INCLUSIVE ACCESS TO SERVICES FOR PERSONS WITH DISABILITIES

Barriers and Facilitators Assessment Report
Jadimura Camp, Teknaf
January 2019
DEFINITIONS

Impairment: A significant deviation or loss in body functioning or structure (World Health Organization Towards a Common Language for Functioning, Disability and Health, 2002). Impairments may be either temporary or permanent, and people may have multiple impairments. Impairments can be physical, sensory (visual, auditory, speech), intellectual, mental/psychosocial. In some cases impairments may be invisible, meaning that they are not immediately apparent.

Disability: Disability is commonly understood as being synonymous with impairment. However, the way we define disability today is not as an impairment, but rather disability is an evolving concept and that disability 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 (United Nations Convention on the Rights of Persons with Disabilities, 2006).

Inclusion: Inclusion means a rights-based approach to community programming, aiming to ensure persons with disabilities have equal access to basic services and a voice in the development and implementation of those services. At the same time it requires that mainstream organization make dedicated efforts to address and remove barriers (International Federation of Red Cross and Red Crescent Societies & HI All Under One Roof, 2015).

Barriers: Barriers are factors that prevent a person from having full and equal access and participation in society. These can be environmental, including physical barriers (such as the presence of stairs and the absence of a ramp or an elevator) and communication barriers (such as only one format being used to provide information), attitudinal barriers (such as negative perceptions of older people or people with disabilities) and institutional barriers (such as policies that can lead to discrimination against certain groups). Some barriers exist prior to the conflict or natural disaster; others may be created by the humanitarian response (referenced from the Humanitarian Inclusion Standards for Older People and People with Disabilities).

Facilitators: Factors that can help reduce or overcome the effects of disability to enable full and equal access and participation in society.

Capacities: The combination of all the strengths, attributes and resources available within an organization, community or society to manage and reduce disaster risks and strengthen resilience. Capacity may include infrastructure, institutions, human knowledge and skills, and collective attributes such as social relationships, leadership and management (Reference from the Humanitarian Inclusion Standards for Older People and People with Disabilities/UNISDR)

Participation: Corresponds to the meaningful involvement of boys, girls, women and men of different age groups (from children to older people), including people with different disabilities, in the design, implementation, monitoring and evaluation of actions or policies affecting them. Being participatory also makes us more accountable, responsive and effective as our decision-making is better informed, more considerate of diverse perspectives, and capitalizes on the lived experience of people facing discrimination (Policy on Disability, Gender and Age, Handicap International).
Since August 2017, violence in Myanmar has driven more than 700,000 Rohingya to cross the border and seek refuge in Bangladesh. Crowding into refugee camps in Cox’s Bazar District, the newly arrived are joined by more than 200,000 Rohingya refugees that fled previous waves of violence, resulting in the highest concentration of refugees anywhere in the world.

In response, hundreds of local, national and international non-governmental organizations (NGOs) are responding to the crisis alongside the Government and UN agencies, delivering protection, food, water, shelter, healthcare and other life-saving assistance. Progress has been made in improving the incredibly difficult circumstances faced by the refugees, but given the scale the crisis and the wide-ranging needs, the refugees continue to face precarious living conditions in the congested, hilly camps prone to landslides and flooding, and struggle to fulfill their needs for a dignified existence.

While these difficulties are universal to the Rohingya community in Bangladesh, the estimated 15% of the Rohingya population with disabilities [1] are among the most marginalized and vulnerable members of the community. Due to an unaccommodating environment for persons with impairments, discrimination, neglect and their general isolation from others, persons with disabilities in emergencies are at an increased risk of protection violations, have unique needs, and face additional barriers to access humanitarian assistance. They may experience preventable limitations in movement or vulnerability due to not enjoying access to rehabilitation services and assistive devices and/or medication and/or having lost their care givers or support persons and/or being in a new less accessible environment. They may face great difficulty in reaching food and aid distribution points, being understood by others when expressing their needs, and registering for services in the camps. As a result, they often do not receive the humanitarian aid and services they need, which has the effect of exacerbating existing vulnerabilities and perpetuating exclusion.

According to the humanitarian principle of impartiality – providing assistance on the basis of need alone – humanitarian actors must take all needed steps to provide assistance and special protection to all groups vulnerable in emergency situations, including persons with disabilities. This necessity for inclusion of persons with disabilities in humanitarian response is underscored by the UN Convention on the Rights of Persons with Disabilities (Article 11), which calls for “all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.”

In the spirit of these humanitarian principles, the human rights based model of understanding disability, and in accordance with its global mandate to “work alongside people with disabilities and vulnerable populations, taking action and bearing witness in order to respond to their essential needs, improve their living conditions and promote respect for their dignity and fundamental rights,” Handicap International -Humanity & Inclusion (HI) is dedicated to improving the inclusion of people with disabilities and other vulnerable groups through its own emergency response programs, and also by working with other humanitarian groups to include people with disabilities in their responses on an equal basis with others, ensuring their basic needs are addressed and human rights upheld.

A core component of HI’s programming in Bangladesh is therefore sharing our expertise to support other actors in inclusion mainstreaming. Inclusion mainstreaming refers to the process of working with humanitarian actors to identify and take practical measures to reduce the barriers faced by persons with disabilities in accessing their assistance. This is currently implemented with support from DFID under the intervention “Inclusive Emergency Assistance to Crisis-affected Populations in Cox’s Bazar, Bangladesh.”
The Access to Services for Persons with Disability (PwD) Assessment in Jadimura Camp was motivated by a need to develop evidenced-based inclusion mainstreaming strategies across the different sectors of intervention in the Rohingya response. While of value to the wider humanitarian community, the assessment will directly inform the design of inclusive approaches for partners within the framework of HI's inclusion mainstreaming activities, implemented with support from DFID. The two main research questions guiding the assessment were therefore constructed with a view to what basic information is necessary to formulate effective and feasible inclusion mainstreaming measures.

- **Research Question 1**: What barriers, risks and situations of exclusion do persons with disabilities face when accessing different services and conversely, what factors facilitate access to different services for persons with disabilities?
- **Research Question 2**: What systems and processes do humanitarian actors currently have in place to address barriers to safe and meaningful access to protection and services for persons with disabilities (with an emphasis on the gaps, limitations and challenges, and best practices)?

Through a cross analysis of data on persons with disabilities needs from their own point of view with data on current service provider gaps, limitations, challenges, and best practices in relation to inclusion, HI will have solid foundation upon which to better support itself and other actors in their mainstreaming initiatives.

Owing to limitations in time, human resources and budget, HI opted to focus data collection in a single location, Jadimura Camp in Teknaf Upazila in Cox Bazar District. Jadimura was firstly selected on the basis of HI's presence there, which enabled HI to leverage its knowledge of the local context, on-site human resources, and relationships with service providers operational in the camp to participate in data collection. Secondly, Jadimura is an underserved location and so challenges faced by PwD may be particularly pronounced, making it a priority area for inclusive programming.
HI's assessment methodology included two main components, each geared towards addressing one of the research questions. The tools used were adapted from HI global tools that have been tested in other countries, including Iraq.

1. PwD Survey: In order to address Research Question 1 and simultaneously promote consultation and participation of persons with disabilities, HI surveyed persons with disabilities in Jadimura Camp (Camp 27). In order to achieve 90% confidence and 10% margin of error, HI selected a sample of 63 PwD on the basis of an estimated camp population of 10,200 persons (including an 10-15% of PwD based on global disability estimates from the World Health Organization (WHO)). As information on the identity of all PwD residing in Jadimura is not known, HI made a random selection from a list of 130 PwD currently receiving assistance from HI. Data collection took place between November 6th to November 18th.

2. Structured Interview with Service Providers: In order to address Research Question 2, HI conducted a structured interview with representatives from 11 different local and international NGOs in Jadimura Camp. Service providers were identified based on a mapping exercise conducted by HI and selected according to their willingness to participate. HI aimed to include organizations working across a broad range of different sectors in the sample (which are detailed in section 6). Representatives from the organization to participate in the survey were primarily program managers and technical staff. Data collection took place between November 19th to December 2nd.

There are some limitations to the research that should be noted and taken into consideration when interpreting the findings. Firstly, data collection with persons with disability was led by HI inclusion staff assisted by community workers for interpretation. While different measures were taken to promote the quality of the interpretation, notably by selecting community workers that have worked with HI previously and by designing survey questions with simple and understandable language, certain limitations exist. Community workers are generally not perfectly fluent in Bangla and are not trained experts in inclusion, and subsequently do not always have a perfect understanding of some of the more technical concepts and vocabulary. Moreover, due to time limitations, persons with disabilities did not directly participate in the data collection or research design process. Additionally, due to certain unavoidable constraints mentioned above, a convenience sampling methodology was relied upon and persons with physical disabilities (self-care and walking) are overrepresented in the sample. As a consequence, results are meant to be indicative and should not be interpreted as generalizable to entire Rohingya PwD community.
FINDINGS: BARRIERS AND FACILITATORS TO ACCESSING SERVICES FOR PERSONS WITH DISABILITIES

This section is intended to shed light on situations of exclusion and barriers and facilitators to accessing humanitarian assistance for persons with disabilities in Jadimura Camp, based on the results of surveys with 63 persons with disabilities. After first detailing the demographic and disability information of the survey participants, the section is organized according to sector: shelter, WASH, food, health, education, livelihoods, and protection, analyzed from the perspective of access, barriers, and facilitators.

SAMPLE DEMOGRAPHICS

The 63 persons with disabilities survey participants included 33 women (52%) and 30 men (48%). As data collection was collected inside of Jadimura Refugee Camp, 62 were members of the refugee community (98%) whereas only one beneficiary was a member of the host community (2%). The average household size among the sample was 5.5, with 32% of households comprised of four or less members and 8% of households comprised of eight or more members.

Moreover, participants were from a range of age groups, 13% 6-11 years, 11% 12-18 years, 13% 19-35 years, 11% 36-50 years, and 52% 50+ years. Given the high proportion of elderly persons with disabilities [2], the large percentage of persons over 50 within the sample are in line with expectations. Of those over the age of 18, 94% are married, although only 45% of married participants are cohabiting with their spouse.

[2] Forty-six percent of people over the age of 60 have disabilities according to UNDESA, Division for Social Policy and Development Disability, Aging and disability.
According to the CRPD definition, the interaction between persons with different types of impairments and diverse barriers result in disabling situations which may hinder full and effective participation in society on an equal basis with others. Therefore, depending on the type and severity of the impairment as well as the context (post emergency, emergency, barrier-free society, having access to rehab services, being a women or a men) etc.) persons with disabilities face unique and varying levels of enjoyment of safety, protection, rights realization, access to services and basic needs and/or challenges. It is therefore preferable to avoid discussing disability in blanket terms and nuance any discussion according to the variation that exists.

There are different strategies to identify persons with disability. For the purpose of this assessment, HI relied on the Washington Group Questions (short set), which are a validated and endorsed set of questions developed to identify people who have difficulties in basic, universal activities and are thus at risk of restricted participation in an unaccommodating environment. Specifically, it asks about difficulty in respect to six basic functional domains (walking, seeing, hearing, cognition, self-care and communication), the results of which are summarized in figure 1 and 2 below.

The above indicates a predominance in the sample of persons with physical difficulties such as walking and self care (washing, grooming, eating, and using the toilet). In fact, 46% of the sample reported that they often (17%) or always (29%) need help using the toilet while 41% said they often (16%) or always (25%) need assistance washing. It is important to emphasize that the sample is not representative of persons with disabilities in the camps, and the high number persons with difficulties in respect to these particular functional domains is a result of the sampling methodology, which drew from HI's beneficiary list, and the type of assistance that HI offers (rehabilitation). While the sample in this case is too small to support a disaggregated analysis according to type of functional impairment, this offers a worthwhile avenue for future larger-scale assessments.

While some participants are only experiencing some difficulties in relation to the six functional domains, others are completely unable to perform some of these universal activities like walking or seeing. According to the self-reporting by the interviewees the causes of the difficulties were attributable to injury (11%), birth defects (19%), age (27%), and illness (43%). A large number (52%), as HI beneficiaries, are currently using assistive devices (of varying types, including crutches, wheelchairs, and glasses), which are designed to mitigate the impact of impairment.

[3] This encompasses using sign Language and spoken languages and being understood.
Given the scale and speed of the movement of Rohingya refugees into Bangladesh, shelters at the beginning were largely improvised and did not provide sufficient protection against the elements, lacked privacy, security, ventilation, and accessibility for persons with disabilities. Gradually, efforts to repair and upgrade shelters so that they are safer and more durable have been made with the distribution of Upgrade Shelter Kits and Tie Down Kits in Jadimura Camp.

According to the July 2018 REACH Multi-sectorial Needs Assessment (MSNA), 91% of households in Jadimura are now living in shelters made of bamboo frame with lattice walls covered in plastic sheeting or matted walls while 65% are sharing their spaces with other families.

The findings of the survey indicate that 67% face a lot of difficulties or cannot move easily within their shelter. No significant difference in access was observed between male and female respondents (Figure 3). When prompted regarding barriers hindering persons with disabilities mobility within their individual shelters, a range of responses were given and are summarized in Figure 4.

**FIGURE 3: MOBILITY WITH SHELTER FOR PERSONS WITH DISABILITIES**

- No difficulty (9%)
- Some difficulty (24%)
- A lot of difficulty (59%)
- Cannot do it at all (8%)
The majority of respondents (79%) reported the **steps leading to the doorways** of shelters were a barrier for them to enter their homes. Steps at the entrances of shelters are common as a result of the hilly topography in Jadimura camp. Moreover, a high number (67%) also mentioned that the **height of the bed** presented a challenge. In most shelters in Jadimura, people are sleeping on mats on the floor and for persons with disabilities with certain types of physical impairments, lowering themselves to this position on the ground and vice versa, from the ground to a standing position, could be relatively more difficult than if the bed was elevated.

An additional 37% cited **narrow doors** as a barrier. Of those respondents, 71% had an assistive device, which depending on the type, could be cumbersome and difficult to pass through narrow doors. Entranceways should be a minimum of 90 centimeters wide with no thresholds or barriers on the ground so that wheelchairs and other assistive devices can pass easily and to allow space so that carers can easily assist[4]. Additionally, floors in the shelters are typically the natural earth lined with mats, leading 21% of respondents to name the **uneven ground** as barrier. Lastly, despite the average space within a shelter occupied by one person in Jadimura Camp being 2.98 m²[5], falling short of the Sphere standard (3.5 m² per person), no person with disability reported that there was not enough room to move easily with their assistive devices.

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**FIGURE 4: BARRIERS TO MOVING EASILY WITHIN SHELTERS FOR PERSONS WITH DISABILITIES**

1. Steps in doorway 79%
2. Bed too high or too low 67%
3. Narrow doors 37%
4. Uneven ground 21%
5. No one to assist 12%
6. No railings 3%
7. Not enough room for assistive device 0%
WATER, SANITATION, & HYGIENE

WATER

Efforts have been made across the camps to transition towards a more sustainable and robust water, sanitation and hygiene (WASH) strategy, characterized by more permanent and high-quality WASH infrastructures in tandem with improved monitoring and management. For drinking water, households in Jadimura camp now rely primarily on communal water sources (one available for every 95 people) which includes handpumps/tube wells, tapstands and water tanks [6].

Survey results indicate low access to drinking water for persons with disabilities, with 43% reporting that they cannot access drinking water at all, 39% reporting that they face a lot of difficulties, and only 5% reporting no difficulty in access. However, access to drinking water may be particularly low for the general population in Jadimura Camp relative to other camps in Cox’s Bazar District.

FIGURE 5: ACCESS TO DRINKING WATER FOR PERSONS WITH DISABILITIES

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
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<tbody>
<tr>
<td>33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57%</td>
<td>30%</td>
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according to other available data, with 92% reporting at least some problems when collecting water [7] and water perceived as the second highest priority need [8].

Interestingly, male persons with disabilities respondents reported slightly more limited access to drinking water relative to their female counterparts (Figure 5). While reasons for this are not immediately clear, it should be noted that in Rohingya communities adult women typically take responsibility for water collection (82% of households) [9]. It is therefore possible that responses from male participants are less grounded in experience.

Figure 6 summarizes the different barriers cited by persons with disabilities respondents to accessing water points. Physical barriers rather than information barriers or attitudes/stigma appear to be the main factors hindering access. No person with disability reported that they were unaware of the water point and only 3% said negative attitudes towards them in public deterred them from making the journey to collect water. What impeded access for persons with disabilities was rather carrying/pumping water (97%), the difficult terrain they had to travel to reach the water points (80%), and the distance (25%).

**Difficulty carrying and pumping water** for persons with disabilities could potentially be exacerbated by certain contextual details. Firstly, for some persons with disabilities, the way certain water containers are designed, often times if without their consultation, can be a barrier. For example, narrow jerrycans with thinner handles on top can be carried simultaneously to using a crutch or other mobility device. However, results of the REACH WASH assessment imply low usage of disability inclusive water containers, with 88% of households using aluminum pitchers, 32% using buckets, 22% using bottles, and 4% using jerry cans. The铝制pitcher (कलसी), is a traditional vessel with a wide base and narrow neck that must be picked up with two hands and is designed to rest on one’s hip while walking. This type of container could create difficulties for persons with any range of physical impairments.

Secondly, of the different types of water points that exist in Jadimura camp, a hand pump, which can be labor intensive to use, particularly if not built using the universal design (with extended handles), is the most common (38%) and may pose additional challenges for persons with disabilities when pumping water.

Potential issues surrounding the physical accessibility of water points could be linked to steep slopes in the camp (topography), the crossing points over drainage canals, the width of pathways, lack of lighting, obstacles like debris or vegetation, or soft surfaces incompatible with wheelchairs or other mobility devices. Further consultation with persons with disabilities is necessary to better understand which specific issues are preventing persons with physical or visual impairments from navigating easily to water points.

[7] NMP Site Assessment Round 13 Camp 27, November 2018

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**FIGURE 6: BARRIERS TO ACCESSING WATER POINTS FOR PERSONS WITH DISABILITIES**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty carrying/pumping water</td>
<td>97%</td>
</tr>
<tr>
<td>Physically not accessible</td>
<td>80%</td>
</tr>
<tr>
<td>Water point is too far</td>
<td>25%</td>
</tr>
<tr>
<td>Negative attitudes from community</td>
<td>3%</td>
</tr>
<tr>
<td>Lack of information on water location</td>
<td>0%</td>
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</table>
The majority of households in Jadimura Camp (83%) are using latrines (one available for every 23 people) according to REACH. Latrine type varies, with 54% of people over the age of five using shared household latrines, 21% using communal/public latrines, and 16% using single household latrines. The remainder are resorting to open defecation or other unsafe methods [12].

Survey results indicate that difficulties accessing latrines for persons with disabilities are significant, although less pronounced than those experienced when accessing water points. Eight percent reportedly cannot access latrines at all, while an additional 56% face a lot of difficulties, and 25% face some difficulties. Only eleven percent report no difficulty in access. Counter to available data on latrine access for the general population [13], female PwD belonging to this sample experience difficulties at a slightly lower rate (82%) compared to male PwD (97%).

When interpreting this finding, one must take into consideration that safety concerns which disproportionately affect women during latrine use and disrupt access are not considered by female PwD to be barriers, or at least are secondary relative to the obstacles they may face as a result of their disability. No respondents (male or female) reported a lack of female appropriate latrines, no locks, or feeling unsafe and preventing them from using latrines.

On the other hand, the primary barrier for latrine use was overwhelmingly a lack of adapted latrines (96%), which could include latrines that have lighting inside with accessible light switches, barrier-free entrance, ramps to access, color contrast so people with visual impairments can more easily identify, accessible handles, handrails at either side, sufficient size to accommodate the wheelchair with the door closed and to enable carers to assist with access or personal care, wide doors to allow a wheelchair or crutch-user to enter etc. A more in depth accessibility assessment of existing latrines is required to determine the precise gaps in adaptations.

[13] ACAPS, Rohingya Influx Overview, November 2018

**FIGURE 7: ACCESS TO LATRINES FOR PERSONS WITH DISABILITIES**
This focus on environmental barriers rather than barriers of information or stigma/discrimination is similar to the results of the analysis on water points. However, in contrast to the findings on water point access, physical accessibility and distances were not deemed as central reasons for why persons with disabilities have difficulties using latrines. This may be related to the higher number of latrines and shorter distances between individual shelters (less than 50 meters for 92% of households) [14], which is more compliant with international inclusion standards on WASH facility distances [15].

[14] WASH Sector Site Profile, Camp 27, August 2018.
[15] In the post emergency phase of a humanitarian crisis 20% of latrines should be located within 30 meters of individual shelters

**FIGURE 8: BARRIERS TO ACCESSING LATRINES FOR PERSONS WITH DISABILITIES**

1. Latrine not adapted for PwD 98%
2. Physically not accessible 14%
3. Not used to using latrine 2%
4. Lack of information on latrine location 0%
5. Not clean 0%
6. Not gender appropriate 0%
7. Not used to using latrine 0%
8. Long lines 0%
9. No locks 0%
10. No lights 0%
11. Feel unsafe going to latrine 0%
12. Latrine is too far 0%
Many households within Jadimura Camp are without any food supplies and are dependent on humanitarian distributions. According to the IOM Round 13 (November) Needs Population Monitoring, more than 50% of locations within Jadimura Camp consider food distributions as their main source of food according to key informants. Ninety-eight percent have a ration card with 92% reportedly receiving fortnightly rations of rice, lentils, and oil from ICRC/WFP [16].

Given the high reliance on food distributions, access is essential. However, persons with disabilities are struggling, with 56% reporting that they cannot access food distributions at all, 35% reporting a lot of difficulty, and 6% reporting some difficulty (Figure 8). No significant differences in access were observed between male and female respondents. Figure 9 summarizes the main barriers encountered by persons with disabilities to access food distributions.

Ninety-five percent of respondents reported that difficulties

![Figure 9: Access to Food Distributions for Persons with Disabilities](image)

| No difficulty (3%) | Some difficulty (6%) | A lot of difficulty (35%) | Cannot do it at all (56%) |

Carrying food was preventing or interfering with their access to distributions. While rations are adjusted depending on household family size, they typically are comprised of 30 kg of rice, 9 kg of lentils and 3 litres of oil [17] and delivered in large, standard WFP sacs, which could prove heavy and difficult to carry for some persons with disabilities. In some cases hired porters, camp authorities/army, or implementing partner staff may be available for carrying food (to be discussed further in Section 6). However, 0% of respondents reported that the availability of daily workers or other external persons functioned as a facilitator, enabling or encouraging their access to distributions.

Difficulties carrying may be interconnected with the issue of the distribution points being too far, which was reported to affect 46% of respondents. While precise data on the distance between individual shelters and distribution points is not readily available, according to IOM NPM Round 13, only 4% of key informants perceived that distribution points being too far constituted a barrier to accessing distributions in Jadimura. However, what is an appropriate distance for the general population may present a challenge for persons with disabilities.

On the other hand, long wait times at the distribution points is barrier to access experienced by the general population and PwD alike. According to IOM NPM Round 13, long wait times was the most highly reported barrier for the population cited by key informants in Jadimura (57%). At the same time, long wait times (especially if distribution points are not well adapted) can place a profound burden on some persons with disabilities, with 95% of survey respondents naming it as a barrier to access.

Finally, 41% of persons with disabilities reported that distribution points are not appropriately adapted to their needs. Adaptations to distribution points can denote a range of measures, including but not limited to separate queues or distribution times for persons with disabilities, communication of messaging in a variety of formats (loudspeakers, large pictures with color contrast etc.) to reach those with hearing, seeing, or intellectual impairments, ensuring the availability of seating, shade, accessible and safe water and sanitary facilities at distribution sites. Further research is required to determine the specific ways in which distribution points are not well adapted. Of those that reported some level of access to food distributions, 100% pointed to the availability of friends and family to assist as a factor that facilitated this participation.

Congested and poor living conditions inside the camp, as well as a lack of adequate food, water and sanitation have contributed to high health needs and have exacerbated the risk of disease outbreak. Moreover, persons with disability in particular require specific health services, including rehabilitation therapy and provision of assistive devices.

Ninety-eight percent of the survey participants reported having sought medical care within the camp. Persons with disabilities who sought medical care primarily went to camp or public hospitals (91%), but some also relied on pharmacies (5%), traditional healers (5%) or private doctors/clinics outside of the camp (5%). As HI beneficiaries, the majority of the sample receives rehabilitation services through HI mobile units but none reported accessing non-rehabilitation health services from other mobile clinics.

One hundred percent of surveyed persons with disabilities reported barriers to accessing health care services (Figure 10). This compares to 58% of the general population in Jadimura who reported challenges to accessing NGO run clinics according to the REACH MSNA [18].

**Figure 10: Existence of Barriers/Difficulties to Accessing Healthcare Services for Persons with Disabilities**

Among persons with disabilities, a lack of physically accessible or adapted healthcare facilities was perceived to be a barrier to accessing healthcare for 85% of respondents. There are different ways in which a health facility can lack adaptations for persons with disabilities and so further research is required to determine the particular gaps. However, well-adapted healthcare facilities are characterized by inclusive building designs (wide doors, ramps, ground-floor entrances, handrails etc.) and are in accessible locations with outreach/mobile services available for those who cannot easily leave their homes.

While HI is providing mobile rehabilitation services to the majority of the sample, and other organizations (International Committee for the Red Cross and the Bangladesh Red Crescent Society) are providing mobile outreach services within Jadimura, it is possible that the mobile response is not commensurate with the needs. This is underscored by the finding that no person with disability reported being serviced by mobile clinics. Additionally, long distances to service providers were considered by 46% of PwD respondents as a notable barrier to accessing healthcare. This compares to 25% of the general population in Jadimura. The high percentage of PwD citing distance as a barrier is consistent with the relatively low number of fixed health centers and the size of Jadimura Camp. In addition to the mobile clinics mentioned previously, there is only one Save the Children fixed health clinic in Jadimura, although the Ministry of Health (MoH) Teknaf Health Clinic is located outside of the camp and there are some clinics in nearby Camp 26 [19].

Long wait times was another aspect that affected PwDs. In contrast, long wait times was absent from the list of barriers to accessing NGO clinics reported by the general population in Jadimura Camp according to the REACH MSNA. As in the case of wait times at distributions, this could be because long wait times are more inconveniencing for persons with physical disabilities, particularly in the absence of proper seating. Finally, a low percentage of PwD respondents cited negative attitudes from staff, low quality or inappropriate services or communication issues.

[19] Health Sector, Bangladesh: Health Facilities by Type in Cox's Bazar's Camp Sites (As of 10 November 2018)
[20] REACH Multi-Sectorial Needs Assessment, Camp 27, July 2018. Note that this figures refers to % of the population that viewed the distance to health facilities as a challenge in accessing NGO run clinics specifically

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**FIGURE 11: BARRIERS & FACILITATORS TO ACCESSING HEALTHCARE FOR PERSONS WITH DISABILITIES**

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>FACILITATORS</th>
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<tbody>
<tr>
<td>1. Physically not accessible/not adapted for PwD</td>
<td>1. Help from family and friends</td>
</tr>
<tr>
<td>2. Service provider too far</td>
<td>2. Assistive device(s)</td>
</tr>
<tr>
<td>3. Long wait times</td>
<td>3. Mobile services provided</td>
</tr>
<tr>
<td>4. Negative attitudes from health service providers</td>
<td>4. Close proximity to health facility</td>
</tr>
<tr>
<td>5. Low quality/inappropriate services</td>
<td>5. Accessibility upgrades/adaptations in health facility</td>
</tr>
<tr>
<td>6. Communication issues</td>
<td></td>
</tr>
<tr>
<td>7. Negative attitudes from community</td>
<td></td>
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<tr>
<td>8. Lack of information on where to go</td>
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Of the 98% of the survey participants who reported receiving medical care within the camp, 100% credited the support of family and friends and 39% their assistive devices as facilitating access. No respondents characterized mobile services, the close proximity of health services, or accessibly upgrades in facilities as factors enabling them to receive healthcare.
5.5

EDUCATION

As an alternative to enrollment in formal education, which is not permitted for Rohingya refugees, learning facilities have been established across the camps in Cox’s Bazar districts, including Jadimura. Moreover, madrasas have been formed with the support of religious organizations and mosques.

In order to better ascertain access and barriers to education for children with disabilities, HI collected relevant data from the 15 school-age PwD survey participants. Due to the small sample size findings should be interpreted as only indicative.

Figure 12 summarizes the attendance rate among the children with disabilities sample, revealing that 8/15 are indeed attending some type of learning facility, including Madrassah (53%). Of those attending school 7/8 are attending daily while the remaining one child with disability is attending monthly. This rate of attendance appears lower than the general population, where 59% of children between 6 to 14 years old are attending NGO-run learning centers and 77% attending Madrassah or Maqtab [21][22].


[22] According to the November 2018 Education Sector Gap Analysis, Jadimura contains less than half the number of learning facilities needed to meet the existing needs of pre-primary and primary aged children 3-14.

Figure 12: Learning Facility Attendance Rate Among Children with Disabilities

- Attending: 8
- Not attending: 8
- Daily: 7
- Monthly: 1


[22] According to the November 2018 Education Sector Gap Analysis, Jadimura contains less than half the number of learning facilities needed to meet the existing needs of pre-primary and primary aged children 3-14.
Figure 11 summarizes the main types of barriers hampering access for children with disabilities to school. A lack of necessary physical adaptations to schools ranks at the top (10 out of 15 children). Adaptations of schools for PwD could include play areas which enable children with disabilities to engage in play with others, blackboards fixed at appropriate heights for children with disabilities seated on the floor, accessible WASH facilities, ramps, appropriate lighting for people with visual impairments etc.. Other physical barriers such as difficulties getting to school (caused by topography, obstacles, crossing points over drainage canals etc) and schools being too far were reported as barriers at comparatively lower rates, by 4 and 1 out of 15 children with disabilities respectively.

Eight of the total 15 respondents also felt that learning materials or methods were not appropriate for children with disabilities' needs. For example, it is recommended that learning materials are in different communication formats (auditory, visual, sign language, pictures with color contrast etc.) as well as different teaching and learning methods (pair and group work, interactive methodologies, simulations etc.) to promote inclusion of children with and without disabilities in the classroom. This lack of adapted learning materials and methods is happening in an educational context which, according to the Education Sector, is characterized by a lack of standardized and relevant learning materials more generally.

Additionally lack of assistance for inclusive learning environments and processes to support children with and without disabilities was considered to be a barrier to attending school for 6 out of 15 children with disabilities. Assistance to support children with disabilities within schools refers to the human resource capacity to maintain an inclusive learning environment and/or give specialized attention to CwD when needed. Nevertheless, of the eight children with disabilities in the sample attending school, half identified supportive teachers as something that facilitated their access.

### FIGURE 13: BARRIERS & FACILITATORS TO ACCESSING EDUCATION FOR CHILDREN WITH DISABILITIES

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>FACILITATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. School not adapted for CwD</td>
<td>Supportive family members</td>
</tr>
<tr>
<td>2. Learning materials not appropriate</td>
<td>Help and support from teachers</td>
</tr>
<tr>
<td>3. No human capacity to provide special assistance for CwD</td>
<td>Close proximity to school</td>
</tr>
<tr>
<td>4. Physically not accessible</td>
<td>Person available to take CwD to school</td>
</tr>
<tr>
<td>5. Negative attitudes from peers or teachers</td>
<td>NGO support</td>
</tr>
<tr>
<td>6. School too far</td>
<td>Materials in school appropriate</td>
</tr>
<tr>
<td>7. Lack of information about school</td>
<td>Positive attitudes in school or community</td>
</tr>
<tr>
<td>8. Belief that school is no necessary for CwD</td>
<td>0</td>
</tr>
<tr>
<td>9.</td>
<td>0</td>
</tr>
</tbody>
</table>
Finally, two children with disabilities of the sample reported that **negative attitudes from peers or teachers** functioned as a barrier, indicating that the education sector may be where negative attitudes and stigmas towards PwD affect access the most. On the other hand, negative attitudes from families (manifesting in the belief that **school is not necessary for children with disabilities**) were not considered to have any adverse affects on access. In fact, of the 8 children in the sample attending school, 5 mentioned family support as facilitating their attendance at school.
In Bangladesh, Rohingya refugees are not legally entitled to formal employment opportunities. In order to foster self-reliance, the humanitarian community is therefore endeavoring to create socio-economic empowerment opportunities to the extent possible through skills enhancement programs and activities such as micro-gardening, food for assets (FFA), and cash for work (CFW) [23].

Inclusion of persons with disabilities into such humanitarian socio-economic empowerment schemes is particularly relevant given that they may have less access to informal working opportunities in restaurants/shops, construction/manual labor, NGO volunteering, and domestic work relative to the general population. According to the REACH MSNA, 44% of adult men and 4% of adult women in Jadimura camp are working to earn an income. This compares to 2% (all men) of the sample who report some form of employment.

Survey results indicate that 0% of working age persons with disabilities are participating in CFW, vocational, or skills training programs. Moreover, no persons with disabilities reported that anyone in their household is participating in CFW, vocational, skills training programs or receiving cash assistance.

Figure 14 outlines what persons with disabilities view as the most significant barriers preventing their access to training and CFW opportunities. The program being not inclusive of person with disabilities was reported as a barrier for 84% of working age PwD respondents. This means that the PwD feel that the type of activities that are being done in exchange for cash are not suitable for persons with their types of impairments. No data is available on CFW programs by type, however anecdotal information suggests that the majority of

[23] Livelihoods Working Group Food Security Sector, Support To Livelihoods Of Host Communities And Resilience Opportunities For The Rohingya refugees, May 2018.
CfW programs involve construction or manual labour work, which may be difficult for persons with disabilities to contribute to.

**Difficulties getting to job sites** was considered equally as a barrier to participating in CfW programs, with 84% of working age PwD reporting that this presented a challenge. Difficulty getting to job sites could be due to a range of factors including job sites being too far, difficult topography, obstacles in pathways, or soft surfaces incompatible with wheelchairs or other mobility devices. These same issues could extend to mobility at the CfW job site itself, particularly if related to construction. Finally, no PwD reported a lack of awareness or information about CfW programs.

**FIGURE 14: BARRIERS TO ACCESSING CASH FOR WORK SCHEMES FOR PWD**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Program not adapted for PwD</td>
</tr>
<tr>
<td></td>
<td>Physically not accessible (difficulty getting to job sites)</td>
</tr>
<tr>
<td></td>
<td>Lack of information on CfW programs</td>
</tr>
</tbody>
</table>
PROTECTION

Rohingya refugees in the camps are exposed to a range of protection risks including sexual and gender-based violence, psychological distress or trauma, natural disasters, recruitment by armed groups, trafficking, child labor and marriage, neglect, and family separation. Persons with disabilities may be especially vulnerable to such safety and security threats because they cannot run for help, communicate or comprehend important messages and as a result may require protection considerations.

Despite this, persons with disabilities survey respondents felt largely very safe (Figure 15). The one respondent who reported feeling only sometimes safe was female. Of the 11 respondents who cited some safety concerns, all mentioned verbal harassment or teasing.

Related to the protection is community participation, which is defined as an individual's interaction with the surrounding social system, including family, peers, or friends. It not only has an influence on mental wellbeing, but such a support network can serve as a protection mechanism, shaping how persons with disabilities share protection concerns, participate in decision making, and gain information about and access to humanitarian assistance.

**Figure 15: Frequency of Feeling Unsafe**

- Not at all (98%)
- Sometimes (2%)
- Always (0%)
At the same time, community participation is an aspect of inclusion that may be adversely affected by disability, putting persons with disabilities at risk of isolation and neglect, particularly in the context of displacement where family and community structures have been disrupted. As mentioned previously, only 45% of the married survey participants are cohabiting with their spouse. For the remaining 55% of survey participants, they have been separated from their spouses or their spouses have deceased.

Figures 17 indicates that the median frequency of persons with disabilities accessing community spaces and activities (mosque, market, women-friendly spaces, meeting with friends etc.) is barely 3-4 times a month. Relative to their male counterparts, female persons with disabilities report that they less frequently participate in community activities. This is likely due to gender norms and conservative attitudes amongst the Rohingya community which restrict women's participation generally. Analysis on the interplay between gender and disability in this case would require more in depth analysis.

**FIGURE 16: ACCESS TO COMMUNITY SPACES FOR PERSONS WITH DISABILITIES**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23%</td>
<td>18%</td>
</tr>
<tr>
<td>No difficulty</td>
<td>73%</td>
<td>61%</td>
</tr>
<tr>
<td>Some difficulty</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>A lot of difficulty</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cannot do it at all</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**FIGURE 17: FREQUENCY OF PARTICIPATION IN COMMUNITY ACTIVITIES**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>0 times per month</td>
<td>27%</td>
<td>40%</td>
</tr>
<tr>
<td>1-2 times per month</td>
<td>37%</td>
<td>18%</td>
</tr>
<tr>
<td>3-4 times per month</td>
<td>0%</td>
<td>21%</td>
</tr>
<tr>
<td>4 or more times per month</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Unfortunately, no known information on frequency of community space access for the non-disabled population is available for comparative purposes. However, persons with disabilities perceived access to community spaces and activities, suggests that community participation is relatively low, with 76% of respondents reporting that they face a lot of difficulty or have no access (no notable differences observed between males and females). Furthermore, 0% of persons with disabilities respondents report participation in decision making committees or bodies within their communities and only 2% reported participation in group activities where they talk about problems.

The above results indicate that persons with disabilities have a low level of participation and engagement at the community level, suggesting that support networks extending beyond the immediate family may not be well developed.
Figure 20 explores the factors which inhibit and facilitate access to community spaces and activities. Community spaces difficult to access without assistance (no accessibility upgrades) was cited by the majority of respondents to act as a barrier to using or accessing community spaces and activities (90%). Potential underlying reasons for this are explained in other sections. Other types of barriers were less unanimously experienced, Thirty-three percent felt that external assistance (friends and family) were not always available to support their attendance of community spaces while 23% felt that the distance to the community spaces and activities hindered their ability to attend.

Finally, 15% perceived negative attitudes in the community towards persons with disabilities represented a barrier for their participation. This factor features as a more substantial barrier for PwD than it does in relation to accessing basic services (with the exception of education). This signals that factors of discrimination and stigma are more obtrusive to the participation of persons with disabilities in the social sphere. On the other hand, elements that enable access were cited to be assistive devices (43%), close proximity to community spaces/activities (38%) and the support of family and friends (37%).
FINDINGS: GAPS AND CHALLENGES TO INCLUSION MAINSTREAMING AMONG SERVICE PROVIDERS

This section aims to provide a snapshot of systems and processes humanitarian actors currently have in place to address barriers to safe and meaningful access to services for persons with disabilities (with an emphasis on the gaps, limitations and challenges), based on the results of the structured interviews with 11 services providers. Given the small sample size, findings are intended to be only indicative.

After first describing the profile of the service provider sample and perceived inclusivity of the services provided in Jadimura Camp, findings are organized according to a few selected humanitarian inclusion standards and sector specific areas of inclusion as defined by Age and Disability Capacity Programme (ADCAP), including human resources, collection of information, and addressing barriers (physical, information/communication, and attitudinal).

SERVICE PROVIDER PROFILE

Service providers interviewed for the purposes of the assessment included both international NGOs (8) and local NGOs (3). Collectively they provide services across a range sectors, including protection (5), education (3), health (2), WASH (1), shelter (1), site management (1), and food (1) (Figure 21). Of the 11 service providers, 10 consider children to be a key target group of their activities, followed by women (7), men (7), youth (7), elderly (4), PwD (3), and unaccompanied or separated children (2) (Figure 22).
PERCEIVED INCLUSIVITY OF SERVICES

Service providers were first prompted to generally assess whether their organization made efforts to include and welcome all persons with different impairments in their services and programming, the results of which are summarized in Figure 23. Almost unanimously, service provider reported that there has been some level of initiative on behalf of better including persons with disabilities. The net result of these efforts however, was perceived to not be sufficient to overcome the multitude of barriers and ensure accessibility of persons with disabilities to services. Figure 24 summarized perception of service accessibility for persons with disabilities in respect to their sector of intervention. The majority of service providers (eight out of eleven) still perceived services to be largely inaccessible.

FIGURE 23: SERVICE PROVIDER HAS TAKEN EFFORTS TO INCLUDE PERSONS WITH DISABILITIES

FIGURE 24: SERVICES ARE ACCESSIBLE FOR PERSONS WITH DISABILITIES
The key humanitarian inclusion standard on human resources requires that ‘staff and volunteers have the appropriate skills and attitudes to implement inclusive humanitarian action’ (see ADCAP Key inclusion standard 8). To achieve this, staff and volunteers should be sensitized on the human rights and disability and receive training on how to include persons with disabilities in humanitarian action on an equal basis with persons without disabilities.

**Sensitization:** According to the results of the interviews with service providers, ten service providers consider their teams to be fully aware of the access needs and rights disabilities and/or difficulties in Jadimura Camp and one service provider considers themselves to be somewhat aware. However, only four service providers can definitively report that sensitization of staff on disability is part of their internal diversity and protection policies while an additional four are not sure and three confirmed that disability and equality training were in fact not integrated into their policies. This signals that perhaps disability awareness is not as widespread across all levels of the organization as may be perceived and that there is need to better underpin efforts to promote disability awareness within organizations with institutionalized policies. Moreover, the finding that 5% of PwD report negative attitudes of staff as a barrier to receiving healthcare suggest that more robust efforts to ensure proper sensitization of staff is worthwhile.

**Figure 25: Staff Sensitization on Disability**

<table>
<thead>
<tr>
<th>Perceived organizational-level awareness on the rights of persons with disabilities</th>
</tr>
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<tr>
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<table>
<thead>
<tr>
<th>Sensitization of staff on disability as part of diversity and protection policies</th>
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</thead>
<tbody>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

**Training:** Figure 26 summarizes the number staff and volunteers who have received training to improve their skills in including PwD in service provision. Only two of the 15 interviewed organizations report that all of their staff have received training. The focus of the disability trainings varied depending of the organization, with some reporting that they delivered or received general and introductory trainings on inclusion of persons with disabilities while in other cases trainings were more focused and tailored to their programming (ie. inclusive teaching techniques). However, many service providers indicated that the training they received or delivered to staff was informal or not comprehensive enough. “The training on disability not enough for us, there is need for more in depth training and external technical support,” said one education service provider.

All service providers expressed a need for in-depth inclusion training, considering it be be priority measure for ensuring better inclusion of persons with disabilities in the short term. This may be particularly relevant for education service providers given that six of the 15 children with disabilities reported a lack of human capacity within schools to provide tailored learning assistance was hindering access. Considering that one in two service providers considers a lack of internal inclusion expertise as a barrier to implementing inclusive programming, a training of trainers by an external inclusion expert may be the most suitable approach.
COLLECTION OF INFORMATION

One key dimension of inclusion in respect to sector inclusion standards is collection of information to ensure that PwD are identified and that their capacities and needs are assessed and monitored. To achieve this it is recommended that information relating to persons with disabilities is collected, analyzed, and reported in all humanitarian information management systems.

**Disaggregating data:** Data collected and analyzed at all stages of the project management cycle should be disaggregated by sex, age and disability (see ADCAP Key inclusion standard 1). Of the interviewed service providers, three consider that they fully (systematically) collect disability disaggregated information, five consider that they sometimes collect disability disaggregated information, and three report that they never collect disability disaggregated information (Figure 24).

**FIGURE 24: DISABILITY DISAGGREGATED DATA COLLECTION**

- Collecting disability disaggregated information
  - None
  - Somewhat
  - Fully

- Collecting data on disability using the Washington Group questions
  - No
  - Don’t know
  - Yes

- Considers more inclusive data collection/monitoring & evaluation systems as one of the top three priority inclusion measure for their organization in the next six months
  - No
  - Yes

**FIGURE 26: STAFF TRAINING ON INCLUSIVE SERVICE PROVISION**

- Staff (refugee, national and international) trained inclusive provision of services to persons with disabilities
  - None
  - Don’t know
  - Some
  - All

- Considers additional disability inclusion training for staff as one of the top three priority inclusion measure for their organization in the next six months
  - No
  - Yes
However, none of the service providers reported that their information management systems were aligned to the Washington Group Questions (WGQs). As discussed in section 5, Washington Group set of questions (short set) are a validated and endorsed means to collect nationally, regionally, and locally comparable data on and identify persons with disabilities. An HI-led project named ‘Disability Statistics in Humanitarian Action’ revealed that when using the WGQs significantly more people with disabilities were identified than when existing data collection methods were used.

WGQs can therefore be a partial solution to the problem of identifying persons with disabilities, which is reported as a challenge to implementing inclusive programming by ten of the 11 interviewed service providers. Accordingly, there is a need for service providers to adapt existing data collection tools to the WGQs. Ten of the 11 interviewed service providers acknowledge the need for the more rigorous and systematic collection of disability data. Such data collection efforts must be linked with referral pathways and defined processes on how to use data for the promotion of more inclusive programming. While data was not systematically collected, many service providers indicated that they are referring externally to HI or other specialized actors.

Consultations with persons with disabilities: Disaggregated data on disability should be accompanied by direct engagement with persons with disabilities to identify and monitor their capacities and needs, and their access to humanitarian assistance. Figure 25 summarizes the extent to which service providers have consulted persons with disabilities in the planning or design of their services in Jadimura. Six service providers self-report that they have not consulted persons with disabilities, while three have somewhat consulted persons with disabilities, and two have fully consulted persons with disabilities. In comparison, only two service provider respondents indicated that a higher level of consultations with persons with disabilities was a top three priority step for their activities to be more inclusive of PwD in Jadimura.

**FIGURE 25: CONSULTATIONS WITH PERSONS WITH DISABILITIES**

Consultation with persons with disabilities in the planning or design of services

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Fully</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>3</td>
<td>2</td>
<td></td>
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</table>

Considers more consultations with persons with disabilities as a top three inclusion measure for their organization in the next six months

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
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<td>9</td>
<td>2</td>
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</table>

**ADDRESSING PHYSICAL BARRIERS**

The key humanitarian inclusion standard on safe and equitable access requires that barriers that affect participation and access to services are addressed and factors that enable persons with disabilities to participate and have access to services are strengthened (see ADCAP Key inclusion standard 2). This section focuses on service provider measures to remove physical barriers, which have been discussed at length in section 5. Figure 26 provides a general summary of such physical inclusion measures, which is followed by a more detailed discussion per sector.
The **shelter** service provider reported integrating several different inclusion measures to overcome physical barriers faced by persons with disabilities. This included installing ramps or building slopes around two to three shelters of persons with disabilities as well as building crossings with bamboo over surface water drainage obstacles. They also noted in the future they will endeavor to build houses without raised entranceways. Moreover, for distributing shelter materials, the organization has door to door delivery available.

The **food** service provider similarly reported offering door to door delivery of food items for persons with disabilities and other vulnerable households that were unable to travel to or carry food from the distribution site. Moreover, special seating is available for persons with disabilities who attend distributions.

The **WASH** service provider reported that they abided by some universal design standards when constructing latrines and when possible, tried to build latrines in close proximity to persons with disabilities shelters.

The two **health** service providers both provide home-based/mobile care to persons with disabilities, have ramps at the entranceways of their health facilities, and have persons available to support persons with disabilities move up and down stairs and around the health facilities in the event that they are not able to do so alone or with the support of their caregiver. Additionally, one of the health service providers delivers care from a ground floor location, has included other inclusive design features to their health facility building, and has selected an accessible and central location for their health facility structure.

All three **education** actors are providing services in ground floor locations and one education service provider reported creating comfortable and suitable seating arrangements (for children with physical disabilities) and created buddy systems or identified volunteers/staff to help walk or carry children with disabilities to and from school where needed. However, largely education actors did not report many physical adaptations to the learning environment for children with disabilities.

Similarly, the four **protection** services providers did not focus their inclusion measures on easing the physical barriers, with the exception of one, which offered a 300 BDT stipend to persons with disabilities for transport costs to their facility.

### Addressing Information & Communication Barriers
This section focuses on service provider measures to remove information and communication barriers, which occur when information is not made available and accessible for everyone. These types of barriers can exclude persons with disabilities, particularly those with mental, communication or sensory impairments.

As shown in Figure 26, three of the eleven service providers reported taking steps to ensure communication methods are appropriate for PwD. All three of these service providers belonged to the education sector. Some are arranging seating close to the blackboard and teacher for children with disabilities with sensory impairments and all reported relying heavily on body language, visual formats, singing, play, dance, and simple language when working with children with disabilities. This was accompanied by inclusive learning materials, which in some cases were provided by HI. No service providers employed sign language or brail, although some reported referring to HI and other actors for assistive device donations.

Notably, many of the service providers from other sectors perform door to door identification and/or home based services. While not reflected in Figure 26, this direct line of communication with persons with disabilities is one means of overcoming information barriers resulting from the exclusion of persons with disabilities from the community and other support networks through which information is commonly channeled. Among service providers there is an expressed need to enhance approaches to inclusive communication with persons with disabilities, with 7 out of 10 reporting that communication with persons with disabilities is a challenge to implementing inclusive programming.

**FIGURE 26: ADAPTATION TO COMMUNICATION METHODS**

![Diagram showing adaptation to communication methods with 7 out of 10 service providers view communication with PwD as a challenge to implementing inclusive programming.]

**ADDRESSING ATTITUDINAL BARRIERS**

This section focuses on service provider measures to remove barriers related to attitudes, which encompasses negative attitudes, discrimination, patterns of overprotective behavior, as well as other misconceptions or lack of awareness on PwD needs and rights. As sensitization of staff on such issues was captured in the section on human resources, the focus here will be on community, family, and PwD attitudes. As shown in Figure 27, four of the eleven service providers report disseminating information on disability and PwD rights in awareness raising or community sensitization activities in Jadimura Camp.

The scope of such awareness raising measures vary from sector to sector but in most cases disability-related
Figure 27: Inclusion Mainstreaming in Awareness Raising/Community Sensitization

Disseminates disability information and rights awareness materials

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
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<tbody>
<tr>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

Considers better incorporation of disability/inclusion messaging as a top three inclusion measure for their organization in the next six months

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>
CONCLUSION & RECOMMENDATIONS

The results of the above analysis indicate that in general persons with disabilities are experiencing barriers to accessing services across the sectors. The specific barriers hindering access vary from sector to sector. However, some general trends can be observed. Notably, persons with disabilities perceive that the types of barriers most hindering access are physical in nature. In other words, they typically attribute their reduced access as relating to factors such as long distances between them and the services, challenging topography, or unadapted infrastructure (staircases, narrow doors, level changes and thresholds etc.). However, again a limitation of the survey is that it primarily includes persons with physical difficulties, which may bias this result.

In contrast, very few ascribe difficulties in access to informational or communication barriers, bearing in mind that perceptions of information barriers as they apply to oneself are vulnerable to subjectivity and unreliability, as inherently the judgment may be made on the basis of incomplete information. Similarly, attitudinal barriers were not highly reported except in relation to access to education and community participation, which have a social dimension. Measurement of attitudinal barriers are similarly not without limitations, as persons with disabilities views on disability are conditioned by the same cultural biases and misconceptions that are entrenched in their communities, they may be unable to detect how attitudes constrain their access.

Service providers have widely demonstrated a conscientiousness of the need for inclusion mainstreaming in their activities. However, the results suggest that inclusion measures implemented by service providers are in some cases ad hoc, are not comprehensive, and are not underpinned by internalized by systems on inclusion at a mission or organizational level. Moreover, in some cases there is a disconnect between the inclusion measures implemented by service providers with the aim of addressing barriers, and the actual barriers reported by persons with disabilities (Figure 28).
### Figure 28: Barriers Versus Inclusion Measures to Improve Accessibility by Sector

<table>
<thead>
<tr>
<th>Top Three PwD Reported Barriers</th>
<th>Service Provider Inclusion Measures to Overcome Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shelter</td>
<td>1. Ramps/slopes</td>
</tr>
<tr>
<td>1. Steps in doorways</td>
<td>2. Upgrading pathways</td>
</tr>
<tr>
<td>2. Beds too high or too low</td>
<td></td>
</tr>
<tr>
<td>3. Narrow doors</td>
<td></td>
</tr>
<tr>
<td>2. WASH</td>
<td>1. Adherence to some universal design standards</td>
</tr>
<tr>
<td>1. Difficulty carrying/pumping water</td>
<td>2. Construction of infrastructure in close proximity to PwD shelters</td>
</tr>
<tr>
<td>2. Latrine not adapted for PwD</td>
<td></td>
</tr>
<tr>
<td>3. Physically not accessible</td>
<td></td>
</tr>
<tr>
<td>4. Food distributions</td>
<td>1. Door to door distribution</td>
</tr>
<tr>
<td>1. Difficulty carrying food</td>
<td>2. Resting areas at distributions</td>
</tr>
<tr>
<td>2. Long lines</td>
<td>3. Information dissemination on PwD risks and rights</td>
</tr>
<tr>
<td>3. Distribution points too far</td>
<td></td>
</tr>
<tr>
<td>6. Health</td>
<td>1. Home-based care</td>
</tr>
<tr>
<td>1. Physically not accessible/not adapted for PwD</td>
<td>2. Accessible building design (ramps, ground floor/central location)</td>
</tr>
<tr>
<td>2. Service provider too far</td>
<td>3. Personnel available to support PwD move up and down stairs</td>
</tr>
<tr>
<td>3. Long wait times</td>
<td>4. Information dissemination on PwD risks and rights</td>
</tr>
<tr>
<td>7. Education</td>
<td>1. Inclusive learning materials/communication methods</td>
</tr>
<tr>
<td>1. School not adapted for CwD</td>
<td>2. Good parenting sessions</td>
</tr>
<tr>
<td>2. Learning materials not appropriate</td>
<td>3. Ground floor locations</td>
</tr>
<tr>
<td>3. No human capacity to provide special assistance for CwD</td>
<td>4. Buddy systems or identified volunteers/staff to help walk or carry CwD</td>
</tr>
<tr>
<td>8. Livelihoods</td>
<td>5. Adapted seating arrangements</td>
</tr>
<tr>
<td>1. Program not adapted for PwD</td>
<td>6. Information dissemination on PwD risks and rights</td>
</tr>
<tr>
<td>2. Physically not accessible (difficulty getting to job sites)</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Protection/ community activities</td>
<td>1. Transport stipend</td>
</tr>
<tr>
<td>1. Community spaces not adapted/physically accessible</td>
<td>2. Information dissemination on PwD risks and rights</td>
</tr>
<tr>
<td>2. No one to assist</td>
<td></td>
</tr>
<tr>
<td>3. Community spaces too far</td>
<td></td>
</tr>
</tbody>
</table>

### Recommendations

The outlined set of recommendations are not intended to be comprehensive or definitive, but are rather targeted to react to the specific findings of this survey. They should be considered in tandem with available general and sector-specific technical guidelines on humanitarian inclusion for persons with disabilities. In the same vein, it is not a substitute for more technically-oriented sector-specific inclusion assessments and accessibility audits by relevant experts, and it is important to note that persons with disabilities should be continually consulted, particularly in dynamic contexts such as Bangladesh.

In light of the gaps observed in inclusion-related human resource capacities, there is a need to systematically **build the capacity of staff and volunteers** by raising awareness of the rights of people with disabilities and training them to include older people and people with disabilities in humanitarian action. Trainings should be tailored to the type of programming and roles and responsibilities of relevant staff involved and should give attention to referral pathways for persons with different types of disabilities. If internal inclusion expertise are unavailable (which reportedly is the case for many), service providers should seek external guidance from HI or other organizations or consultants(s) with said expertise.
For many service providers, information on the situation of persons with disabilities is not systematically collected or relies on unreliable measurement tools. To facilitate the identification of persons with disabilities and the design of inclusive service delivery for PwD, align data management systems to the Washington Group questions. Further, disaggregation of data according to disability should extend to all phases of the data management cycle, including indicator design, analysis and reporting. Moreover, it should be linked to referral pathways and mechanisms to ensure corrective actions are implemented in response to disability-related findings (level of participation, needs, barrier types etc.)

Consultation with persons with disabilities is only reported by a few service providers and appears limited in scope and depth. As a result, service providers should give increased attention to consulting with persons with disabilities at all phases of project implementation, including during needs assessments, endline assessments, and routine project monitoring. Where possible, use participatory monitoring and evaluation methodologies that directly engage PwD in developing and implementing data collection and monitoring systems. Outreach and set up of disability-focused organizations and community groups (including HI) could yield insights into creating disability inclusive programming and can help in mobilizing or potentially identifying persons with disabilities.

Physical accessibility of services is a widespread and crosscutting challenge experienced by persons with disabilities. It is therefore recommended that site management and shelter consult with persons with disabilities on challenges and perform an accessibility audit on footpaths and access routes throughout the camp. This will provide a foundation for developing a plan to reduce barriers linked to physical accessibility, which could include ensuring that pathways are at least 150 cm wide, there are crossing points over all open drainage canals, pathway slopes are reduced where possible and handrails are installed for inclines steeper than 1:20, shaded resting places at 200 meter intervals are available along main circulation routes, pathways are covered with gravel or similar materials.

Existing shelter sector initiatives to include persons with disabilities should be reinforced, scaled up, and formalized through integration into all internal standard operating procedures. Moreover, they should be expanded, with priority given to the following based on the main barriers reported by persons with disabilities:

1. Make necessary adaptations so that a barrier-free entrance is ensured for persons with disabilities. This could include the elimination of steps and thresholds through ramps or by taking advantage of natural inclines or building slopes to minimize the difference between the ground level inside and outside the shelter.
2. Steps should be taken to ensure that NFI and shelter kits items are suitable for all persons with disabilities. For example, the mat beds on the floors of Rohingya shelters revealed themselves to be a significant problem for many persons with disabilities. After further consultation with persons with disabilities, replacement of floor mats with raised beds for persons with specific types of physical disabilities should be considered.
3. Shelter actors should respect the inclusion guideline on door width which stipulates that doors should be a minimum of 90 cm wide to respond to the problematic area of narrow doors faced by many persons with disabilities.

Universal design principles of WASH infrastructure should be reviewed and more rigorously applied through adaptations. Several specific actions corresponding to the main barriers highlighted by persons with disabilities are as follows:

1. In consideration of the high number of persons with disabilities who cited difficulties in carrying water, it is recommended that WASH service providers give greater scrutiny to the design of distributed water containers. Detailed guidance on universal and inclusive designs are available, but in summary could include smaller water containers that would be easier to carry, water containers which can be carried over ones shoulder or back, or narrower vessels with thinner handles on top that can be carried simultaneous to using a crutch or other mobility device.
2. Difficulties in pumping water reported by persons with disabilities could additionally be exacerbated by inaccessible water point designs, which should be assessed further and responded to accordingly with adaptations. This could include but is not limited to features such as extended water pump handles, automatic pumps, a water evacuation system to reduce slipperiness of surfaces, and accessible platforms.

3. Conduct an accessibility audit of existing latrines and consult further with persons with disabilities to determine in which ways latrines are inconsistent with universal design standards and adapt accordingly (see Section 5.2 for

4. To address distance related challenges to water points, ensure that 20% of water points are clearly signposted and located within 30 meters of individual shelters.

07 Food distribution inclusion measures are generally well suited for the types of barriers reported by persons with disabilities, but can be strengthened and broadened so that they better translate into improved accessibility for persons with disabilities.

1. Difficulty carrying food, which was the top barrier reported by persons with disabilities, implies a need for daily laborers or other persons to support persons with disabilities in navigating the distribution site, communication, and carrying food. However, the food actor involved in the assessment reported that this measure was already in place, while at the same time, no person with disability in the sample reported having taken advantage of such a provision. This suggests that persons with disabilities have successfully been able to rely on their caregivers and support networks to collect in their stead or awareness on this measure is low. It is therefore recommended that food service providers conduct in depth consultations with persons with disabilities to determine if and how door to door food distribution options are being used.

08 2. Taking into account the long lines at food distributions, food actors should set up priority lines with specific assistance for persons with disabilities (and others who may need it) clearly signposted, with shaded resting areas and accessible toilets nearby. While resting areas at distribution sites are reportedly provided by food service providers, there is a need for the service providers to self assess if upgrades are in line with sector standards and if prioritization for persons with disabilities in seating areas is being enforced.

3. Where budget, time, and human resource capacity permit, it is recommended that food distribution actors organize a larger number of smaller distributions so that they may be in closer proximity to persons with disabilities homes and thus reduce barriers related to distance to distribution points.

09 Health service provider inclusion measures are variable, but are in many ways in tune with the types of barriers reported by persons with disabilities. Priority recommendations based on assessment results include:

1. Regardless of measures to adapt health facilities, unadapted health facilities have reportedly remained a challenge for many persons with disabilities. It is therefore recommended that health actors conduct accessibility audits of health facilities and make adaptations accordingly, examples of which are found in Section 5.4.

2. Home-based care is reportedly available by most health service providers in the sample. On the other hand, none of the sample reported being the recipient of mobile service aside from HI. A closer examination of the underlying causes (potentially limited resources, the beneficiary identification process, persons with disabilities awareness) prior to defining recommendations. However, better outreach may in part be facilitated by improved identification of persons with disabilities techniques (Recommendation 2) or strengthened referral pathways.

3. To ameliorate the barriers imposed on persons with disabilities by long wait times, it is recommended that service providers consider prioritizing persons with disabilities in lines where appropriate or arranging dedicated visiting times.

10 Education service providers collectively are taking several relevant steps to promote inclusion of children with disabilities, although the sophistication of such measures varies from actor to actor. To maximize impact
it is recommended that education actors focus on the following:

1. As with the other sectors, a lack of adapted facilities was reported as a barrier to accessing education. An **accessibility audit** is required to determine the precise gaps and opportunities for upgrades, some examples of which are found in Section 5.5.

2. Results indicate that the existing education service provider practice of incorporating inclusive learning materials and methods should be amplified. As part of the ongoing initiative of the education sector to roll out a blueprint curriculum within NGO learning centers through the Learning Competency Framework and Approach (LCFA), it is recommended that some specific elements be included for children with disabilities. Moreover, where resources permit, it is recommended that **individual education plans** be developed for each child with disability suited to their needs and capacities.

3. Service providers and persons with disabilities alike sided a lack of available teachers (in terms of quantity and training), to provide special assistance for children with disabilities. As part of the further **trainings** proposed under recommendation 1, there should be an emphasis on inclusive education targeted towards education staff.

11 No **livelihood** service providers were among the sample, however, based on feedback from persons with disabilities the following is recommended:

1. Provide **inclusive cash for work programs** where persons with different types of impairments can participate (will vary according to sector and disability type but will require adaptation or removal of barriers faced by persons with disabilities) or consider alternatives such as unconditional cash grants that can stimulate their household economy in a similar way. Ensure that the tasks carried out and tools used by persons with disabilities are adapted to individual capacity.

2. If the cash for work activity selected is unsuitable for persons with disabilities and alternatives are not possible, consider **targeting households with persons with disabilities** so that persons with disabilities who cannot work will indirectly benefit.

3. To overcome the difficulties in getting to job sites, it is recommended that sites be located in accessible, **centrally located locations** close to the homes of persons with disabilities. Moreover, **buddy systems** with other CfW participants could be arrange to ensure that the persons with disabilities are supported to reach the activity.

12 Despite a low rate of attitudinal barriers reported by persons with disabilities within this particular sample, as a good practice it is recommended that services providers continue and increase efforts to **sensitize and increase awareness of the community and caregivers** on persons with disabilities, rights, needs, and risks. However, given that barriers related to discrimination and stigma were most predominant in social and learning environments, these types of initiatives should be give utmost attention by the respective service providers.

13 Communication and informational barriers did not take precedence according to persons with disabilities. However, as those in the sample primarily had physical disabilities, it is still recommended that service providers aim to deliver messages door to door when possible and use multiple communication formats such as large visual formats with color contrast, auditory, sign language if relevant etc., which has thus far not largely not been a part of organizational efforts to make their services more inclusive.

14 There is a need to conduct a larger-scale assessment on barriers and facilitators to accessing services with a stratified sample which ensures representation of persons with different types of disabilities, in terms of severity and type of functional difficulty. This is recommended given the limitation of this particular survey, which primarily included persons with physical disabilities. As previously mentioned, the lack of representation of persons with intellectual or psychosocial disabilities, who in many contexts face a lot of stigma and discrimination, could account for the low number of persons with disabilities reporting attitudinal barriers. Such a sampling technique would allow more detailed analysis of the relationship between difficulty type and severity with access and barriers.