with SPP round 4, findings show a decrease in reports of clothing as a priority need, reported as second and third priority need by only around one in ten households during this round, compared to roughly a quarter of households in the previous round. These findings are consistent with Ground Truth Solutions surveys that reported that food security and food assistance were cited as the top most important unmet needs according to respondents.[63]

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[58] REACH Initiative, *Water, Sanitation, and Hygiene Assessment*, p. 35.
[59] Ibid., p. 49
[60] Ground Truth Solutions, *Needs and Services*, p. 2.
[61] ISCG, *J-MSNA*.
[62] Ground Truth Solutions, *Rohingya Bulletin, Feedback and relationships* (Cox's Bazar, 2019).
[63] Ground Truth Solutions, *Needs and Services*, p. 2.