

COX'S BAZAR, BANGLADESH

# Joint Multi-Sector Needs Assessment (J-MSNA)

Host Community

December 2021



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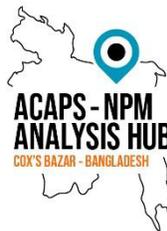


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## EXECUTIVE SUMMARY

The District of Cox's Bazar, located in southern Bangladesh, has some of the poorest living conditions in the country. It is characterised by low access to basic infrastructure and services compared to the national average.<sup>1</sup> At the same time, over the past four decades, in successive waves, the district has received Rohingya refugees fleeing violence in Rakhine State, Myanmar. Since August 2017, an estimated 750,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 900,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.<sup>2, 3</sup>

Needs in Ukhiya and Teknaf arise mainly from existing development challenges. However, they have been compounded by the refugee influx.<sup>4</sup> With the refugee population being almost double the host community population in the two upazilas,<sup>5</sup> the massive increase in population density following the influx, coupled with the pre-existing lack of livelihoods, levels of poverty and vulnerability among the host community population, has led to tensions over labour competition, falling wages and price hikes of daily essentials. Perceived increases in crime, security concerns, and high pressures on the environment leading to deforestation and depleting water sources have further been reported as sources of tension.<sup>6</sup>

The return of refugees to Myanmar continues to be uncertain.<sup>7</sup> In addition, the host community along the Bay of Bengal coast is exposed to frequent and sometimes severe cyclone winds and tidal surges, with recurrent flooding, as witnessed most recently during a large flood event that affected more than 80,000 individuals.<sup>8</sup> Lastly, the outbreak of the COVID-19 pandemic and associated containment measures severely disrupted livelihoods among the host community. This led to an exacerbation of needs in particular related to food security, health-seeking behaviour, education, and protection. As a result, host community households increasingly resorted to adopting coping mechanisms to meet their basic needs, including some crisis-level ones.<sup>9</sup> A renewed lockdown, implemented in April 2021, may have further aggravated the situation.

Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across host community populations and Rohingya refugee populations to support detailed humanitarian planning to meet the multi-sectoral needs of the affected populations and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. The general objective of the J-MSNA was to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners, through the provision of up-to-date, relevant and comparable information on the multi-sectoral needs of the host community populations in Teknaf and Ukhiya Upazilas.

<sup>1</sup> ACAPS, *Cox's Bazar: Upazila Profiles (September 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 30 November 2021).

<sup>2</sup> Compare [https://data2.unhcr.org/en/situations/myanmar\\_refugees](https://data2.unhcr.org/en/situations/myanmar_refugees).

<sup>3</sup> Information is applicable at the time of data collection (July-August 2021).

<sup>4</sup> Inter Sector Coordination Group (ISCG), *2020 Joint Response Plan, Rohingya Humanitarian Crisis, January – December 2020, Bangladesh (Cox's Bazar, 2019)*. Available [here](#) (accessed 30 November 2021).

<sup>5</sup> Bangladesh Bureau of Statistics, *Population & Housing Census-2011, National Volume-2: Union Statistics* (Dhaka, 2011).

<sup>6</sup> ACAPS, 2020; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Communities – In-Depth | August – September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 30 November 2021).

<sup>7</sup> International Crisis Group (ICG), *A Sustainable Policy for Rohingya Refugees in Bangladesh*, Asia Report N°303, 27 December 2019 (Brussels, 2019). Available [here](#) (accessed 30 November 2021).

<sup>8</sup> ACAPS, *CrisisInSight Weekly Picks, 04 August 2021* (Geneva, 2021). Available [here](#) (accessed 30 November 2021).

<sup>9</sup> ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Community, May 2021* (Cox's Bazar, 2021). Available [here](#) (accessed 30 November 2021).

The 2021 J-MSNA built on previous MSNAs, most notably the [2019](#) and [2020](#) J-MSNAs, with the aim to facilitate an understanding of the evolution of needs and service gaps across time, where possible. It was funded by UNHCR, the International Organization for Migration (IOM), and the Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO). The assessment was coordinated through the Inter Sector Coordination Group's (ISCG) MSNA Technical Working Group (TWG), led by the ISCG and composed of UNHCR, IOM Needs and Population Monitoring (IOM NPM), World Food Programme Vulnerability Analysis and Mapping (WFP VAM), ACAPS, and Helvetas with REACH as a technical partner. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses. This report focuses on the findings relating to the host community component of the J-MSNA.

The J-MSNA targeted Bangladeshi households living in Ukhiya and Teknaf Upazilas. Sectors and topics covered included Food Security and Livelihoods, WASH, Shelter and Non-food items (NFIs), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition and Communication with Communities (CwC). Both quantitative and qualitative data were collected. For the quantitative component, households were sampled from a UNHCR host community database, as well as UNHCR, WFP and IOM beneficiary databases, using a stratified random sampling approach, with the unions as the strata. Results are representative of the population included in the sampling frame, i.e. households registered with phone numbers in the databases and in areas with mobile reception, at the union level at a 95% confidence level and with a 10% margin of error. They are representative at the response level at a 95% confidence level and with a 3% margin of error. A total of 1,118 interviews were carried out between 12 July and 18 August 2021. Basic descriptive analysis was conducted, complemented by testing for statistically significant differences in outcomes between households of different socio-economic characteristics, and a comparison of 2019, 2020 and 2021 results, where possible. Qualitative focus group discussions (FGDs) were used to contextualise and validate the findings. A total of 20 FGDs were conducted and analysed by NPM and ACAPS, with men and women of different age groups between 21 and 29 September 2021.

Quantitative data collection was conducted remotely over the phone. This limited the type and quantity of information that could be collected and put constraints on the populations that could be included in the sampling frame. While the FGDs and secondary data as well as the sampling approach allowed to mitigate the impact of those constraints, results should be interpreted cognisant of possible gaps and biases, for instance phone ownership possibly being slightly biased towards better educated households. In addition, an overarching multi-sectoral analysis, and the estimation of the proportion of households in need and corresponding caseloads were beyond the scope of this assessment. However, qualitative results and secondary data were used to contextualise quantitative findings and draw qualitative links between sectoral outcomes to provide a more holistic picture of needs and service gaps. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures in place at the time of data collection, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of existing levels of need and not as an evaluation of the lockdown or COVID-19 containment measures.

## Key findings

**Host community households appeared to still be affected by the COVID-19 outbreak and its secondary impacts on livelihoods, with a further risk of an erosion of coping capacities and a deterioration of living standards.** Findings showed that needs most prioritised by households included access to food (as reported by 65% of households among their top three priority needs), shelter materials/upgrades (53%), and access to income-generating activities

(IGAs) (37%). Over the past three years, the proportions of households having reported these needs among their top three priority needs have steadily increased. In line with these trends, **Food Consumption Scores (FCS) were found to have deteriorated further compared to 2020 J-MSNA findings**, while the **reported adoption of certain livelihoods-based coping strategies remained at levels comparable to 2020 J-MSNA findings**.<sup>10, 11</sup> All of these trends are indicative of households still being affected by the COVID-19 outbreak and its secondary impacts on livelihoods. Moreover, at the time of data collection, roughly one third of households continued to report monthly per capita expenditures below the Minimum Expenditure Basket (MEB), indicating that they may not have been able to meet their basic needs.

As such, needs and service gaps have also remained across sectors. Almost three quarters of households (71%) continued to report having had issues with their **shelters** at the time of data collection, while roughly one third of households reported not having made shelter improvements or repairs in the 6 months prior to data collection despite having reported issues. With reportedly very limited shelter support from humanitarian actors having been received, a **lack of money to pay for materials or labour remained the most frequently reported reasons for not having implemented shelter improvements or repairs**.

Moreover, despite access to **water** reportedly having improved over the past three years, **roughly one third of households reported not having had enough water** at the time of data collection, and one in four households in Teknaf, or one in three households in Ukhiya, were reportedly using shallow tube wells as their main source of drinking water at the time of data collection. In addition, **roughly one fifth (18%) of households reported using an unimproved sanitation facility**, while roughly half the households reported female (49%) or male (47%) household members to have faced problems related to latrines at the time of data collection. **Large gaps also existed in relation to waste management**, with almost half the households (44%) reportedly not having had access to bins at the time of data collection, and roughly two thirds of households (69%) reportedly not having segregated waste.

**Gaps further remained in relation to education**. Compared to pre-COVID-19 enrolment rates, lower proportions of children had reportedly accessed home-based learning while schools were closed, indicating that **previously enrolled children missed out on their education while schools had been closed** (among households with school-aged children, 37% of households had reported at least one child as not having been enrolled in schools pre-COVID-19, while 50% of households had reported at least one child as not having accessed home-based learning while schools were closed). This may at least in part be attributed to a **lack of resources and the technological equipment needed to access home-based learning**, with the latter having been the most frequently reported barrier towards accessing home-based learning. Moreover, in particular **older children, and especially girls, may be at risk of having ended their education early** as a result of the COVID-19 outbreak, and barriers, such as marriage and households' inability to afford educational costs. **Young children**, on the other hand, who could not start their education through home-based learning when they should have normally got enrolled into schools had they been open, **may have experienced a delayed start in their education**. Lastly, while the majority of households were reportedly planning to send children back to schools, **difficulties covering related expenses were a frequently reported major expected challenge**.

Overall, **roughly half the households (51%) perceived unmet needs of children** in their community at the time of data collection – in line with the overall results, **most commonly related to education and food**. In addition, **barriers**

<sup>10</sup> ISCG, 2021.

<sup>11</sup>The Food Consumption Score (FCS) is a composite score based on (1) dietary diversity; (2) food frequency; and (3) relative nutritional importance of nine weighted food groups. The FCS is recorded from a seven-day recall period. In Bangladesh, thresholds for FCS classifications set by WFP are as follows: > 42 = Acceptable; > 28 - 42 = Borderline; ≤ 28 = Poor. 2019 and 2020 results: ISCG, 2019; ISCG, 2021c.

**accessing or using protection services** were reported, most commonly problems not being resolved (39%), followed by the services or staff having been unavailable due to the COVID-19 outbreak (16%). These may possibly be compounding perceived existing safety and security challenges.

Furthermore, **reported access to nutrition services in the host community was limited**, with low reported rates of screening of both children and pregnant or lactating women (PLW). This may in part be linked to **methodological limitations** of the assessment having resulted in **under-reporting of screening**. At the same time, however, the **containment measures put in place in April 2021 led to more limited access to the host community**, while also **promoting isolation for PLW**, which may have further contributed to a **reduction in the use of nutrition services**.

Lastly, while COVID-19-related negative trends in **health-seeking** behaviour observed in the 2020 J-MSNA<sup>12</sup> may have been partially reversed, pharmacies or drug shops remained the most commonly reported health treatment locations. In addition, **roughly half the households (51%) reported having experienced or expecting experiencing barriers when needing to access health care**, most commonly the specific medicine, treatment or service needed being unavailable, and long waiting times for services or overcrowding, thus indicating **continuing gaps in access to health care among the host community**.

**Some households were found to be more likely than others to report gaps or challenges**. These households included households with persons with disabilities, female-headed households, less educated households, and large households. **Households with persons with disabilities, female-headed households, and less educated households** were all more likely than households than without persons with disabilities, male-headed households, or better educated households, respectively, to report **worse outcomes across sectors**. Likely as a result, households with persons with disabilities were found to have been more likely to resort to coping strategies, with households with persons with disabilities having been more likely than households without persons with disabilities to report having adopted livelihoods-based coping strategies to meet their needs in the 30 days prior to data collection. Moreover, **children in vulnerable households may be at a higher risk of not receiving an education**, with higher proportions of households with persons with disabilities, female-headed households, and less educated households than households without persons with disabilities, male-headed households, or better educated households, respectively, having reported at least one child as not having been enrolled in formal schools pre-COVID-19 or that would not have been sent back to schools once they would have re-opened. Lastly, while **large households** were not found to have had disproportionate unmet needs, they were **more likely than small households to report having met their needs, especially education and health care needs, by adopting livelihoods-based coping strategies**. Moreover, also **in large households, children may face a particularly high risk of not receiving an education**.

Given the likely further exacerbated needs compared to last year and a risk of erosion of coping capacities, in the near and medium term, it will be important to **continue to closely monitor needs and service gaps** to allow for continued evidence-based programming addressing those needs. The results of the J-MSNA are characteristic of the very specific circumstances that prevailed at the time of data collection. As the situation changes, especially the **most concerning trends, such as food security and livelihoods outcomes, and likely accompanying adverse impacts, e.g. on education and child well-being, should be closely monitored**. Secondly, a **better understanding of the continued impacts of the COVID-19 outbreak and containment measures on the most vulnerable households** may help more effectively alleviate those.

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<sup>12</sup> ISCG, 2021.

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## List of Acronyms

<b>AAP</b>	Accountability to Affected Populations
<b>BDT</b>	Bangladeshi Taka
<b>COVID-19</b>	Coronavirus Disease 2019
<b>CwC</b>	Communication with Communities
<b>DAP</b>	Data analysis plan
<b>ECHO</b>	Directorate-General for European Civil Protection and Humanitarian Aid Operations
<b>FCS</b>	Food Consumption Score
<b>FGD</b>	Focus group discussion
<b>GBV</b>	Gender-based violence
<b>GiHAWG</b>	Gender in Humanitarian Action Working Group
<b>IGA</b>	Income-generating activities
<b>ISCG</b>	Inter Sector Coordination Group
<b>IOM NPM</b>	International Organization for Migration Needs and Population Monitoring
<b>J-MSNA</b>	Joint Multi-Sector Needs Assessment
<b>JRP</b>	Joint Response Plan
<b>LPG</b>	Liquefied petroleum gas
<b>MUAC</b>	Mid-upper arm circumference
<b>NFI</b>	Non-Food Item
<b>NGO</b>	Non-Governmental Organisation
<b>PLW</b>	Pregnant/lactating women
<b>PSEA</b>	Protection against sexual exploitation and abuse
<b>SEG</b>	Strategic Executive Group
<b>SGBV</b>	Sexual and gender-based violence
<b>SOP</b>	Standard Operating Procedure
<b>TWG</b>	Technical Working Group
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>USD</b>	United States Dollar
<b>VAM</b>	Vulnerability Analysis and Mapping Unit (of WFP)
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WFP</b>	World Food Programme

## Geographical Classifications

<b>District</b>	Third tier of administration in Bangladesh, forming sub-units of divisions
<b>Upazila</b>	Fourth tier of administration in Bangladesh, forming sub-units of districts
<b>Union</b>	Fifth tier of administration in Bangladesh, forming sub-units of upazilas
<b>Ward</b>	Sixth tier of administration in Bangladesh, forming sub-units of unions

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## INTRODUCTION

The District of Cox's Bazar, located in southern Bangladesh, has some of the poorest living conditions in the country. It is characterised by low access to basic infrastructure and services compared to the national average.<sup>13</sup> At the same time, over the past four decades, in successive waves, the district has received Rohingya refugees fleeing violence in Rakhine State, Myanmar. Since August 2017, an estimated 750,000 Rohingya refugees have fled to Cox's Bazar District, Bangladesh, where approximately 900,000 refugees are now residing in 34 camps in Ukhiya and Teknaf Upazilas.<sup>14, 15</sup>

Ukhiya Upazila is characterised by above-average levels of poverty and poor living conditions compared to the rest of the country. It is ranked the poorest upazila in Cox's Bazar District and among the 50 most socially deprived in the country. Despite all of Ukhiya being under the rural electrification network, the majority of the population does not have access to electricity. The upazila has the highest open defecation rate in the district, high rates of child labour, and low levels of food security. Evidence suggests that the refugee influx further exacerbated levels of poverty in Ukhiya.<sup>16</sup>

Teknaf is also among the poorest upazilas in Cox's Bazar and ranking among the 50 most socially deprived in the country. Levels of food insecurity are high, as is the population's level of vulnerability to market price fluctuations. The upazila is also characterised by low levels of access to electricity, and limited access to drinking water, sanitation and health facilities. It has the lowest literacy rate in Cox's Bazar District and a high prevalence of child labour. Both may have been compounded by the refugee influx – on the one hand, by host community teachers having left schools to work for higher wages in camps, and on the other hand, by boys increasingly having dropped out of school to make use of increased working opportunities in and around camps.<sup>17</sup>

Needs in Ukhiya and Teknaf arise mainly from existing development challenges, but have been compounded by the refugee influx.<sup>18</sup> With the refugee population being almost double the host community population in the two upazilas,<sup>19</sup> the massive increase in population density following the influx, coupled with the pre-existing lack of livelihoods, levels of poverty and vulnerability among the host community population, has led to tensions over labour competition, falling wages and price hikes of daily essentials. Perceived increases in crime, security concerns, and high pressures on the environment leading to deforestation and depleting water sources have further been reported as sources of tension.<sup>20</sup>

The return of refugees to Myanmar continues to be uncertain.<sup>21</sup> In addition, the host community along the Bay of Bengal coast is exposed to frequent and sometimes severe cyclone winds and tidal surges, with recurrent flooding, as witnessed most recently during a large flood event that affected more than 80,000 individuals.<sup>22</sup> Lastly, the outbreak of the COVID-19 pandemic and associated containment measures severely disrupted livelihoods among the host

<sup>13</sup> ACAPS, *Cox's Bazar: Upazila Profiles (September 2020)* (Cox's Bazar, 2020). Available [here](#) (accessed 30 November 2021).

<sup>14</sup> Compare [https://data2.unhcr.org/en/situations/myanmar\\_refugees](https://data2.unhcr.org/en/situations/myanmar_refugees).

<sup>15</sup> Information is applicable at the time of data collection (July-August 2021). One camp has since been closed.

<sup>16</sup> ACAPS, 2020

<sup>17</sup> Ibid.

<sup>18</sup> Inter Sector Coordination Group (ISCG), *2020 Joint Response Plan, Rohingya Humanitarian Crisis, January – December 2020, Bangladesh* (Cox's Bazar, 2019). Available [here](#) (accessed 30 November 2021).

<sup>19</sup> Bangladesh Bureau of Statistics, *Population & Housing Census-2011, National Volume-2: Union Statistics* (Dhaka, 2011).

<sup>20</sup> ACAPS, 2020; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Communities – In-Depth | August – September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 30 November 2021).

<sup>21</sup> International Crisis Group (ICG), *A Sustainable Policy for Rohingya Refugees in Bangladesh*, Asia Report N°303, 27 December 2019 (Brussels, 2019). Available [here](#) (accessed 30 November 2021).

<sup>22</sup> ACAPS, *CrisisInSight Weekly Picks, 04 August 2021* (Geneva, 2021). Available [here](#) (accessed 30 November 2021).

community. This led to an exacerbation of needs in particular related to food security, health-seeking behaviour, education, and (child) protection. As a result, host community households increasingly resorted to adopting coping mechanisms to meet their basic needs, including some crisis-level ones.<sup>23</sup> A renewed lockdown, implemented in April 2021, may have further aggravated the situation.

Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across host community populations to support detailed humanitarian planning to meet the multi-sectoral needs of the affected populations and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. The general objective of the J-MSNA was to inform evidence-based strategic planning of humanitarian response activities by the Strategic Executive Group (SEG), the Inter Sector Coordination Group (ISCG) Secretariat, sectors, and sector partners, through the provision of up-to-date, relevant and comparable information on the multi-sectoral needs of the host community populations in Teknaf and Ukhiya Upazilas.

The 2021 J-MSNA built on previous MSNAs, most notably the [2019](#) and [2020](#) J-MSNAs, with the aim to facilitate an understanding of the evolution of needs and service gaps across time, where possible. It was funded by UNHCR, the International Organization for Migration (IOM), and the Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO). The assessment was coordinated through the Inter Sector Coordination Group's (ISCG) MSNA Technical Working Group (TWG), led by the ISCG and composed of UNHCR, IOM Needs and Population Monitoring (IOM NPM), World Food Programme Vulnerability Analysis and Mapping (WFP VAM), ACAPS, and Helvetas with REACH as a technical partner. Sectors were actively involved in research design, preparations for data collection, and the discussion of results and analyses.

In the following chapter, the specific objectives of the assessment and the research questions will be introduced. The scope of the assessment and the methodology will be then outlined, including the sampling strategy, data collection and data analysis parameters. Moreover, ethical considerations, and challenges and limitations will be highlighted. Thereafter, key findings will be presented. The report will then close with a concluding summary and outlook.

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<sup>23</sup> ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Host Community, May 2021* (Cox's Bazar, 2021). Available [here](#) (accessed 30 November 2021).

## METHODOLOGY

### Specific objectives and research questions

Aiming to expand the body of analysis and address key information gaps by providing an accurate snapshot of the situation, the 2021 J-MSNA was conducted with the specific objectives to:

1. Provide a comprehensive evidence base of the diverse multi-sectoral needs among host community populations to inform the 2022 Joint Response Plan (JRP);<sup>24</sup>
2. Provide an analysis of how host community population needs have changed in 2021;
3. Provide the basis for a joint multi-stakeholder analysis process.

To this end, the J-MSNA sought to answer the following research questions:

1. What are the needs and service gaps within the host community?
2. How do needs differ between geographic areas?
3. What are the characteristics of households most in need?
4. What coping strategies are households adopting in order to meet their needs?
5. How have reported needs and service gaps changed for key indicators since 2020?
6. What are households' preferred modalities of assistance and priorities for 2022?

### Scope and tool development

In line with the geographical coverage of all previous as well as the 2022 JRP, the assessment targeted Bangladeshi households living in Ukhiya and Teknaf Upazilas. Sectors and topics covered included Food Security and Livelihoods, WASH, Shelter and Non-food items (NFIs), Protection, including the Child Protection and Gender-Based Violence Sub-Sectors, Health, Education, Nutrition and Communication with Communities (CwC). All aforementioned sectors or working groups as well as the Gender in Humanitarian Action Working Group (GiHAWG) were consulted during tool design. Both quantitative and qualitative data collection were conducted.

#### *Quantitative component*

For the quantitative household survey, indicators were identified, and the tool developed jointly with sectors. As interviews had to be conducted remotely over the phone, questionnaire length had to be limited. Therefore, sectors prioritised the identified indicators. The MSNA TWG subsequently finalised the tool, giving priority to questions as indicated by sectors. The final tool consisted of 12 sections of closed-ended questions, covering basic household- and individual-level information, as well as the sectors/topics outlined above. It was translated to Bengali prior to enumerator training and data collection. Data was collected via phone, from randomly sampled households, and data was collected by Bangladeshi enumerators between July 12 and August 26, 2021<sup>25</sup>

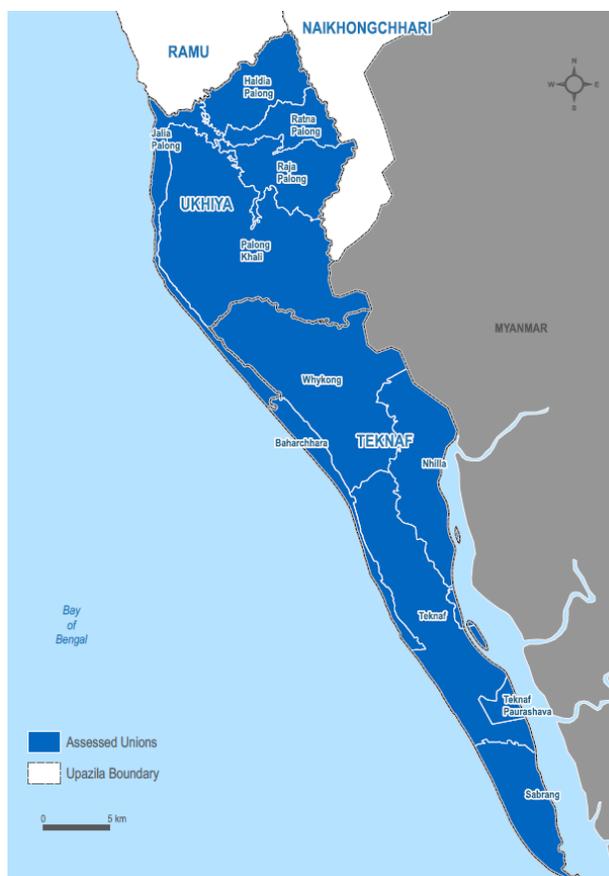
<sup>24</sup> A separate J-MSNA with the same objectives was simultaneously conducted in the refugee community.

<sup>25</sup> Phone numbers were accessed from the WFP beneficiary database following a data sharing policy agreement.

### Qualitative component

The question route for the focus group discussions (FGDs) was developed by the MSNA TWG and built upon the research questions least addressed by the quantitative tool, as well as the preliminary analysis of the household survey data, aiming to fill remaining information gaps and provide in-depth explanations and context around the quantitative results. The tool was translated to Bengali prior to enumerator training and data collection. A total of 20 FGDs were conducted and analysed by NPM and ACAPS, with equal gender representation between 21 and 29 September 2021.

**Map 1** Assessed unions in Ukhiya and Teknaf Upazilas, Cox’s Bazar



## Sampling strategy

### Quantitative component

Households, defined as a group of people living in the same shelter, and regularly eating from the same pot (sharing food), were the unit of measurement for this assessment.<sup>26</sup> Target sample sizes were based on the 2011 Bangladesh census.<sup>27</sup> A stratified random sampling approach was used, with the unions as the strata, and households were

<sup>26</sup> In line with the definition of a household used in the Bangladesh 2011 Census – “a group of persons, related or unrelated, living together and taking food from the same kitchen”.

<sup>27</sup> Bangladesh Bureau of Statistics, 2011.

sampled with the aim of generating results representative at the union level at a 95% confidence level and with a 10% margin of error, and overall results representative at a 95% confidence level and with a 3% margin of error.

Due to the absence of a comprehensive sampling frame, the sampling frame was constructed from partners' host community and beneficiary databases, including a UNHCR host community database covering host community populations living within 6 km of UNHCR camps, as well as WFP, UNHCR and IOM beneficiary databases. In order to ensure a geographical spread of the sample across the unions, the sample was drawn at the ward level. Each ward was only sampled from one database, though, to avoid sampling households twice. In most cases, the sample for each ward was taken from the database that contained the highest number of households for the ward. However, in order to avoid large biases towards a certain beneficiary population at the union level, it was ensured that for each union, the sample was drawn from a mix of databases. Sample sizes at the ward level were proportional to the ward-level population included in the sampling frame for each union.<sup>28</sup>

Only households registered with phone numbers could be included in the sampling frame. Furthermore, households in areas with little or no phone connection could not be reached. Lastly, due to Teknaf Sadar and Teknaf Paurashava not having been distinguished in all databases, these two unions were sampled and analysed as one stratum.

A buffer estimated based on the 2020 J-MSNA remote data collection experience was included into all sample size calculations to account for (1) non-eligible households (5%), such as mixed Rohingya-Bangladeshi households also being registered as refugees; (2) non-response (30%), including non-functional phone numbers, households without mobile reception, or switched off phones; (3) non-consenting or child-headed households (9%), including households not consenting to or not finishing the survey, or households without an appropriate respondent, including all households without a consenting individual aged 18 and above; and (4) data cleaning/errors (10%), including completed surveys that would be removed during data cleaning and therefore not be part of the final sample. A separate sample was drawn to pilot the tool.

The interviews were conducted with the person answering the phone, provided that consent was given and the respondent was aged 18 or above. The enumerator teams were composed of roughly equal numbers of male and female enumerators. While female enumerators could interview respondents of either gender, male enumerators were instructed to only interview male respondents, and agree on a time with female respondents for a female enumerator to call them back. Generally, with any respondent, three call-backs were attempted, before the sample point was registered as a non-response. Overall, 55% of respondents were female and 45% of respondents were male. Twenty-nine percent (29%) of female respondents and 1% of male respondents reported having replied on behalf of a female-headed household, with the remaining respondents having replied on behalf of male-headed households.

### *Qualitative component*

A total of 20 FGDs (10 with men and 10 with women), conducted by NPM and ACAPS, spread across different unions were targeted. The FGDs were designed to include participants from different age and gender groups, including 6 FGDs with 18 to 24 year-olds (3 with males, 3 with females), 7 FGDs with 25 to 40 year-olds (4 with males, 3 with females), 4 with 41 to 59 year-olds (2 with males, 2 with females), and 3 with 60+ year-olds (1 with males, 2 with females). FGD participants were purposively sampled from households having participated in the household survey,

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<sup>28</sup> The share of the sample for each union drawn from each database is detailed in [annex 1](#).

who gave consent to be contacted again but aiming to include household members other than the respondent of the household survey.

## Data collection

### *Quantitative component*

Quantitative data collection took place between 12 July and 18 August 2021. Due to heavy rainfall and subsequent flooding in the surveyed areas, data collection was interrupted from 3 to 15 August. A total of 1,118 households were surveyed across all 11 unions of Teknaf and Ukhiya Upazilas. Achieved sample size at the union level ranged from a minimum of 102 surveyed households (obtained in Nhillia and Ratna Palong) to a maximum of 130 surveyed households (as reached in Haldia Palong).<sup>29</sup> Results are therefore representative at the union level of all host community households included in the sampling frame at a 95% confidence level and with a 10% margin of error. Overall results are representative of all host community households included in the sampling frame at a 95% confidence level and with a 3% margin of error. They can further serve as a proxy of the entire host community population in Teknaf and Ukhiya Upazilas. Data collection was led by REACH and conducted by 5 teams of IOM NPM enumerators, consisting of 12 enumerators each (60 enumerators in total).

Prior to data collection, enumerators underwent a three-day online training to familiarise themselves with the tool and data collection protocols.<sup>30</sup> Sector representatives facilitated training sessions on the questionnaire sections pertaining to their sectors to ensure that the intent and wording of each question was well understood. The tool and data collection protocols were piloted with a sample of refugee households during a full-day remote piloting exercise to identify and rectify problems before the full roll-out of data collection. Following the piloting, another full day was dedicated to the review of the pilot, further refining the tool based on lessons learnt during the pilot related to phrasing/understanding of the questions by both the enumerators and the respondents, displaying/sequencing of questions on the screen or missing response options.

During the interviews, data was entered directly into tablets using the KoBoCollect software. At the end of each day, surveys were uploaded to the UNHCR server, where raw data was accessible only to one individual within REACH and one individual within UNHCR. Data was checked and cleaned on a daily basis according to a set of pre-established Standard Operating Procedures (SoPs) in line with defined minimum standards, including outlier checks, the categorisation of “other” responses, the identification and removal or replacement of incomplete, inaccurate or incoherent records, and the recoding and standardisation of entries.<sup>31</sup> All changes to the data were documented in a data cleaning log. Based on observations during the pilot, 25 minutes was established as the minimum length of the interview required to ensure an acceptable level of data quality. Any interviews falling below this threshold were excluded from the final dataset. Moreover, each respondent in the sample was allocated an ID, based on which and together with information on location (union and ward number), it was attempted to verify that the correct households had been interviewed. In total, 1 of 1,119 completed interviews were deleted from the final dataset due to an issue related to duplicate respondent IDs that could not be corrected.

<sup>29</sup> A full list of completed interviews by union is included in [annex 2](#).

<sup>30</sup> The enumerator training agenda is included in [annex 4](#).

<sup>31</sup> Compare [IMPACT Data Cleaning Minimum Standards checklist](#).

### *Qualitative component*

Qualitative data collection took place between 21 and 29 September 2021. A total of 20 FGDs were conducted, including 10 FGDs with men and 10 FGDs with women. In total, 5 FGDs with 18 to 24 year-olds (3 with males, 2 with females), 6 FGDs with 25 to 40 year-olds (3 with males, 3 with females), 5 FGDs with 41 to 59 year-olds (2 with males, 3 with females), and 4 FGDs with 60+ year-olds (2 with males, 2 with females) were conducted.<sup>32</sup>

Data collection was led and conducted by ACAPS and NPM with a team of 12 enumerators (6 males, 6 females). Prior to the training, the tool was discussed with and reviewed by the Bangladeshi enumerators. Enumerators underwent a one-day in-person training to familiarise themselves with the tool, and data collection protocols. The training included practice sessions to test the phrasing and understanding of the questions. Following the training and prior to the start of data collection, the tool was finalised based on enumerator feedback during the training.

All FGDs were conducted in-person, in Bengali by Bangladeshi enumerators, recorded and transcripts translated into English.

### **Data analysis**

Results were analysed by sector. An overarching multi-sectoral analysis, and the estimation of the proportion of households in need and corresponding caseloads were beyond the scope of this assessment. However, qualitative results and secondary data were used to contextualise quantitative findings, and draw qualitative links between sectoral outcomes to provide a more holistic picture of needs and service gaps. Lastly, while current levels of need have to be explained within the context of the COVID-19 outbreak and associated containment measures, it was beyond the scope of this assessment to analyse expected levels of need if the containment measures had not been put into place. The findings are therefore intended as an overview of levels of need existing at the time of data collection and not as an evaluation of COVID-19 containment measures.

### *Quantitative component*

A basic data analysis plan (DAP) was drafted, outlining stratifications, additional composite indicators to be constructed and the basic descriptive statistics to be calculated. The DAP was reviewed by sectors and finalised by the MSNA TWG based on sector inputs. To account for the unequal distribution of households across the unions, results were weighted at the union level during the basic descriptive analysis.

Secondly, based on sector characterisations of vulnerable households, outcomes were tested for statistically significant differences between households of different socio-economic characteristics. Pearson's chi-square test of goodness of fit was used to determine whether or not there was an association between the household characteristics and indicator outcomes. Relationships were determined to be statistically significant for p-values  $\leq 0.05$ . For tests involving more than two distinct groups of households across a certain characteristic, if a significant difference was generally found to exist between the groups, a post-hoc analysis based on the residuals of the chi-square test was conducted to determine the group(s) driving the significant difference. Data was further analysed by gender of respondent.

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<sup>32</sup> A full list of completed FGDs is included in [annex 3](#).

Lastly, in cases in which indicators were comparable, 2021 J-MSNA results were compared to 2019 and 2020 J-MSNA results. No statistical significance testing was conducted for comparisons across time because of differences in methodology in the different assessments, e.g. large differences in sample size, differences in the sampling frames, and not always consistent indicator phrasing. However, any possible trends were still considered in the interpretation of the results and are presented in the following, where relevant.

Preliminary findings, including basic descriptive statistics, selected significance tests, and comparisons across time, were shared with sectors prior to presenting the preliminary findings to each sector. During individual sector meetings, the preliminary findings were presented, discussed, validated and opportunities for additional analyses identified. The discussed additional analyses were conducted and integrated into the findings before findings were presented and disseminated more widely.

#### *Qualitative component*

FGD recordings were translated and transcribed from Bengali to English at the end of the data collection process. An analytical framework was developed to guide and facilitate the analysis of qualitative data in a systematic manner. The translated transcripts were analysed to draw out trends, themes, and key messages across interviews. Main findings were shared with the MSNA TWG and incorporated in the factsheets and shared with sectors.

## Secondary data review

To support the contextualisation of the findings from the primary data collection exercise, each sector was given the opportunity to provide additional sources of information. Where available, this information was used for the triangulation of primary data collection results, and is integrated and referenced throughout this report.

## Ethical considerations and dissemination

During the research design, a data protection risk assessment was conducted to ensure that all necessary measures were taken to prevent harm to respondents from accidentally exposing their identities. In advance of the survey, respondents were informed of their right not to participate, not to answer specific questions or to end the interview when they wished. Informed consent was sought, received and documented at the start of each interview. Moreover, the enumerator training included dedicated training sessions on research ethics and code of conduct, including Accountability to Affected Populations (AAP), Protection from Sexual Exploitation and Abuse (PSEA), referral mechanisms and good interviewing practices. The Protection Sector was consulted during research design and during the training, in order to safeguard against exposing respondents, and in particular women, to risks as a result of the remote nature of the survey, during which privacy could not be ensured.

Personally identifiable information was only collected for the purpose of verifying respondents, and if households had agreed to provide the information. Any personally identifiable information was removed from the dataset following data cleaning, and only the fully anonymized dataset was shared with sectors. The collected data was only used for research purposes, not shared with any third party, and safely stored. For the FGDs, most participants were the ones already involved in the survey and who gave consent to be contacted again. Recordings and transcripts were safely stored.

Following the discussion of preliminary findings with sectors, factsheets for the [camps](#) and [host community](#) highlighting key results from both the quantitative and the qualitative component were produced by the MSNA TWG. The factsheets were reviewed by sectors before they were disseminated more widely.

## Challenges and limitations

Challenges and limitations of the assessment included:

- **Sampling frame:** As the sampling frame did not cover the entire host community population, results can be considered representative of the population included in the sampling frame. They are indicative of the host community as a whole. Due to limitations in the sampling frame, Teknaf Sadar and Teknaf Paurashava Unions were sampled and analysed as one stratum.
  - Furthermore, when interpreting the findings, a possible bias towards beneficiary populations has to be considered for areas outside the UNHCR host community database coverage, as those were exclusively sampled from different beneficiary databases.
- **Remote data collection:** Due to restrictions on movement and face-to-face interviews as part of the COVID-19 preventative measures, all interviews were conducted over the phone. This created some challenges and limitations:
  - Given the expected poor connectivity and the lack of personal interaction during a phone interview, the household survey tool was limited in length in line with sector prioritisations of indicators to avoid losing respondents' attention.
  - Unequal phone ownership may have slightly biased results towards better educated households.
- **Proxy reporting:** Data on individuals was collected by proxy from the respondent, not directly from household members themselves. Results may therefore not accurately reflect lived experiences of individual household members.
- **Respondent bias:** Certain indicators, such as perceived changes in the safety and security situation in the host community, may be under- or over-reported due to the subjectivity and perceptions of respondents. Respondents might have the tendency to provide what they perceive to be the “right” answer to certain questions (“social desirability bias”).
- **Perceptions:** Questions on household perceptions may not directly reflect the realities of service provision in the host community but only respondents’ perceptions of them.
- **Limitations of household surveys:**
  - While household-level quantitative surveys seek to provide quantifiable information that can be generalised to the population of interest, the methodology is not suited to provide in-depth explanations of complex issues. Thus, questions on “how” or “why” (e.g. reasons for adopting coping strategies, differences between population groups, etc.) were further investigated through the accompanying qualitative component of the assessment (FGDs), as well as secondary data.
  - Since “households” are the unit of analysis, intra-household dynamics, for instance related to gender norms, roles, disability or age, cannot be captured. Readers are reminded to supplement and triangulate household-level findings with other data sources.
- **Subset indicators:** Findings that refer to a subset of the assessed population, e.g. only to households with school-aged children, may have a wider margin of error, yielding results with lower precision. Any findings representative only with lower levels of precision are indicated as such throughout the report.

- **Timing of assessment:** When interpreting the findings, users are informed that data collection was: (1) conducted following the implementation of a renewed lockdown in mid-April 2021; (2) carried out during the monsoon season; and (3) included the festival of *Eid-ul-Adha*; as well as (4) a [major flood event](#) at the start of August 2021.
- **Limitations of FGDs:**
  - Given the nature of the selected methodology, findings are to be considered indicative. It is not possible to generalise them by camp, gender or age groups.
  - While the qualitative component was meant to include participants from households which were already part of the survey, it resulted challenging to engage the same people and, at the same time, follow the designed sampling strategy.
  - As the FGD tool was designed based on the preliminary quantitative findings and with the aim of providing an improved contextual understanding and cover information gaps, not all sectors were included in the tool in the same way. Moreover, the tool included open-ended questions allowing participants to discuss areas and topics which they thought were most relevant.
- **Data analysis:** An overarching multi-sectoral analysis, and the estimation of the proportion of households in need and corresponding caseloads were beyond the scope of this assessment. However, qualitative results and secondary data were used to contextualise quantitative findings, and draw qualitative links between sectoral outcomes to provide a more holistic picture of needs and service gaps.

**Box 1** Assessing sensitive and protection-related topics over the phone

**Assessing sensitive and protection-related topics over the phone:**

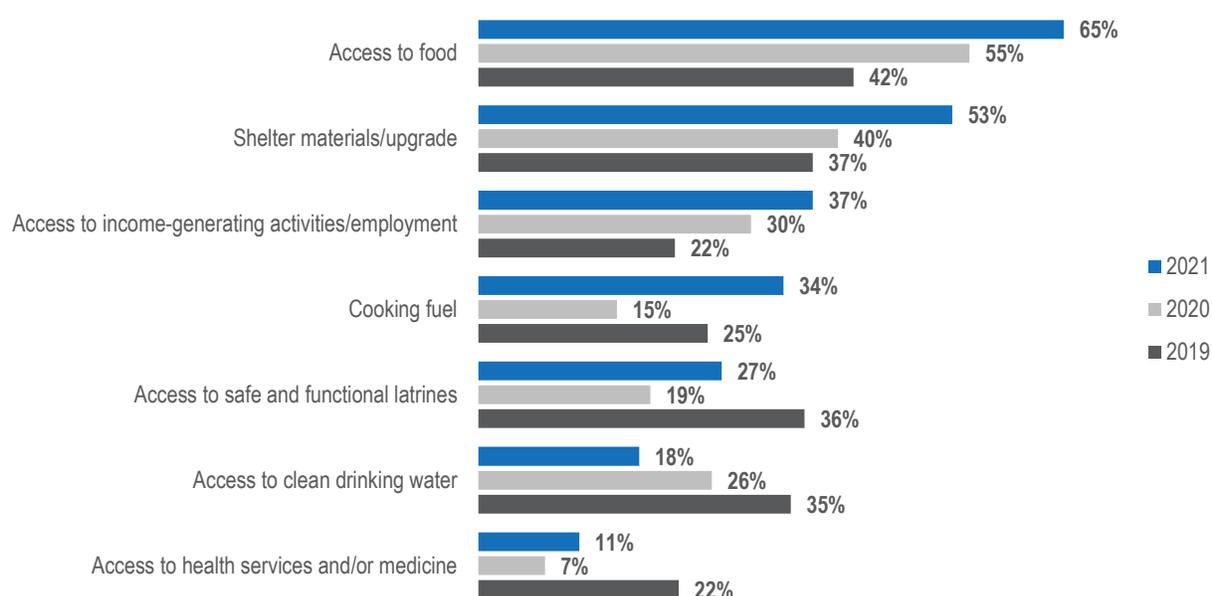
- Limitations related to remote data collection, such as a lack of face-to-face interaction, limited possibilities to ensure privacy, and possibly enhanced concerns of respondents related to the confidentiality of their information, may particularly affect the accuracy of findings related to sensitive topics.
- Moreover, vulnerable households (with enhanced protection concerns) may be less likely to have or use mobile phones. Therefore, **sensitive issues may be under-reported.**

## FINDINGS

### Priority needs

The most commonly reported priority needs included access to food, shelter materials/upgrades, and access to income-generating activities (IGAs)/employment, with a steady increase in the proportions of households having reported these needs among their top three priority needs over the past three years (Figure 1). In particular the increasing proportions of households having reported access to food and access to IGAs among their top three priority needs may be reflective of households still being affected by the COVID-19 outbreak and its secondary impacts on livelihoods (see also next [chapter “Continued secondary impacts of the COVID-19 outbreak”](#)).

Figure 1 % of households reporting top three priority needs for 2021, compared to 2019 and 2020 results<sup>33</sup>



Generally, female respondents were significantly more likely than male respondents to report access to food (reported by 72% of female respondents, compared to 56% of male respondents),<sup>34</sup> and cooking fuel (42% of female respondents, 24% of male respondents)<sup>35</sup> among their top three priority needs. Male respondents were significantly more likely than female respondents to report access to health services and/or medicine (6% of female respondents, 18% of male respondents),<sup>36</sup> and access to education for children (4% of female respondents, 12% of male respondents)<sup>37</sup> among their top three priority needs.<sup>38</sup>

<sup>33</sup> ISCG, 2021; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA), Host Communities in Teknaf and Ukhiya Upazilas, September 2019* (Cox's Bazar, 2019). Available [here](#) (accessed 30 November 2021).

<sup>34</sup> p-value ≤ 0.0001.

<sup>35</sup> p-value ≤ 0.0001.

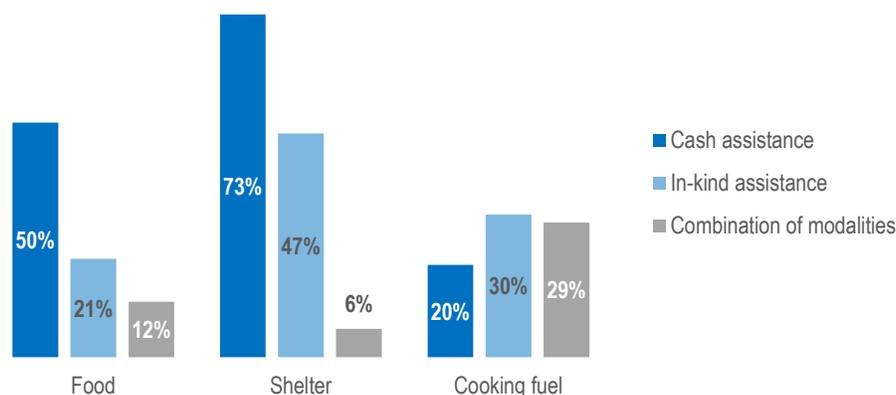
<sup>36</sup> p-value ≤ 0.0001.

<sup>37</sup> p-value ≤ 0.0001.

<sup>38</sup> Results for female respondents are representative with a +/- 4% margin of error (n = 624). Results for male respondents are representative with a +/- 5% margin of error (n = 494).

Related to the preferred modality of assistance, higher proportions of households reported preferring receiving cash food or shelter assistance than reported preferring in-kind food or shelter assistance or a combination of modalities. However, in relation to cooking fuel, higher proportions of households reported preferring in-kind assistance or a combination of modalities than reported preferring cash assistance (Figure 2). In addition, 12% of households reported preferring labour support as a form of shelter assistance.

Figure 2 % of households reporting preferred modalities of assistance to meet each need<sup>39</sup>



The reported preferred modality of food and fuel assistance differed between male and female respondents. Specifically, higher proportions of female respondents than male respondents reported preferring cash assistance (53% of female respondents reported preferring cash food assistance, compared to 45% of male respondents; 27% of female respondents reported preferring cash fuel assistance, compared to 4% of male respondents), while lower proportions reported preferring in-kind assistance (18% of female respondents reported preferring in-kind food assistance, compared to 26% of male respondents; 25% of female respondents reported preferring in-kind fuel assistance, compared to 41% of male respondents).<sup>40</sup>

## Continued impact of the COVID-19 outbreak on food security and livelihoods

**Households appeared to still be affected by the COVID-19 outbreak and its secondary impacts on livelihoods, with a potential risk of a deterioration of coping capacities and living standards.** Overall vulnerability in the host community had increased in 2020, driven by economic contraction and a decline in economic activity during the first lockdown in 2020, and this has occurred in a population highly dependent on daily wage labour that was still struggling to recover economically.<sup>41</sup> Likely linked, between the 2019 and the 2020 J-MSNAs, the proportion of households with

<sup>39</sup> Households were asked their preferred modality to receive these items if they had reported them among their top three priority needs. The denominator for each indicator is as follows: food, n = 720 (results are representative with a +/- 4% margin of error); shelter materials, n = 573 (results are representative with a +/- 5% margin of error) – households could select multiple options; cooking fuel, n = 394 (results are representative with +/- 5% margin of error).

<sup>40</sup> Households were asked their preferred modality to receive these items if they had reported them among their top three priority needs. The denominator for each indicator is as follows: food, female respondents, n = 445 (results are representative with a +/- 5% margin of error); food, male respondents, n = 275 (results are representative with a +/- 6% margin of error); cooking fuel, female respondents, n = 267 (results are representative with +/- 6% margin of error); cooking fuel, male respondents, n = 127 (results are representative with a +/- 9% margin of error).

<sup>41</sup> WFP, *Refugee influx emergency vulnerability assessment (REVA 4)* – Cox's Bazar, Bangladesh (April 2021) (Cox's Bazar, 2021a). Available [here](#) (accessed 30 November 2021).

acceptable Food Consumption Scores (FCS) was also found to have dropped.<sup>42</sup> In line with the increase in the proportions of households having reported access to food, as well as access to IGAs, among their top three priority needs in the current assessment, **FCS were found to have deteriorated further compared to 2020 J-MSNA findings.** At the same time, the **reported adoption of certain livelihoods-based coping strategies remained at the high levels found in the 2020 J-MSNA.**<sup>43</sup>

### *Food consumption*

**The FCS was found to have deteriorated further compared to 2020 J-MSNA findings.** This deterioration may be a result of **high food prices and low purchasing power** at the time of data collection. From October 2020 until June 2021, the cost of the food basket had steadily increased each month, while purchasing power had decreased. Specifically, by June 2021, the cost of the food basket had increased by 25% compared to June 2020, while household purchasing power had decreased by 30%. This increase in prices by June 2021 can be attributed to the impact of the COVID-19 lockdown, the *Eid-ul-Adha* festival and the onset of the monsoon season, further exacerbated by a broader global upward trend in import restrictions and rising of local transportation costs.<sup>44</sup> At the time of data collection, in July 2021, the cost of the food basket was only 8% higher still, and household purchasing power 9% lower, than in July 2020.<sup>45</sup> However, the impact of months of increased food prices, compounded by reduced household earnings during successive lockdowns, may still have been felt by households at the time of data collection.

In fact, in most FGDs, participants highlighted the negative impact of the COVID-19 outbreak and associated containment measures on livelihoods, as people had lost their jobs or were not able to work regularly anymore. As a result, **income was frequently reported as being insufficient to cover basic needs.** Moreover, in 5 of 20 FGDs, participants raised challenges related to accessing food, including a lack of assistance for the most vulnerable, insufficient assistance or the reception of assistance items being less preferred by households.

In the household survey, roughly half the households (47%) reported casual or daily labour as their main livelihood in the 30 days prior to data collection. Being reliant on a daily income may make those households particularly vulnerable to disruptions of income-earning (daily and weekly wage labourers active during the lockdown 2020 had on average experienced a 47% income drop<sup>46</sup>). It may also make households less likely to have reserves to be able to cope with recurring disruptions, with the average reported monthly per capita income from all livelihoods in the 30 days prior to data collection among households with casual or daily labour as their main livelihood having been BDT 1,814,<sup>47</sup> compared to BDT 2,354 among households having reported cash for work or monthly salaried work as their main livelihood, or BDT 2,729 among households having reported an own business as their main livelihood. Possibly as a result, households reportedly not having had an own income as their main livelihood, and households having reported casual or daily labour as their main livelihood, reported having adopted livelihoods-based coping strategies, especially crisis-level ones and especially in order to access or pay for food, at slightly higher proportions than other households. This may indicate that particularly households without an own income and households with casual or daily labour as their main livelihood may have faced food access challenges at the time of data collection. As such, **while the deterioration of FCS was found among all households, households without an own income as their main**

<sup>42</sup> ISCG, 2021.

<sup>43</sup> ISCG, 2021.

<sup>44</sup> World Food Programme (WFP), *FAO-WFP Joint Market Monitor, July 2021* (Cox's Bazar, 2021b). Available [here](#) (accessed 30 November 2021).

<sup>45</sup> World Food Programme (WFP), *FAO-WFP Joint Market Monitor, August 2021* (Cox's Bazar, 2021c). Available [here](#) (accessed 30 November 2021).

<sup>46</sup> World Bank, *Cox's Bazar Panel Survey: Rapid Follow-up Round 1, Impacts of COVID-19 on Work and Wages in Cox's Bazar* (Cox's Bazar, 2020). Available [here](#) (accessed 30 November 2021).

<sup>47</sup> BDT 1 = USD 0.011648545 ([XE currency converter](#), as of 18 November, 2021).

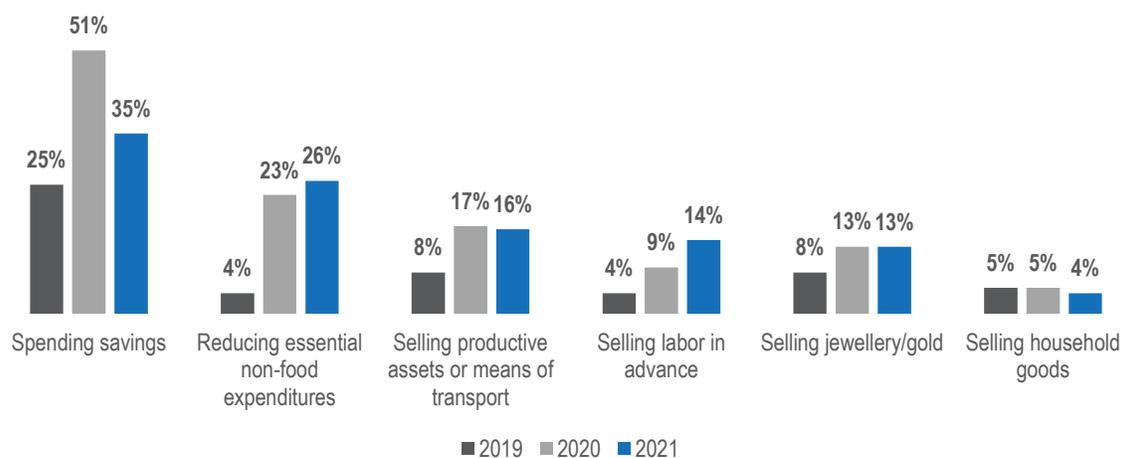
**livelihood and households having reported casual or daily labour as their main livelihood also tended to have worse FCS than households reportedly having had other income sources as their main livelihoods.**

### *Livelihoods-based coping*

The proportions of households reporting having adopted livelihoods-based coping strategies, such as reducing essential non-food expenditures, selling productive assets or means of transport, jewellery/gold, or household assets, remained similar to those found in the 2020 J-MSNA, which were higher than those found in the 2019 J-MSNA (Figure 3). In the 2020 J-MSNA, these increasing proportions of households having adopted livelihoods-based coping strategies to meet their needs were attributed to the negative impacts of COVID-19 on livelihoods or access to IGAs, which had led to increased proportions of households having to resort to coping strategies to meet their needs. The fact that the proportions of households reporting having adopted those strategies in 2021, remained at 2020 levels suggests that households are still affected by the COVID-19 outbreak and its secondary impacts on livelihoods, with **high proportions of households continuing to be able to meet their needs only through the adoption of livelihoods-based coping strategies. If not reversed, in the long term, this trend may lead to an erosion of coping capacities.**

In 2021, already 20% of households reported spending savings as a coping strategy not to have been available to them or to have exhausted it, with the proportion of households reportedly having adopted this coping strategy having decreased compared to 2020 J-MSNA findings. In addition, a slight increase in the proportion of households having reported selling labour in advance was found (Figure 3).

**Figure 3** % of households reporting having adopted coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection, by year<sup>48</sup>



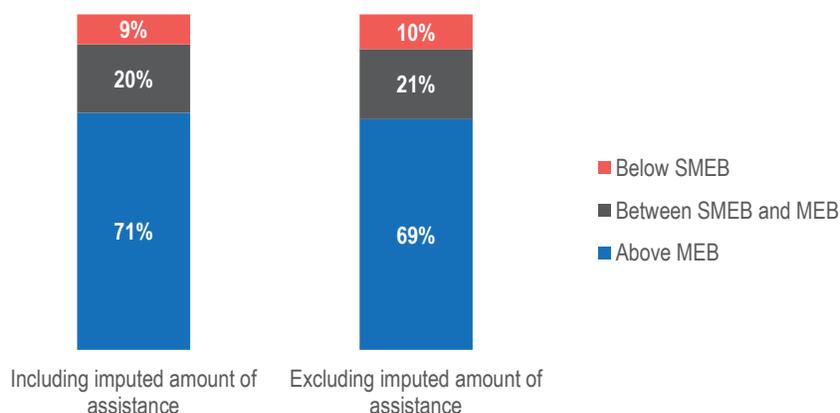
### *Expenditures*

Lastly, the fact that not all households may be able to meet their basic needs is represented in the reported monthly per capita expenditure. Figure 4 shows the average monthly per capita expenditure, both including and excluding the

<sup>48</sup> ISCG, 2021.

reported value of assistance received and consumed by households, in relation to the Minimum Expenditure Basket (MEB) and the Survival Minimum Expenditure Basket (SMEB).<sup>49</sup> Only roughly three quarters of households reported a monthly per capita expenditure above the MEB, i.e. potentially being able to meet their basic needs. While these results are similar to past assessment results,<sup>50</sup> they may still represent an overestimation of households having reported spending above the MEB, as household spending was not disaggregated to distinguish between cash expenditures and spending on credit, while the latter would normally count as a coping strategy.

**Figure 4** % of households by average monthly per capita expenditure in the 30 days prior to data collection in relation to the MEB



## Other needs and service gaps

Given pre-existing levels of poverty, and the impacts of the COVID-19 outbreak on livelihoods outlined above, gaps in access to basic goods and services were reported across sectors.

### Shelter and NFIs

The majority of households (63%) reported having lived in vulnerable shelter types (*jhupries* or *kutchas*)<sup>51</sup> at the time of data collection. In addition, almost three quarters of households (71%) reported having had shelter issues at the time of data collection, most commonly leaking during rain (as reported by 62% of households). Among those having reported shelter issues, the most commonly reported reason for issues was damaged roofing (82%).<sup>52</sup> While half the households (50%) reported having made shelter improvements or repairs in the 6 months prior to data collection, most commonly having replaced tarpaulin (34%), **roughly one third of households reported not having made improvements or repairs to their shelter despite having reported issues / damages** (Figure 5).

<sup>49</sup> In line with REVA 4, SMEB and MEB thresholds were set as: BDT 1,138 monthly per capita spending as the SMEB threshold, and BDT 1,736 monthly per capita spending as the MEB threshold. The following expenditure items were included in the calculation: food items (spending and value of assistance); non-food household items for regular purchase (e.g. hygiene items, such as soap, detergents, sanitary materials for women and girls, etc.) (spending and value of assistance); fuel (spending and value of assistance); transportation (spending and value of assistance); shelter maintenance or repair (spending); non-food household items for infrequent purchase (e.g. blankets, cooking pots, clothing, lightbulbs, etc.) (spending); health-related expenditures (spending); education-related expenditures (spending); livelihood inputs (for agriculture, fishing, business) (spending).

<sup>50</sup> WFP, 2021a.

<sup>51</sup> *Jhuprie*: Shelter made of earth, bamboo, wood, and corrugated iron (CGI) sheets or thatch as roofs; *Kutchas*: Shelter made of branches, bags, tarpaulin, jute, etc.

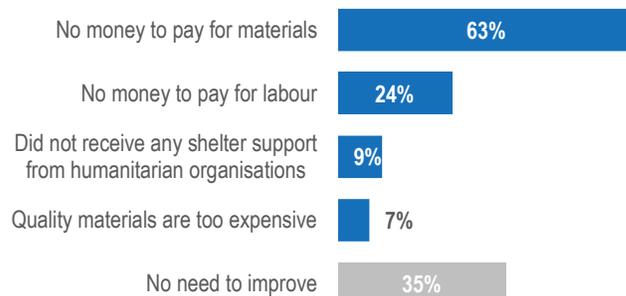
<sup>52</sup> The denominator for this indicator is all households having reported shelter issues (n = 799). Results are representative with a +/- 4% margin of error.

Among those reportedly having made improvements or repairs, **shelter support from humanitarian actors was reported to have been very limited** (Figure 7). At the same time, **households may often lack the resources to independently implement shelter improvements or repairs**, with the most commonly reported reasons for not having made shelter improvements or repairs – other than not having needed any – having been a lack of money to pay for materials or labour (Figure 6).

**Figure 5** % of households reporting not having made improvements/repairs to their shelter despite having reported issues



**Figure 6** % of households reporting main reasons for not having improved or repaired their shelter among households not having made improvements/repairs in the 6 months prior to data collection<sup>53</sup>



**Figure 7** % of households reporting having received shelter materials from a humanitarian organisation among households having made shelter improvements/repairs<sup>54</sup>

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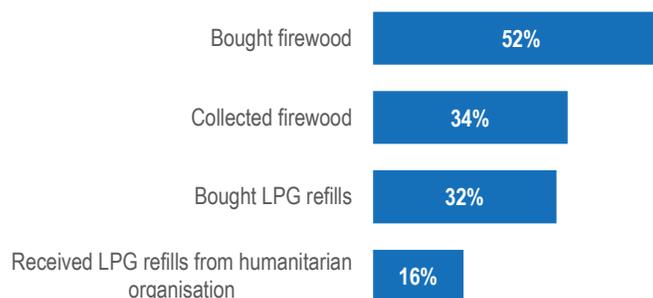
Positive trends were found in relation to liquefied petroleum gas (LPG), with the **proportion of households reportedly having used exclusively LPG as their source of cooking fuel having increased from 15% in 2019 to 29% in 2021** (Figure 8). However, when interpreting these results, the **potential bias towards beneficiary populations in 2020 and 2021** needs to be considered, as it may have biased results towards households more likely to be receiving LPG from humanitarian actors.

At the same time, **firewood remained the most commonly reported source of cooking fuel** (Figure 9), likely indicating persisting gaps in access to LPG, and with further implications for environmental sustainability and fire safety.

**Figure 8** % of households reporting having used exclusively LPG for cooking in the 4 weeks prior to data collection



**Figure 9** % of households reporting sources of cooking fuel in the 4 weeks prior to data collection<sup>55</sup>



<sup>53</sup> The denominator for this indicator is households reportedly not having made any improvements (n = 567). This may include households having reported and not having reported shelter issues. Results are representative with a +/- 5% margin of error. Households could select up to 3 options.

<sup>54</sup> The denominator for this indicator is households reportedly having made improvements (n = 550). Results are representative with a +/- 5% margin of error.

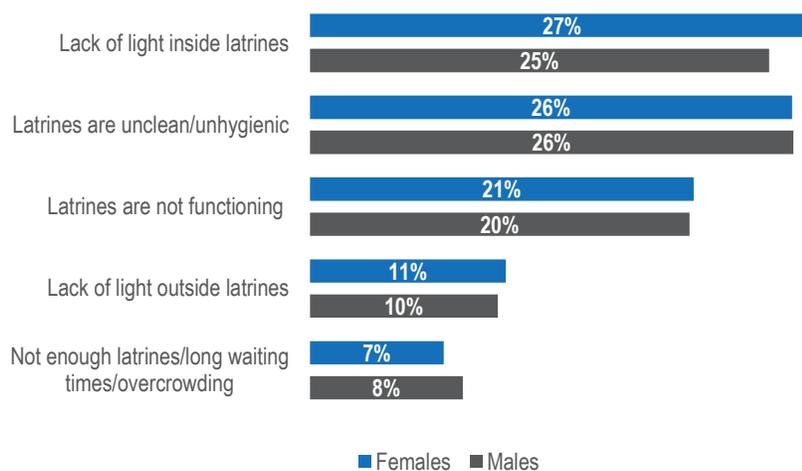
<sup>55</sup> Households could select multiple options.

## WASH

In most FGDs, participants reported that access to water had improved over the past three years due to tube wells having been installed in the host community. Nevertheless, roughly one third of households (33% of households in Teknaf and 35% of households in Ukhiya) reported not having had enough water at the time of data collection,<sup>56</sup> and 27% of households reported adopting coping strategies throughout the year to adapt to a lack of water, most commonly fetching water from a source further away than the usual one (18%). Moreover, while deep tubewells were the most commonly reported source of water, one quarter of households in Teknaf and one third of households in Ukhiya were reportedly using shallow tube wells as their main drinking water source at the time of data collection.<sup>52</sup> Challenges related to access to water that were reported in the FGDs included unsafe roads and long distances to water points, as well as water scarcity during the dry season. **Thus, despite reported improvements in access to water, gaps also remained both in relation to accessing improved water sources and in relation to accessing sufficient amounts of water.**

In 6 of 10 FGDs with women, participants reported that most households had their own latrines. During the household survey, 62% of households reported using a pit latrine with a slab and platform as their usual sanitation facility, and 16% of households reported using a flush/pour-flush toilet. However, **18% of households also reported using unimproved sanitation facilities**, such as a pit latrine without a slab or platform (13%) or an open hole (5%). In addition, roughly half the households reported problems related to latrines female (49%) or male (47%) household members had faced at the time of data collection, most commonly a lack of light inside latrines, latrines being unclean or unhygienic, and latrines not functioning (Figure 10).

**Figure 10** % of households with female or male individuals reporting problems related to latrines females/males in their households faced at the time of data collection<sup>57</sup>

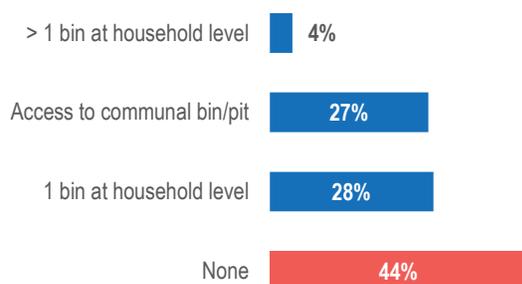


<sup>56</sup> Results for Teknaf are representative with a +/- 5% margin of error (n = 551). Results for Ukhiya are representative with a +/- 5% margin of error (n = 567). Due to known differences in water availability in Teknaf and Ukhiya, results related to water are disaggregated by upazila.

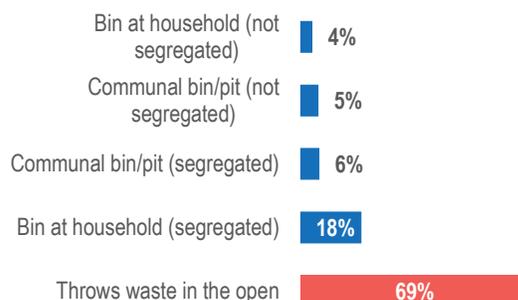
<sup>57</sup> The denominator for this indicator is households with female individuals reporting problems females in their household faced, and households with male individuals reporting problems males in their household faced (households with females, n = 1,118; households with males, n = 1,101). Households could select up to 5 options.

Among households having reported problems related to latrines, 54% reported having coped with those by having relied on less preferred latrines, while 36% reported having relied on communal latrines.<sup>58</sup> At the same time, though, FGD participants reported that **those who did not have their own latrines faced difficulties, such as a lack of shared latrines, and latrines being far, unsafe, and unclean or unhygienic.**

**Figure 11** % of households reporting types of bins they had access to at the time of data collection<sup>59</sup>



**Figure 12** % of households reporting where they usually dispose of household waste, and how (segregated/not segregated)<sup>59</sup>



Lastly, there appeared to be **large gaps in relation to waste management**, with almost half the households reportedly not having had access neither to bins at the household level, nor communal bins or pits (Figure 11), and roughly two thirds of households reportedly having disposed of their waste by throwing it into the open (Figure 12).

## Education

**Both challenges accessing and the perceived effectiveness of home-based learning may have led to gaps in learning as a result of COVID-19-related school closures. A lack of money may further have prevented children from having been sent back to schools after they had re-opened in September 2021.** Between one third and two thirds of children aged 3 to 18 were reported as not having regularly accessed home-based learning while schools were closed (Figure 13). Overall, half the households with school-aged (ages 6 to 18) children reported at least one school-aged child as not having regularly accessed home-based learning.<sup>60</sup> Moreover, reported pre-COVID-19 enrolment rates having been higher than the proportions of children reportedly having accessed home-based learning (Figure 13) may be indicative of not all those who were previously enrolled having been able to access home-based learning. Thus, a **relatively large proportion of children may have missed out on their education over the one and a half years of school closures.**

**Children aged 15 to 18, in particular girls, may be at the highest risk of dropping out of their education as a result of school closures.** Results indicate that not all individuals aged 15 to 18 who were enrolled in schools pre-COVID-19 would have been sent back to schools after they had re-opened, with the proportions of boys and girls aged 15 to 18 who would have reportedly been sent back to schools having been slightly lower than the proportions of them having been reported as having been enrolled pre-COVID-19 (Figure 13). Drawing from the FGDs, poverty and marriage were two of the main factors driving this trend. In two FGDs with men, participants reported that some girls

<sup>58</sup> The denominator for this indicator is households having reported problems females or males in their household faced related to latrines (n = 540). Results are representative with a +/- 5% margin of error. Households could select multiple options.

<sup>59</sup> Households could select multiple options.

<sup>60</sup> The denominator for this indicator is households with girls or boys aged 6-18 (n = 933). Results are representative with a +/- 4% margin of error.

had been married off due to school closures. Girls aged 18 and 19 were also recognised in two FGDs with women as being most at risk of not going back to schools due to marriage and education costs being unaffordable for their parents.

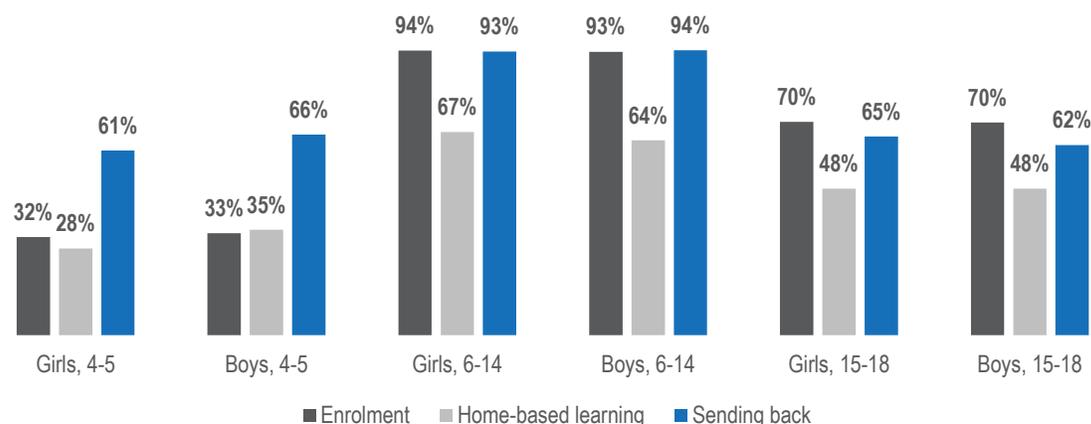
*“Our children have already started going to school, but the schools have only been open for one week. Many people are not sending their children to school, saying that it is not possible to learn anything in one day. They also argue that nothing can be taught to children who haven’t gone to school for over two years in just one hour of school per week and that it is preferable [for the children] to work for a living as there will be more earners in the family. Most of the poor families in my area think like this, and families are trying to marry off the girls who have crossed 13-14 years of age. It was possible to marry off girls with less dowry during the lockdown and because of that, child marriage has increased in my area recently.”* – FGD with men, ages 18-24

*“There are many problems that girls face in the community. Some girls are unable to attend learning centres due to financial constraints. Those who are able to attend would form relationships with boys, which is a problem for us. As a result, parents are hesitant to send their daughters to the learning centres and are now arranging marriages for their daughters.”* – FGD with men, ages 25-40

*“I have a daughter and I am not sending her to school anymore because I cannot afford the costs. My two sons go to an Islamic school.”* – FGD with women, ages 25-40

**Young children, on the other hand, may have experienced a delayed start of their education.** Among children aged 3 to 5, higher proportions would reportedly have been sent (back) to schools than were reported as having been enrolled before the COVID-19 outbreak, or as having accessed home-based learning (Figure 13). This may be indicative of only previously enrolled children having regularly accessed home-based learning, while those that under normal circumstances may have got enrolled during the one and a half years of school closures may have missed out on the education they would have normally started receiving.

**Figure 13** % of children aged 4-18 reported as having been enrolled in formal or non-formal schools before schools closed in March 2020 (pre-COVID-19), having regularly accessed home-based learning since the start of the 2021 school year, and that will be sent back once schools will re-open<sup>61</sup>



<sup>61</sup> The denominator for this indicator is all individuals in the specified gender and age groups (girls, 4-5, n = 147; boys, 4-5, n = 145; girls, 6-14 years, n = 767; boys, 6-14 years, n = 795; girls, 15-18 years, n = 278; boys, 15-18 years, n = 297). Results for girls and boys aged 4-5 are representative with a +/- 9% margin of error. Results for girls and boys aged 6-14 are representative with a +/- 4% margin of error. Results for girls and boys aged 15-18 are representative with a +/- 6% margin

**A lack of resources or means to access both remote and in-person education may be the main barrier towards children receiving an education.** Overall, roughly 70% of households with children aged 4 to 18 reported having experienced challenges accessing home-based learning,<sup>62</sup> most commonly a lack of the means needed to access home-based learning, such as technological devices, teaching materials, as well as a lack of mobile network, children not being able to concentrate at home, and home-based learning being perceived as not very effective.

Similarly, in 6 of 10 FGDs with men, participants reported that only children in households with smartphones had been able to access online classes. Poor internet connection and an inability to afford internet were also reported to have been major challenges, resulting in some children reportedly having been unable to continue with classes or to take their exams while schools were closed. FGD participants reported that families had tried to support their children by helping them with their online classes or through private tuition. However, most women in the FGDs reported that the majority of households could not afford private tuition.

*“Only those children who had smartphones at home could access online classes. My children did not have smartphones, so they could not attend classes. They were so desperate to know what lessons had been taught, they had to wait until other students finished their classes and came out of their homes, so my children could take notes from them and ask about the classes. I faced many challenges arranging online classes for my children. Many people faced these challenges.”* – FGD with men, ages 40-69

A majority of households was reportedly planning to send children back to school, as reported both during the household survey and the FGDs. However, roughly 60% of households reportedly sending at least one child aged 4 to 18 back to schools reported **expecting challenges when sending children back, most commonly a lack of money.**<sup>63</sup> **A lack of money was also the second most commonly reported reason – after not having been enrolled pre-COVID-19 – for not sending children back to schools at all.** This was confirmed by FGD participants, with participants in 5 of 10 FGDs with women reporting that parents would not send their children back to schools due to a lack of money to afford uniforms, materials, etc. Some FGD participants further reported that due to the two-year gap, children may be reluctant to return to schools, and in 8 of 20 FGDs, participants reported that children from poor families had started working and would not stop.

*“I have three children who are studying continuously. Two are studying Norani [Islamic education] and one is studying in Chittagong. And he said he has to go to Rajshahi to study more and needs more money. So, I said I cannot afford your expenses anymore, you have come back home, I cannot take any more loans. My child was crying and said, ‘how can I come back from the middle of my study?’”* – FGD with women, ages 60+

When asked for **suggestions to make it more likely for children to go back to schools**, participants in 17 of 20 FGDs suggested that it would be beneficial if schools taught **job-related skills**, e.g. computer or technical skills, such as driving, mechanics, sewing, or electronics repair. In 9 of 20 FGDs, participants suggested that **cash or incentives**

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of error. Results are presented out of all assessed children in the specified age groups, which may not correspond to the target population for Education Sector support, if not all individuals of the specified age groups are targeted for support.

<sup>62</sup> The denominator for this indicator is households with girls or boys aged 4-18 (households with girls, n = 741; households with boys, n = 752). Results are representative with a +/- 4% margin of error.

<sup>63</sup> The denominator for this indicator is households with at least one girl or boy aged 4-18 that will reportedly be sent back (households with at least one girl that will reportedly be sent back, n = 650; households with at least one boy that will reportedly not be sent back, n = 673). Results are representative with a +/- 4% margin of error.

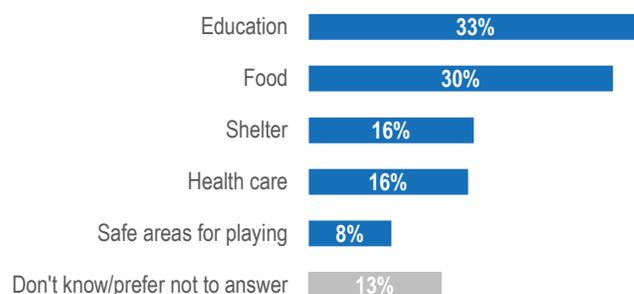
should be provided to cover for children’s educational expenses, and/or children should be provided with books, transport costs, umbrellas, and other essential items. Moreover, awareness-raising on the value of education among both parents and children was suggested.

*“Since the lockdown, the condition of our area has turned into what it was in the year 1971. If the NGOs want to make every student school-bound, they need to provide them with a package. What I mean by the ‘package’ is that the NGOs should arrange a scheme by which the parents receive 30 kilograms of rice if they send one child to school, 45 kilograms for two, and 80 kilograms for three. If this is done, the parents will send their children to school at any cost. Arranging schemes like this with rice or money will work really well.” – FGD with men, ages 24-40*

### Protection

Likely linked in particular to the food security and education-related results, one third of households reported that education and food needs of children in their community were not adequately met. This was followed by unmet shelter and health care needs (Figure 14). Overall, **roughly half the households (51%) perceived unmet needs of children in their community at the time of data collection.**

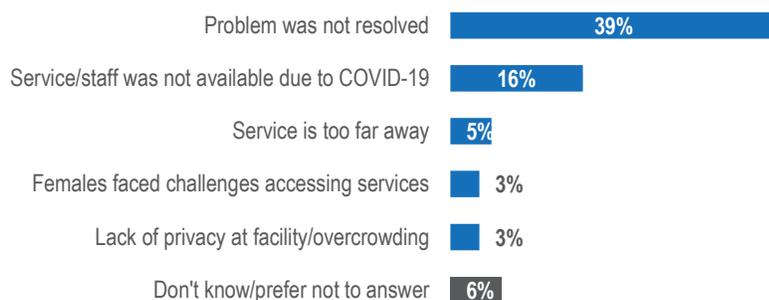
**Figure 14** % of households reporting perceiving that needs of children in their community were not adequately met to ensure their well-being at the time of data collection<sup>64</sup>



Twenty-two percent (22%) of households reported areas considered unsafe by girls and women in their community at the time of data collection, and 14% of households reported areas considered unsafe by boys and men. At the same time, though, roughly half the households having reported community members needing or accessing protection services reported barriers towards accessing those services, most commonly problems not being resolved, followed by services or staff having been unavailable due to COVID-19 (Figure 15). Thus, **gaps in access to protection services may possibly compound perceived safety and security challenges.**

<sup>64</sup> Households could select multiple options.

Figure 15 % of households having reported community members needing or accessing protection services reporting barriers<sup>65</sup>



In the household survey, most commonly households reported that they would refer a friend who had been abused or assaulted to law enforcement officials, union parishads/Nari Nirjaton Protirodh Committees, or family and relatives. This was followed by community-based dispute resolution mechanisms. In most FGDs with men, participants said they would consult village elders or chairmen on issues related to safety and security. In all FGDs with women, participants said they would consult elders, chairmen and union members. In some FGDs, participants also said they would go to court if the issue could not be resolved through local mechanisms. In only three FGDs with women, participants mentioned the police. Conflicts within the family, were reported to primarily also be addressed within the family (and only in extreme cases, if they could not be resolved, to be addressed through other mechanisms, including community-based mechanisms, union councils, and the police). Similarly, issues of violence against women or girls were largely reported to be kept within the family or not discussed at all.

### Nutrition

**Reported access to nutrition services among the host community was limited.** Overall, roughly 8 in 10 households with children aged 6 to 59 months reported at least one child as not having been screened for malnutrition by community nutrition volunteers or nutrition facility staff (Figure 16). Moreover, only 18% of households with children aged 6 to 59 months reported having received messages related to the mother-led MUAC programme<sup>66</sup> (Figure 17), and 9% of households reported mothers or caregivers having screened at least one of their children for malnutrition using MUAC tape.<sup>67</sup>

Overall, five percent (5%) of children were reported as having been screened and referred, or already having been enrolled, and having received treatment (Figure 18). This corresponds to known rates of acute malnutrition in the host community.<sup>68</sup> The reported rate of screening, however, compares to programme data showing rates of screening of 80%-90% during the same time period. **This difference might partially be due to service delivery through health facilities rather than nutrition facilities, which may have led to under-reporting of screening by nutrition staff.**

<sup>65</sup> The denominator for this indicator is households having reported community members needing or having accessed protection services (n = 47). Results are representative with a +/- 14% margin of error. Households could select multiple options.

<sup>66</sup> The mother-led MUAC programme is a programme that trains caregivers in measuring the mid-upper arm circumference (MUAC) of their children to identify malnutrition, and learn how and where to refer a malnourished child.

<sup>67</sup> The denominator for this indicator is all households with children aged 6-59 months (n = 504). Results are representative with a +/- 5% margin of error.

<sup>68</sup> Action Against Hunger (ACF), *Follow up SMART Nutrition Survey in Ukhiya and Teknaf Upazila* (Cox's Bazar, 2021). Available [here](#) (accessed 30 November 2021).

**Figure 16** % of households with children aged 6-59 months reporting at least one child as not having been screened for malnutrition by community nutrition volunteers or nutrition facility staff since the start of Ramadan (14 April 2021)<sup>67</sup>



**Figure 17** % of households with children aged 6-59 months reporting having received messages related to the mother-led MUAC programme from community nutrition volunteers or nutrition facility staff since the start of Ramadan<sup>67</sup>



**Figure 18** % of children aged 6-59 months were reported as having been screened and referred, or already having been enrolled, and having received treatment since the start of Ramadan<sup>67</sup>



Similar to the results for children, only 15% of pregnant or lactating women (PLW) were reported as having been screened for malnutrition by community nutrition volunteers or nutrition facility staff during the current pregnancy or while breastfeeding, 7% of PLW were reported as having received supplementary feeding supplies, and 23% of PLW were reported as having received iron and folic acid tablets.<sup>69</sup> However, also in this case, the reported rate of screening compares to programme data showing rates of screening of 80%-90% during the same time period, with screening by nutrition staff potentially having been under-reported in the current assessment due to service delivery through health rather than nutrition facilities. At the same time, though, access to the host community was limited during the lockdown (at the time of data collection), while COVID-19 preventative messages moreover promoted home isolation for PLW, which may have further reduced the use of existing nutrition services.<sup>70</sup>

## Health

**The negative impact of COVID-19 on health-seeking behaviour observed in the 2020 J-MSNA may have partially reversed in the current assessment.** Between 2019 and 2020, the proportion of individuals reported as having required health treatment in the 4 weeks prior to data collection had dropped from 31% to 14%. This was interpreted as being indicative of a reduction in health-seeking behaviour.<sup>71</sup> As such, 24% of individuals having been reported as having had a health problem and needing to access health care in the 4 weeks prior to data collection during the current assessment may indicate a reversal of this trend.

At the same time, **gaps in access to or the utilisation of clinics remained**, as individuals continued to most commonly seek treatment at pharmacies or drug shops, when needed. Despite some FGD participants having reported health services having improved since NGOs had started working in their areas, in the household survey, less than two thirds of individuals were reported as having sought treatment at a clinic, when needed (Figure 19).

<sup>69</sup> The denominator for this indicator is all PLW (n = 205). Results are representative with a +/- 7% margin of error.

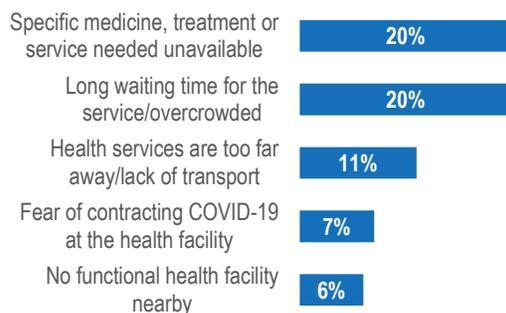
<sup>70</sup> Nutrition Sector (personal communication, October 2021).

<sup>71</sup> ISCG, 2021.

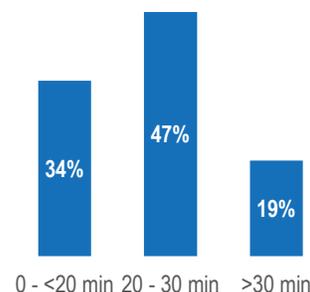
**Figure 19** % of household members reportedly having had a health problem and needing to access health care in the 3 months prior to data collection reported as having sought treatment at a clinic<sup>72</sup>



**Figure 20** % of households reporting having experienced or expecting experiencing barriers when needing to access health care<sup>73</sup>



**Figure 21** % of households reporting travel time to get to the nearest functional health facility by their normal mode of transportation



Roughly half the households (52%) reported having experienced or expecting experiencing barriers when needing to access health care, most commonly the specific medicine, treatment, or service needed not being available, long waiting times or overcrowding, and distance or a lack of transport (Figure 20). Moreover, roughly one in five households reported being more than 30 minutes of travel distance from the nearest functional health facility (Figure 21). Lastly, 51% of households reportedly having adopted livelihoods-based coping strategies in the 30 days prior to data collection reported having done so to access or pay for health care,<sup>74</sup> indicating that households often lacked the resources to access the health care they needed.

Similarly, issues highlighted in the FGDs included long waiting times at clinics due to a lack of doctors, distance to hospitals, a lack of treatment options or improper treatment in local hospitals, a lack of hygiene in government hospitals, and expensive treatment in private hospitals.

*“We think the treatment process is a bit better now compared to before, as there are many new NGO hospitals open and due to the coronavirus outbreak, all the doctors and health volunteers are a bit active now to take care of the patients.” – FGD with women, ages 41-59*

*“People are particularly concerned about their health, because the lockdowns have reduced their income, preventing them from purchasing the necessary medicines to cure their underlying health conditions.” – FGD with men, ages 18-24*

In sum, **barriers towards accessing health care are mainly related to a perceived lack of offers, both in relation to the types of services available and in relation to the frequency with which they are offered, hospitals often being far, and certain kinds of treatment being expensive and as such, a lack of money preventing access.**

<sup>72</sup> The denominator for this indicator is all individuals having had a health problem and needing to access health care (n = 2,323). Results are representative with a +/- 2% margin of error.

<sup>73</sup> Households could select up to 3 options.

<sup>74</sup> The denominator for this indicator is households reportedly having adopted livelihoods-based coping strategies (n = 992). Results are representative with a +/- 4% margin of error.

## Vulnerability

**Some households may be more likely to be in need or to have worse outcomes than others.** Households that have often been identified as most vulnerable in the past include households with persons with disabilities, female-headed households or households without a male of working age, and large households (5+ members) (or households with a high dependency ratio (>2)).

Households with persons with disabilities typically spend more money on medical expenses and incur higher levels of debt to pay for those expenses. This leaves them less money to spend on food and other essential items, and increases their use of negative coping mechanisms to meet their needs.

Female-headed households or households without males of working age are often more vulnerable, as they have substantially less access to self-reliance activities, and face more barriers accessing any type of assistance due to limited social networks, lower levels of education and language skills, limited working opportunities, increased exposure to sexual and gender-based violence (SGBV), childcare duties, and sociocultural norms, which restrict their mobility.

Lastly, large households tend to be more economically vulnerable. Previous studies, for instance, found those households to be more likely to borrow money, e.g. to meet food needs and cover health-related costs.<sup>75</sup>

These patterns of vulnerability were also reflected in the current assessment, such that particularly households with persons with disabilities, female-headed households, and less educated households that also tend to have less access to resources were found to have worse outcomes, than households without persons with disabilities, male-headed households, and better educated households with more access to resources. In addition, large households appeared to be more likely than small households to meet their needs through adopting coping strategies.

Moreover, differences in outcomes were found between households living in different unions.

### *Households with persons with disabilities*<sup>76</sup>

**Across sectors, households with persons with disabilities were often more likely than households without persons with disabilities to report worse outcomes.** This included households with persons with disabilities having been significantly more likely than households without persons with disabilities to report shelter issues<sup>77</sup>, and having been significantly less likely to report having used exclusively LPG as a source of cooking fuel.<sup>78</sup> Moreover, households with persons with disabilities were significantly less likely to report having used an improved water source as their main source of drinking water,<sup>79</sup> and significantly more likely to report barriers having prevented at least one household member that needed health care from having sought it at a clinic.<sup>80</sup> Lastly, households with persons with disabilities

<sup>75</sup> ACAPS, *ACAPS Thematic Analysis – Bangladesh: Characteristics of vulnerable households in the Rohingya refugee response* (Cox's Bazar, 2020). Available [here](#) (accessed 30 November 2021); ISCG, 2021; WFP, 2021a.

<sup>76</sup> Results for households with persons with disabilities are representative with a +/- 8% margin of error (n = 160). Results for households without persons with disabilities are representative with a +/- 4% margin of error (n = 958), unless stated otherwise.

<sup>77</sup> p-value ≤ 0.05.

<sup>78</sup> p-value ≤ 0.01.

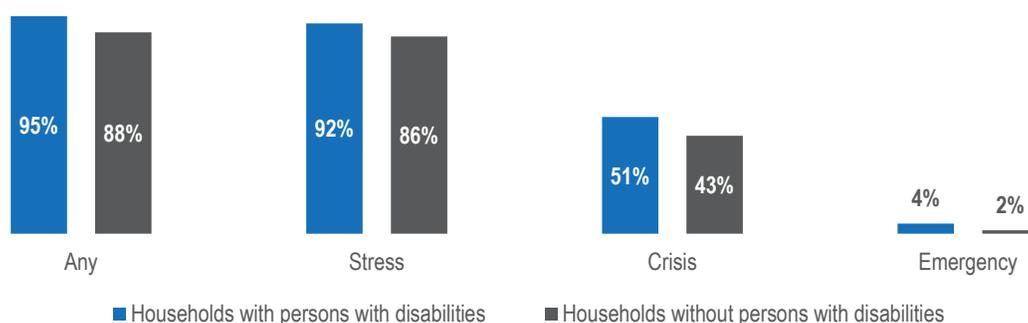
<sup>79</sup> p-value ≤ 0.05.

<sup>80</sup> p-value ≤ 0.01.

were significantly more likely than households without persons with disabilities to have worse FCS<sup>81</sup> (for more details, refer to the [factsheet](#), pg. 5).

**Facing greater challenges accessing services and meeting their needs may make households with persons with disabilities more likely to resort to coping strategies.** Specifically, significantly higher proportions of households with persons with disabilities than households without persons with disabilities reported having adopted livelihoods-based coping strategies (Figure 22).

**Figure 22** % of households with and without persons with disabilities reporting having adopted coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection (any coping strategy (p-value ≤ 0.01), or stress-, crisis-, emergency-level coping strategies)<sup>82</sup>



Moreover, households with persons with disabilities were significantly more likely than households without persons with disabilities to report at least one school-aged child, in particular girls, as not having been enrolled in formal schools before their closure due to the COVID-19 outbreak,<sup>83</sup> as well as at least one school-aged child that would not have been sent back to schools<sup>84</sup> (for more details, refer to the [factsheet](#), pg. 6). This may be linked to households with persons with disabilities not only being more likely than households without persons with disabilities to have unmet needs, but possibly also having fewer adult household members who are able to work or perform household chores, if adult household members are persons with disabilities. **As a means of coping, therefore, children may be more likely to have to take on tasks that otherwise adult household members would carry out, which may make children less likely to receive an education.**

Lastly, in relation to humanitarian assistance, results showed that **households with persons with disabilities may be more likely than households without persons with disabilities to be consulted by humanitarian actors, but they are less likely to feel heard.** Specifically, among households having received humanitarian assistance in the 6 months prior to data collection, households without persons with disabilities were significantly more likely than households with persons with disabilities to report not having been consulted by humanitarian actors on the type of aid

<sup>81</sup> p-value ≤ 0.001.

<sup>82</sup> Livelihoods-based coping strategies were categorised in line with REVA 4. Stress coping strategies included: selling household goods; selling jewellery/gold; spending savings; buying food on credit; borrowing money to buy food; selling labour in advance. Crisis coping strategies included: selling productive assets or means of transport; reducing essential non-food expenditures; asking other community members for food support due to a lack of money/food; selling, sharing and exchanging food rations; selling non-food items that were provided as assistance; adults working long hours or in hazardous conditions. Emergency coping strategies included: begging; children working long hours or in hazardous conditions; child marriage; accepting high-risk, illegal/temporary jobs; entire household migrated.

<sup>83</sup> All children: p-value ≤ 0.01, girls: p-value ≤ 0.01.

<sup>84</sup> All children: p-value ≤ 0.0001, girls: p-value ≤ 0.01; boys: p-value ≤ 0.05.

they would like to receive, or the modality of assistance.<sup>85</sup> On the other hand, however, households with persons with disabilities were significantly more likely than households without persons with disabilities to report having been consulted but feeling that their opinions had not been taken into account<sup>86</sup> (for more details, refer to the [factsheet](#), pg. 6).

### *Female-headed households<sup>87</sup>*

With largely male household members having been reported as having earned an income in the 30 days prior to data collection, 89% of female-headed households reported having earned an income, compared to 97% of male-headed households.<sup>88</sup> At the same time, the reported average per capita income from all livelihoods (including support from friends and relatives, donations, etc.), both including and excluding assistance, is significantly lower among female-headed households than among male-headed households.<sup>89</sup> This can be attributed to women being disproportionately engaged in low productivity livelihoods<sup>90</sup> due to social norms that limit women's freedom of movement outside their homes.<sup>91</sup>

**As such, female-headed households may have less economic capacity than male-headed households to meet their needs, possibly making female-headed households more likely to have unmet needs.** For instance, female-headed households were significantly less likely than male-headed households to report having used exclusively LPG as their source of cooking fuel in the 4 weeks prior to data collection.<sup>92</sup> They were also significantly less likely to report having had soap at the time of data collection,<sup>93</sup> while being significantly more likely than male-headed households to report having used an unimproved sanitation facility.<sup>94</sup> In addition, among households with members reportedly having accessed health care in the 3 months prior to data collection, female-headed households were significantly more likely than male-headed households to report having faced challenges when accessing health care<sup>95</sup> (for more details, refer to the [factsheet](#), pp. 6-7).

Lastly, **children in female-headed households may be at a higher risk than in male-headed households of not receiving an education, particularly girls.** Specifically, female-headed households were significantly more likely than male-headed households to report at least one school-aged child (both boys and girls) who had not been enrolled in formal schools before their closure due to the COVID-19 outbreak,<sup>96</sup> as well as at least one school-aged child, in particular girls, who would not have been sent back to schools<sup>97</sup> (for more details, refer to the [factsheet](#), pg. 7).

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<sup>85</sup> p-value ≤ 0.0001.

<sup>86</sup> p-value ≤ 0.0001.

<sup>87</sup> Results for female-headed households are representative with a +/- 8% margin of error (n = 183). Results for male-headed households are representative with a +/- 4% margin of error (n = 935), unless stated otherwise.

<sup>88</sup> p-value ≤ 0.0001.

<sup>89</sup> p-value ≤ 0.05.

<sup>90</sup> Government of Bangladesh & United Nations, *District Development Plan for Cox's Bazar – Phase I* (Cox's Bazar, 2019). Available [here](#) (accessed 30 November 2021).

<sup>91</sup> ACF, Save the Children & Oxfam, *Rohingya Refugee Response Gender Analysis, Recognizing and responding to gender inequalities* (Cox's Bazar, 2018). Available [here](#) (accessed 30 November 2021); ACAPS, 2020.

<sup>92</sup> p-value ≤ 0.01.

<sup>93</sup> p-value ≤ 0.01.

<sup>94</sup> p-value ≤ 0.01.

<sup>95</sup> p-value ≤ 0.05.

<sup>96</sup> All children: p-value ≤ 0.0001, girls: p-value ≤ 0.0001; boys: p-value ≤ 0.001.

<sup>97</sup> All children: p-value ≤ 0.05, girls: p-value ≤ 0.01.

### Less educated households<sup>98</sup>

Results could not be analysed by households with and without an income, as almost all households reported some form of income. They were, however, analysed by the highest level of education in the household, with **less educated households often having been found to have reported worse outcomes** than better educated households. This may in part be linked to more limited resources having been available to less educated households, as they reported **lower average per capita incomes from all livelihoods than better educated households** (Table 1).

**Table 1** Average per capita income (BDT) from all livelihoods in the 30 days prior to data collection, by highest level of education in the household (p-value ≤ 0.0001)

Highest level of education in the household	Including the imputed amount of humanitarian assistance	Excluding the imputed amount of humanitarian assistance
Primary or less	2,074	2,060
Some secondary	2,177	2,175
Secondary and above	3,194	3,194

As such, less educated households reported at higher proportions than better educated households living in vulnerable shelter types (*kutchas* or *jhupries*). They were significantly more likely to report having had shelter issues at the time of data collection,<sup>99</sup> as well as to report not having made shelter improvements or repairs in the 6 months prior to data collection despite having reported shelter issues.<sup>100</sup> Moreover, less educated households were significantly more likely than better educated households to report having used an unimproved sanitation facility,<sup>101</sup> as well as to report adopting coping strategies throughout the year to adapt to a lack of water,<sup>102</sup> and they were significantly more likely to have worse FCS<sup>103</sup> (for more details, refer to the [factsheet](#), pp. 7-8).

Lastly, **also in less educated households, children may be at a higher risk than in better educated households of not receiving an education**. Specifically, among households with school-aged children, less educated households were significantly more likely than better educated households to report at least one school-aged child who had not been enrolled in formal schools before the COVID-19 outbreak, at least one school-aged child who had not regularly accessed home-based learning since the start of the 2021 school year, and at least one school-aged child that will not be sent back to school once schools will re-open<sup>104</sup> (for more details, refer to the [factsheet](#), pg. 8).

### Large households<sup>105</sup>

Large households also reported lower average per capita incomes than small households (Table 2), indicating less economic capacity to meet their needs.

<sup>98</sup> Results for households with primary education or less are representative with a +/- 6% margin of error (n = 334). Results for households with some secondary education are representative with a +/- 4% margin of error (n = 585). Results for households with secondary education and above are representative with a +/- 8% margin of error (n = 175), unless stated otherwise.

<sup>99</sup> p-value ≤ 0.0001.

<sup>100</sup> p-value ≤ 0.01.

<sup>101</sup> p-value ≤ 0.0001.

<sup>102</sup> p-value ≤ 0.05.

<sup>103</sup> p-value ≤ 0.05.

<sup>104</sup> Pre-COVID-19 enrolment: p-value ≤ 0.01; home-based learning: p-value ≤ 0.05; sending back: p-value ≤ 0.01.

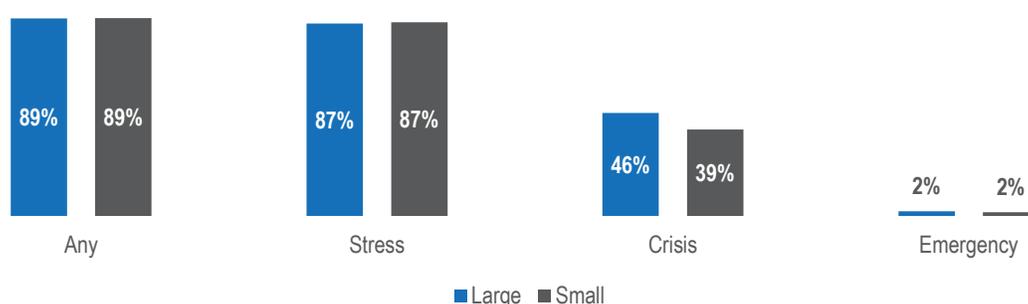
<sup>105</sup> Results for large households are representative with a +/- 4% margin of error (n = 741). Results for small households are representative with a +/- 5% margin of error (n = 377), unless stated otherwise.

**Table 2** Average per capita income (BDT) from all livelihoods in the 30 days prior to data collection, by size of household (p-value ≤ 0.01)

Household size	Including the imputed amount of humanitarian assistance	Excluding the imputed amount of humanitarian assistance
Large	1,965	1,959
Small	2,890	2,886

At the same time, they were largely not found to be significantly more likely than small households to have unmet needs. They were found to be **more likely to adopt livelihoods-based coping strategies, in particular crisis-level ones**, though (Figure 23).

**Figure 23** % of large and small households reporting having adopted coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection (any coping strategy, or stress-, crisis- (p-value ≤ 0.05), emergency-level coping strategies)

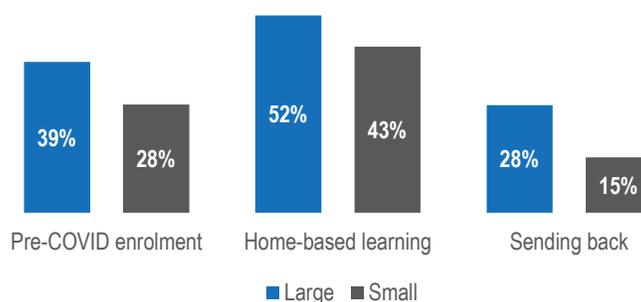


**Large households particularly reported at higher proportions to have adopted livelihoods-based coping strategies to access or pay for health care, as well as education.** Specifically, among households reportedly having adopted livelihoods-based coping strategies, 55% of large households reported having done so to access or pay for health care, compared to 42% of small households, and 23% of large households reported having done so to access or pay for education, compared to 11% of small households.<sup>106</sup> This is clearly indicative of large households being particularly likely to face challenges meeting those needs with the resources they have.

**Possibly related, also in large households, children appeared to be at a higher risk than in small households of not receiving an education.** Significantly greater proportions of large households than small households with school-aged children reported at least one child as not having been enrolled in formal schools pre-COVID-19, as not having regularly accessed home-based learning, and that would not have been sent back to schools once they reopened (Figure 24).

<sup>106</sup> The denominator for this indicator is households reportedly having adopted any coping strategy (large households, n = 659 – results are representative with a +/- 4% margin of error; small households, n = 333 – results are representative with a +/- 6% margin of error). Households could select multiple options.

**Figure 24** % of large and small households with school-aged children reporting at least one school-aged child as not having been enrolled in formal schools before schools closed in March 2020 due to the COVID-19 outbreak (p-value  $\leq 0.01$ ), as not having regularly access home-based learning since the start of the 2021 school year (p-value  $\leq 0.05$ ), and that would not have been sent back to schools (p-value  $\leq 0.0001$ )<sup>107</sup>



### Differences between unions in Teknaf and Ukhiya<sup>108</sup>

Some differences in outcomes were also found between households living in different unions or upazilas.<sup>109</sup> **Households in Teknaf appeared to be more likely to have access to aid, while appearing to be less likely to have access to other services, such as education, health and nutrition services.** Households in Teknaf were significantly more likely than households in Ukhiya to report having received humanitarian assistance (Figure 25). Camp vicinity may have played a role, with the highest proportions of households reportedly having received humanitarian assistance having been found in Teknaf (Sadar and Paurashava), Whykong, and Palong Khali, followed by Nhilla and Baharchhara (also see map in [annex 6](#)).

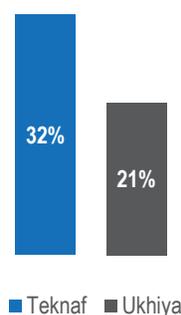
Possibly related to the above, households in Teknaf were also significantly more likely than households in Ukhiya to report having used exclusively LPG as their source of cooking fuel (Figure 26), driven by higher proportions of households in Teknaf than households in Ukhiya reportedly having received LPG from humanitarian actors. **While almost equal proportions of households in both upazilas reported having bought LPG refills, 21% of households in Teknaf reported having received LPG refills from humanitarian organisations, compared to 9% of households having reported so in Ukhiya.** Again, the highest proportions of households reportedly having received LPG refills and reportedly having used exclusively LPG were found in Teknaf, Nhilla, Whykong, and Palong Khali (also see map in [annex 6](#)).

<sup>107</sup> The denominator for this indicator is households with girls or boys aged 6-18 (large households, n = 694 – results are representative with a +/- 4% margin of error; small households, n = 239 – results are representative with a +/- 7% margin of error).

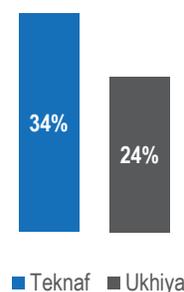
<sup>108</sup> Mapped results for the indicators described in this section can be found in [annex 6](#). Results for both Teknaf (n = 551), and Ukhiya (n = 567) are representative with a +/- 5% margin of error, unless stated otherwise.

<sup>109</sup> Upazila is an administrative region in Bangladesh, functioning as a sub-unit of a district. Unions are the fifth tier of administration, forming sub-units of upazilas.

**Figure 25** % of households in Teknaf and Ukhiya reporting having received humanitarian assistance in the 6 months prior to data collection (p-value  $\leq 0.0001$ )

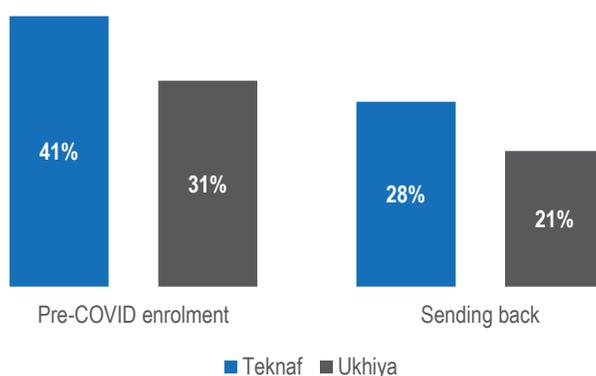


**Figure 26** % of households in Teknaf and Ukhiya reporting having used exclusively LPG for cooking in the 4 weeks prior to data collection (p-value  $\leq 0.001$ )



Moreover, similar to the results of the J-MSNA conducted simultaneously in the refugee community, **households in Teknaf were significantly less likely than households in Ukhiya to report not having used an improved water source as their main source of drinking water at the time of data collection, to report household members having faced problems related to latrines at the time of data collection, and to report usually disposing of their waste in the open.** Specifically, 39% of households in Ukhiya did not report having used an improved water source, compared to 31% of households in Teknaf.<sup>110</sup> Related to waste management, 73% of households in Ukhiya reported having disposed of their waste by throwing it in the open, compared to 66% of households in Teknaf.<sup>111</sup> Differences in relation to problems household members were reportedly facing related to latrines were only significant at the upazila level for problems reported for female household members. Among households with female household members, 52% of households in Ukhiya reported problems females were facing, compared to 46% of households in Teknaf<sup>112</sup> (also see maps in annex 6).

**Figure 27** % of households with school-aged children in Teknaf and Ukhiya reporting at least one school-aged child as not having been enrolled in formal schools before schools closed in March 2020 due to the COVID-19 outbreak (p-value  $\leq 0.01$ ), and that would not have been sent back to schools (p-value  $\leq 0.05$ )



<sup>110</sup> p-value  $\leq 0.05$ .

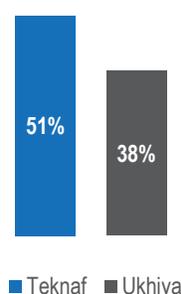
<sup>111</sup> p-value  $\leq 0.05$ .

<sup>112</sup> p-value  $\leq 0.05$ .

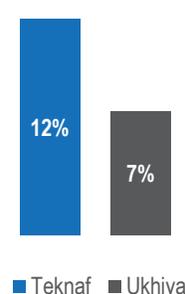
On the other hand, access to education, health, and nutrition services appeared to be lower among households in Teknaf than households in Ukhiya. For instance, among households with school-aged children, 41% of households in Teknaf reported at least one child as not having been enrolled in formal schools pre-COVID-19, compared to 31% of households in Ukhiya. Similarly, 28% of households in Teknaf reported at least one child who would not have been sent back to schools, compared to 21% of households in Ukhiya (Figure 27), thus potentially indicating **more limited access to education in Teknaf compared to Ukhiya** (also see maps in [annex 6](#)).

Households in Teknaf were further significantly more likely than households in Ukhiya to report barriers when accessing health care (Figure 28). The barriers in particular reported by higher proportions of households in Teknaf than households in Ukhiya included the specific medicine, treatment or service needed not being available and long waiting times or overcrowding, i.e. indicating that **health service availability is more limited in Teknaf than in Ukhiya**. Possibly linked, slightly higher proportions of households in Teknaf than households in Ukhiya also reported at least one child under the age of 2 as having been born at home (Figure 29) (also see map in [annex 6](#)).

**Figure 28** % of households with at least one member reportedly having needed health care in the 3 months prior to data collection and having sought treatment at a health facility or hospital reporting barriers they experienced when accessing health care (p-value  $\leq 0.01$ )<sup>113</sup>



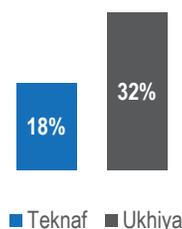
**Figure 29** % of households reporting at one child under the age of 2 having been born at home (p-value  $\leq 0.05$ )



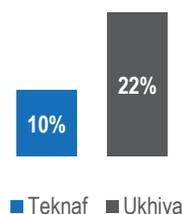
Lastly, and possibly also linked to the above in cases in which nutrition services are delivered through health facilities, the **reach of nutrition services appeared to be lower in Teknaf than in Ukhiya**. Specifically, significantly lower proportions of households in Teknaf than households in Ukhiya reported having received messages for PLW related to basic food and nutrition, infant and young child-feeding practices, malnutrition, personal hygiene, etc. (Figure 30), as well as PLW having been screened (Figure 31). Moreover, significantly larger proportions of households in Teknaf than households in Ukhiya reported at least one child as not having been screened (Figure 32) (also see map in [annex 6](#)).

<sup>113</sup> The denominator for this indicator is all households with at least one member having needed health care in the 3 months prior to data collection and having sought treatment at a health facility or hospital (Teknaf, n = 184 – results are representative with a +/- 8% margin of error; Ukhiya, n = 204 – results are representative with a +/- 7% margin of error).

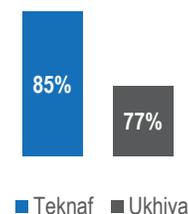
**Figure 30** % of households with PLW reporting having received messages related to basic food and nutrition, infant and young child-feeding practices, malnutrition, personal hygiene, etc. from community nutrition volunteers or nutrition facility staff during the current pregnancy or while breastfeeding (p-value ≤ 0.05)<sup>114</sup>



**Figure 31** % of households with PLW reporting PLW as having been screened for malnutrition by community nutrition volunteers or nutrition facility staff during the current pregnancy or while breastfeeding (p-value ≤ 0.05)<sup>114</sup>



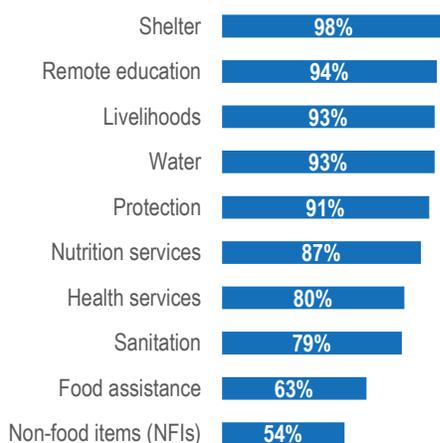
**Figure 32** % of households with children aged 6-59 months reporting at least one child as not having been screened for malnutrition by community nutrition volunteers or nutrition facility staff since the start of Ramadan (p-value ≤ 0.05)<sup>115</sup>



## Communication with Communities

Among households reportedly having received assistance in the 6 months prior to data collection, **large proportions reported information gaps, not having been consulted, and facing challenges when providing feedback. A lack of awareness or understanding of the processes appeared to be the most common barrier.**

**Figure 33** % of households reportedly having received humanitarian assistance reporting not having been able to access (receive and understand) enough clear information in the 6 months prior to data collection, by type of service<sup>116</sup>



**Figure 34** % of households reportedly having received humanitarian assistance reporting having faced problems when accessing (receiving and understanding) information in the 6 months prior to data collection<sup>117</sup>



<sup>114</sup> The denominator for this indicator is all households with PLW (Teknaf, n = 114 – results are representative with a +/- 10% margin of error; Ukhiya, n = 93 – results are representative with a +/- 11% margin of error).

<sup>115</sup> The denominator for this indicator is all households with children aged 6-59 months (Teknaf, n = 271 – results are representative with a +/- 6% margin of error; Ukhiya, n = 233 – results are representative with +/- 7% margin of error).

<sup>116</sup> The denominator for this indicator is all households having received humanitarian assistance (n = 294). Results are representative with a +/- 6% margin of error. The question was asked separately for each type of service.

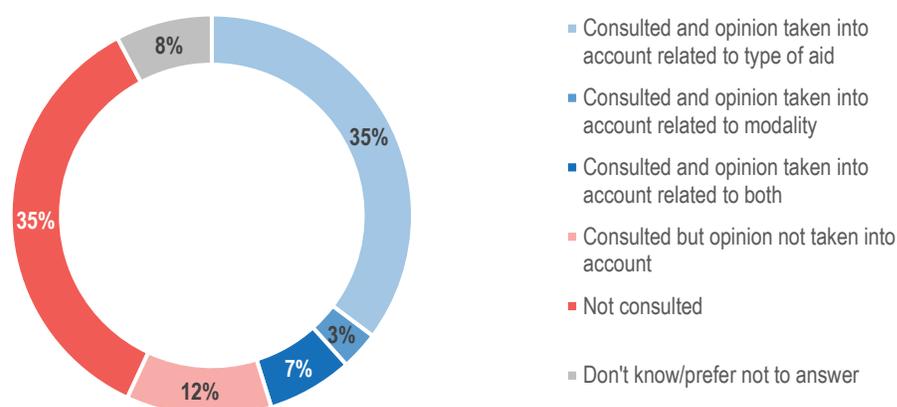
<sup>117</sup> The denominator for this indicator is all households having received humanitarian assistance (n = 294). Results are representative with a +/- 6% margin of error. Households could select up to 3 options.

**Almost all households reportedly having received humanitarian assistance in the 6 months prior to data collection reported having been unable to access enough clear information on the types of assistance available to them (99%).** Types of assistance about which households most frequently reported not having received enough clear information included shelter, remote education, livelihoods, water and protection services (Figure 33).

In addition, 36% of households reportedly having received humanitarian assistance reported having faced problems when accessing (receiving and understanding) information in the 6 months prior to data collection, most commonly not knowing where to get the information or who to ask, not enough information on how to access services being available, and not enough information on the services itself being available (Figure 34).

Moreover, **roughly half the households reportedly having received humanitarian assistance reported either not having been consulted by aid providers on the type of aid they would like to receive and how they would like to receive it, or having been consulted but feeling that their opinions had not been taken into account** (Figure 35).

**Figure 35** % of households reportedly having received humanitarian assistance reporting having been consulted and felt that aid providers took their household's opinion into account related to the type of aid they would like to receive and how they would like to receive it in the 6 months prior to data collection<sup>118</sup>



Finally, **26% of households reportedly having received humanitarian assistance reported having faced challenges when providing feedback or complaints on any issues related to aid or the process of receiving aid in the 6 months prior to data collection**, most commonly not knowing where, whom or how to provide feedback or complaints (as reported by 20% of households).<sup>113</sup>

All of the above was confirmed in the FGDs. Participants in most FGDs reported not feeling included in humanitarian decision-making. In 6 of 20 FGDs, participants reported not feeling that their opinions were taken into account. Moreover, in most FGDs, participants reported perceiving inconsistencies in how different households in the host community received assistance in terms of the type, quality and quantity of assistance received. Participants reported aid distributions to sometimes involve favouritism.

<sup>118</sup> The denominator for this indicator is all households having received humanitarian assistance (n = 294). Results are representative with a +/- 6% margin of error.

*“We are not informed by distributors. Those who are getting [assistance] have relatives in the distribution. As we have neither a member of the union council working with them, nor leaders/chairmen, we don’t get [aid] regularly.” – FGD with women, ages 25-40*

*“There are some people who make friends with NGO staff and they register their relatives’ names on the [beneficiary] list, taking advantage of their relationship with the staff. Because of that, needy and deserving people are excluded from receiving the assistance.” – FGD with men, ages 41-60*

*“Whenever an NGO worker visits here to learn about the area, a local agent stays with him as a guide. The agent only takes him to the people he likes.” – FGD with men, ages 18-24*

Participants in some FGDs also reported bribery in relation to aid provision, as well as in relation to filing complaints. Bribery was reported to be initiated by both humanitarian workers or those in charge of aid distributions and beneficiaries.

*“Bangladeshi humanitarian workers who deal with beneficiaries ask for something or money in exchange for assistance. They always take a percentage of the assistance they are assigned to provide. Everyone, including beneficiaries and some authorities, know about it.” [...] “I cannot say that NGOs ask for something or money in exchange for assistance. It mostly happens between Bangladeshi humanitarian workers and beneficiaries. Beneficiaries seek extra assistance by giving bribes to the humanitarian workers. But at the end of the day, the humanitarian workers are blamed.” – FGD with men, ages 18-24*

*“They have to pay people whenever [people] file a complaint or [ask for help to] solve their problems.” – FGD with women, ages 41-50*

Means to improve the provision of assistance suggested by participants included better targeting, the elimination of “middlemen” for distributions, and providing assistance that benefits the entire community (e.g. road construction).

*“They should change the way they are providing us with the assistance. Nowadays, NGOs provide us with assistance indirectly by assigning special Bangladeshi people for distribution. It’s not good for us, because those who make the list of beneficiaries prioritise their relatives, friends, and neighbours. So, if they don’t provide us with the assistance through Bangladeshi humanitarian workers, it will be better for us.” – FGD with men, ages 18-24*

## CONCLUSION

The District of Cox’s Bazar, located in southern Bangladesh, faces some of the poorest living conditions in the country. At the same time, approximately 900,000 Rohingya refugees continue to reside in camps in Ukhiya and Teknaf Upazilas. While needs in Ukhiya and Teknaf mainly arise from existing development challenges, they have been compounded by the refugee influx. With the return of refugees to Myanmar continuing to be uncertain, there is a continued need for up-to-date information on the needs and vulnerabilities of all affected populations. At the same time, the outbreak of the COVID-19 pandemic and associated containment measures severely disrupted livelihoods among the host community for most of 2020, leading to exacerbated needs, which may have been further aggravated by a renewed lockdown implemented in April 2021. Against this background, the J-MSNA was conducted to support detailed humanitarian planning to meet the multi-sectoral needs of affected populations and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. The assessment covered host community populations residing in Teknaf and Ukhiya Upazilas, and was implemented through the ISCG’s MSNA TWG.

Findings show that needs most prioritised by households included access to food, shelter materials/upgrades, and access to IGAs, with a steady increase over the past three years in the proportions of households having reported these needs. In line with these trends, FCS were found to have deteriorated further compared to 2020 J-MSNA findings, while the reported adoption of certain livelihoods-based coping strategies remained at levels comparable to 2020 J-MSNA findings. All of this is indicative of households still being affected by the COVID-19 outbreak and its secondary impacts on livelihoods, with a potential risk of a deterioration of coping capacities and living standards. At the time of data collection, roughly one third of households continued to report monthly per capita expenditures below the MEB, indicating that they may not have been able to meet their basic needs.

As such, needs and service gaps have also remained across sectors. Almost three quarters of households continued to report having had issues with their shelters, while one third of households reported not having made shelter improvements or repairs despite having reported issues. With reportedly very limited shelter support having been received from humanitarian actors, a lack of money to pay for materials and labour remained the most frequently reported reasons for not having implemented shelter improvements or repairs.

Moreover, despite access to water reportedly having improved over the past three years, roughly one third of households reported not having had enough water at the time of data collection, and one in four households in Teknaf, or one in three households in Ukhiya, were reportedly using shallow tubewells as their main source of drinking water at the time of data collection. In addition, roughly one fifth of households reported using an unimproved sanitation facility, while roughly half the households reported problems related to latrines. Large gaps also existed in relation to waste management, with almost half the households reportedly not having had access to bins at the time of data collection.

Gaps further remained in relation to education. Compared to pre-COVID-19 enrolment rates, lower proportions of children had reportedly accessed home-based learning while schools were closed, indicating that previously enrolled children missed out on their education while schools were closed. This may at least in part have been linked to a lack of resources and the technological equipment needed to access home-based learning. Moreover, in particular older children, and especially girls, may be at risk of having ended their education early as a result of the COVID-19 outbreak, and other barriers, including marriage and households’ inability to afford educational costs, which may be preventing

them from resuming school following school re-openings. Young children, on the other hand, who could not start their education through home-based learning when they should have normally got enrolled in schools, may have experienced a delayed start in their education. Lastly, while the majority of households were reportedly planning to send children back to schools, difficulties in covering the expenses were a frequently reported major expected challenge.

Overall, roughly half the households perceived unmet needs of children in their community at the time of data collection – in line with the overall results, most commonly related to education and food. In addition, barriers accessing or using protection services were reported, which may possibly be compounding perceived existing safety and security challenges.

The reported access to nutrition services in the host community was limited, with low reported rates of screening of both children and PLW. This may in part be linked to methodological limitations of the assessment having resulted in under-reporting of screening. At the same time, however, access to the host community was limited at the time of data collection due to COVID-19 containment measures, which further promoted home isolation for PLW, possibly also reducing the use of nutrition services.

Lastly, while COVID-19-related negative trends in health-seeking behaviour may have been partially reversed, pharmacies or drug shops rather than clinics remained the most commonly reported treatment locations. In addition, roughly half the households reported having experienced or expecting experiencing barriers when needing to access health care, which is indicative of continuing challenges accessing health care among the host community.

Some households were found to be more likely than others to report gaps or challenges. These households included households with persons with disabilities, female-headed households, less educated households, and large households. Households with persons with disabilities, female-headed households, and less educated households were all more likely than households without persons with disabilities, male-headed households, or better educated households, respectively, to report worse outcomes across sectors. Likely as a result, households with persons with disabilities were found to have been more likely to resort to coping strategies as they have been more likely than households without persons with disabilities to report having adopted livelihoods-based coping strategies to meet their needs in the 30 days prior to data collection. Moreover, children in vulnerable households may be at a higher risk of not receiving an education, with higher proportions of households with persons with disabilities, female-headed households, and less educated households than households without persons with disabilities, male-headed households, or better educated households, respectively, having reported at least one child as not having been enrolled in formal schools pre-COVID-19 or that would not have been sent back to schools once they would have re-opened. Lastly, while large households were not found to have had disproportionate unmet needs, they were more likely than small households to report having met their needs, especially education and health care needs, by adopting livelihoods-based coping strategies. Moreover, also in large households, children may face a particularly high risk of not receiving an education.

Given the likely further exacerbated needs compared to last year and a risk of erosion of coping capacities, it is important to continue to closely monitor needs and service gaps in the near and medium term to allow for continued evidence-based programming addressing those needs. The results of the J-MSNA are characteristic of the very specific circumstances that prevailed at the time of data collection. As the situation changes, the most concerning trends, such as food security and livelihoods outcomes, likely accompanying adverse impacts, e.g. on education and child well-

being, should be closely monitored. Secondly, a better understanding of the continued impacts of the COVID-19 outbreak and containment measures on the most vulnerable households may help more effectively alleviate those.

## ANNEXES

## Annex 1: Sampling frame

Table 3 Share of union-level sample drawn from each database

Union	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Ward 9
Raja Palong	3%	13%	14%	7%	13%	19%	7%	10%	14%
Haldia Palong	6%	20%	19%	8%	6%	5%	7%	7%	22%
Jalia Palong	8%	8%	8%	7%	7%	5%	6%	24%	27%
Ratna Palong	5%	7%	6%	6%	30%	20%	6%	7%	10%
Palong Khali	8%	6%	6%	9%	5%	4%	28%	18%	15%
Nhilla	4%	7%	8%	7%	5%	4%	19%	10%	36%
Sabrang	9%	8%	13%	6%	5%	12%	14%	18%	15%
Whykong	26%	23%	12%	16%	8%	5%	6%	2%	4%
Baharchara	12%	6%	16%	14%	13%	17%	6%	7%	9%
Teknaf (Sadar and Paurashava)	16%	16%	11%	10%	9%	14%	8%	6%	10%

Database colour codes:

- UNHCR host community database
- UNHCR beneficiaries
- WFP beneficiaries
- IOM beneficiaries

## Annex 2: Household surveys completed per union

Table 4 List of surveys completed per union against union population and targeted minimum number of surveys per union

Upazila	Union	Total number of households	Targeted minimum number of surveys	Completed number of surveys
Ukhiya	Raja Palong	10,596	95	112
	Haldia Palong	9,006	95	130
	Jalia Palong	8,511	95	115
	Ratna Palong	4,238	94	102
	Palong Khali	5,589	94	108
Teknaf	Nhilla	8,271	95	102
	Sabrang	9,970	95	106
	Whykong	8,867	95	114
	Baharchara	4,832	94	123
	Teknaf (Sadar and Paurashava)	13,219	95	106
<b>Total</b>		<b>83,099</b>	<b>947</b>	<b>1,118</b>

## Annex 3: Focus group discussions completed by age and gender group

**Table 5** List of focus group discussions completed, overall and by gender of participants

Age group	Number of FGDs with men	Number of FGDs with women	Total
18-24	3	2	5
25-40	3	3	6
41-59	2	3	5
60+	2	2	4
<b>Total</b>	<b>10</b>	<b>10</b>	<b>20</b>

## Annex 4: Agenda of enumerator training

### AGENDA Joint Multi-Sector Needs Assessment Training, 4-8 July 2021 (facilitated by REACH with Sector support)

**Overall aim:** To strengthen the capacity of enumerators to conduct data collection for the 2021 Joint Multi-Sector Needs Assessment (J-MSNA) to a high quality and ethical standard.

**Learning outcomes:**

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

**Timing:**

- Please note that the training will be held from **8:30 am start to 5:30 pm each day**.
- Two 15 minute breaks and a 1-hour lunch break will be given across the day.
- The times given in the agenda are a guide only. **Training venue:** Google Hangouts ([camps](#), [HC](#)) – **please make sure you have a stable internet connection.**

Date & Time	Session	Objectives	Facilitator
<b>Day 1, 4 July 2021 (Sunday)</b>			
08:30 – 9:00 am	Registration Hangouts/testing connection	Ensure all participants are able to connect.	REACH
9:00 – 9:30 am	Welcome & agenda	Welcome everyone and ensure a common understanding of the training and its objectives.	REACH
9:30 – 10:15 am	Introduction to Kobo collect	Ensure everyone is familiar with the data collection app.	REACH
10:15 – 10:30 am	Overview of field team roles	Ensure everyone understands roles and responsibilities and who to report to.	REACH
10:30-10:45 am	Tea break		
10:45 – 1:00 pm	Data collection instructions	Ensure everyone understands data collection procedures.	REACH
1:00 -2:00 pm	Lunch break		
2:00 – 2:15 pm	Introduction to the MSNA	Ensure everyone understands background of the MSNA.	REACH
2:15 – 3:15 pm	Research ethics	Ensure everyone understands research ethics, including confidentiality, PSEA and referrals.	REACH
3:15 – 3:45 pm	Brief overview of methodology	Ensure everyone understands the methodology.	REACH
3:45 - 4:00 pm	Tea break		
4:00 – 5:00 pm	Good interviewing practices	Ensure everyone understands and is able to apply good practices.	REACH
5:00 – 5:30 pm	Clarification of any open questions and closing	Ensure no questions remain open and plan for next day is clear.	REACH
<b>Day 2, 5 July 2021 (Monday)</b>			
8:30 – 9:00 am	Registration	Ensure all participants are able to connect.	REACH
9:00 – 10:30 am	Introduction to questionnaire (Hard copy)	Discuss first (opening questions, household and individual information) and last (priority needs, referrals, closing) parts of questionnaire	REACH
10:30 – 10:45 am	Tea break		
10:45 – 11:15 am	Shelter (camps) / CwC (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors

Date & Time	Session	Objectives	Facilitator
11:15 – 11:45 am	Food security (camps) / Health (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
11:45 – 12:15 pm	WASH (camps) / Shelter (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
12:15 – 12:45 pm	Protection, incl. referral (until 1pm, camps) / Food security (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
12:45 – 1:00 pm	Open questions	Ensure everyone has a very good understanding of each question and its rationale.	REACH
12:45 – 2:00 pm	Lunch break		
2:00 – 2:30 pm	Nutrition (camps) / WASH (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
2:30 – 3:00 pm	Education (camps) / Protection (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
3:00 – 3:30 pm	CwC (camps) / Nutrition (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
3:30 – 3:45 pm	Open questions	Ensure everyone has a very good understanding of each question and its rationale.	REACH
3:45 – 4:00 pm	Tea break		
4:00 – 4:30 pm	Health (camps) / Education (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
4:30 – 5:00 pm	Site Management (camps) / Gender (HC)	Ensure everyone has a very good understanding of each question and its rationale.	REACH/sectors
5:00 – 5:30 pm	Gender (camps) / open questions (HC)	Ensure all training content has been clear, and there are no more open questions.	REACH
<b>Day 3, 6 July 2020 (Tuesday)</b>			
8:30-9:00 am	Registration	Ensure all participants are able to connect.	REACH
9:00 – 10:45 am	Mock interview sessions using KoBo tool (small group calls between enumerators with team leader feedback within their small groups)	Ensure everyone is familiar with the KoBo tool, questions are clear and the tool works as intended.	REACH
10:45 – 11:00 am	Tea break		
11:00 – 12:00 pm	Feedback and clarification of any questions	Ensure everyone is familiar with the KoBo tool, questions are clear and the tool works as intended.	REACH
12:00 – 1:00 pm	Continuation of mock sessions	Ensure everyone is familiar with the KoBo tool, questions are clear and the tool works as intended.	REACH
1:00-2:00 pm	Lunch break		
2:00 – 3:30 pm	Continuation of mock sessions	Ensure everyone is familiar with the KoBo tool, questions are clear and the tool works as intended.	REACH
3:30 – 3:45 pm	Feedback and clarification of any questions	Ensure everyone is familiar with the KoBo tool, questions are clear and the tool works as intended.	REACH
3:45 – 4:00 pm	Tea break		
4:00 – 5:00 pm	Logistics for pilot	Ensure everyone is ready for the pilot data collection.	REACH
5:00 – 5:30 pm	Clarification of any open questions and closing	Ensure all training content has been clear, and there are no more open questions.	REACH
<b>Day 4, 7 July 2020</b>	Pilot data collection (8:30 am – 4:30 pm)	Pilot data collection	REACH
<b>Day 5, 8 July 2020</b>	Pilot review (online, 8:30 am – 5:30 pm)	Pilot data collection and review, clarification of any open questions	REACH

## Annex 5: Partners involved in the assessment

**Table 6** List of partners involved in each stage of the assessment

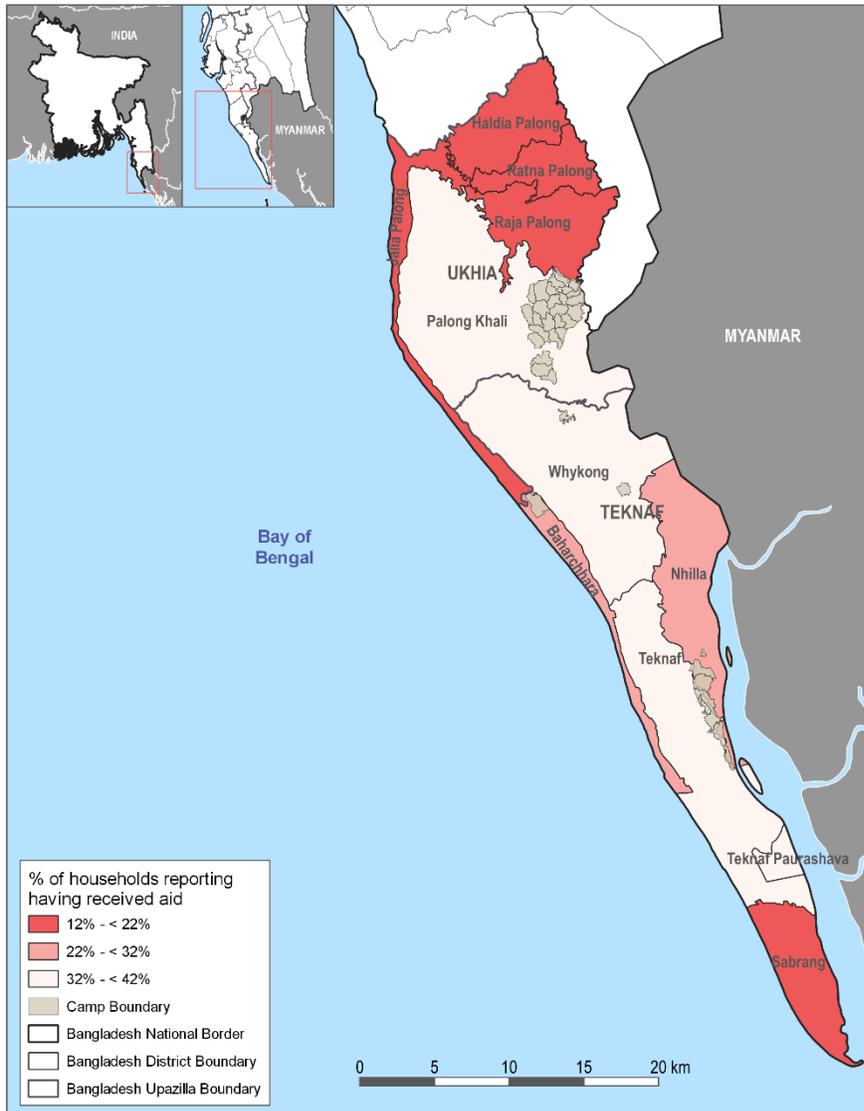
Stage of the assessment	Partners involved
Research design	MSNA TWG, led by the ISCG and comprised of ACAPS, IOM NPM, WFP VAM, UNHCR and REACH
Tool design	Sectors, MSNA TWG
Enumerator training	Sectors, REACH
Data collection	IOM NPM, Helvetas, REACH
Data cleaning, transcription and translation	REACH (quantitative component), ACAPS and NPM (qualitative component)
Data analysis	Sectors, REACH (quantitative component), ACAPS and NPM (qualitative component)
Dissemination	MSNA TWG

## Annex 6: Maps

Union-level results presented in the following are representative at a 95% confidence level and with a +/- 10 % margin of error, unless stated otherwise.

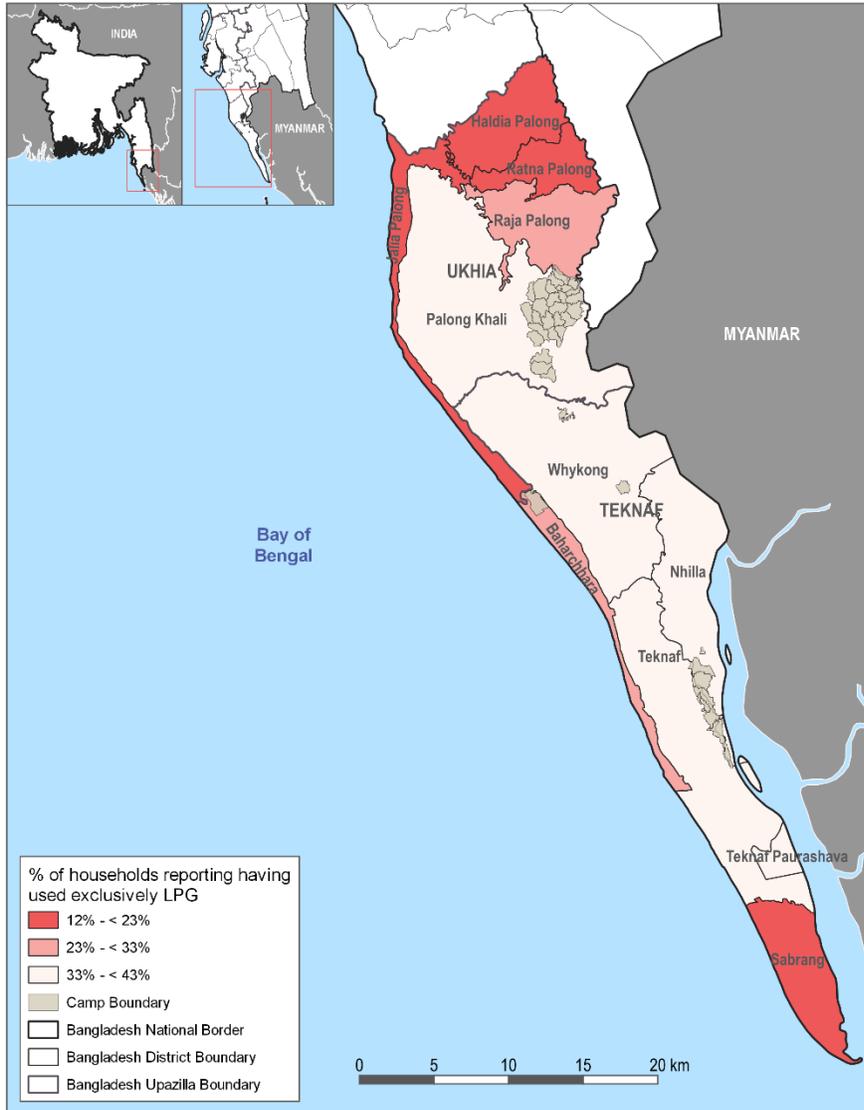
### Receiving aid

**Map 2** % of households reporting having received humanitarian assistance in the 6 months prior to data collection, by union



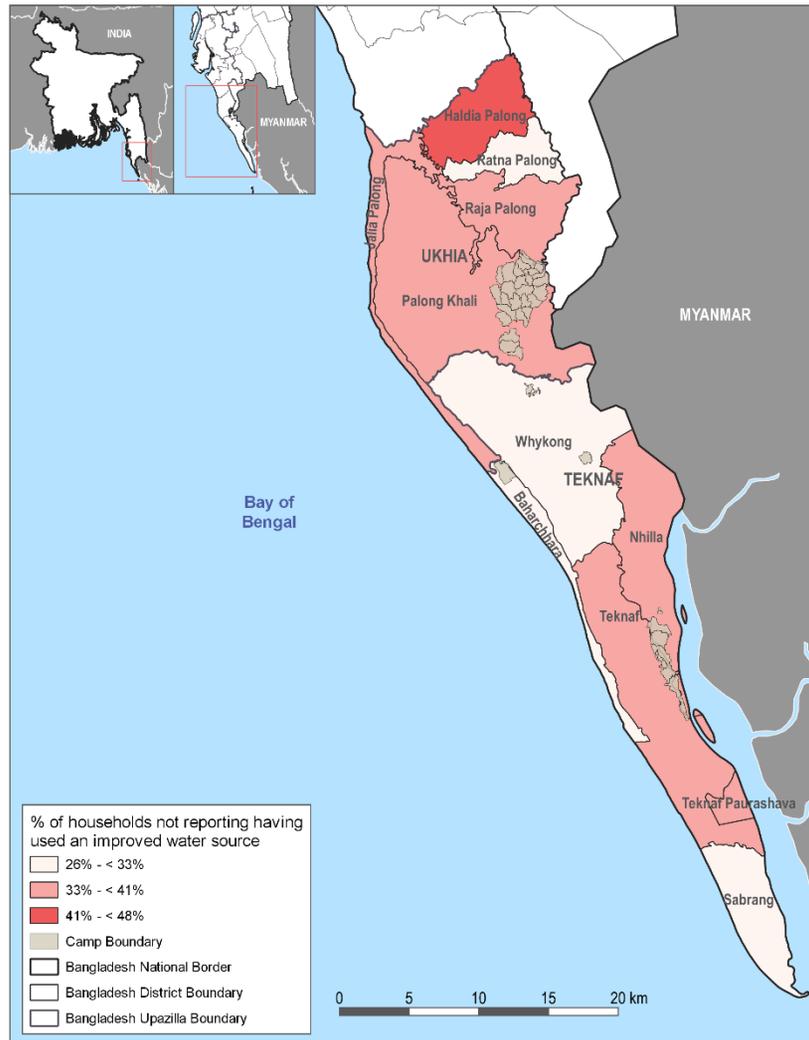
Shelter and NFIs

Map 3 % of households reporting having used exclusively LPG for cooking in the 4 weeks prior to data collection, by union

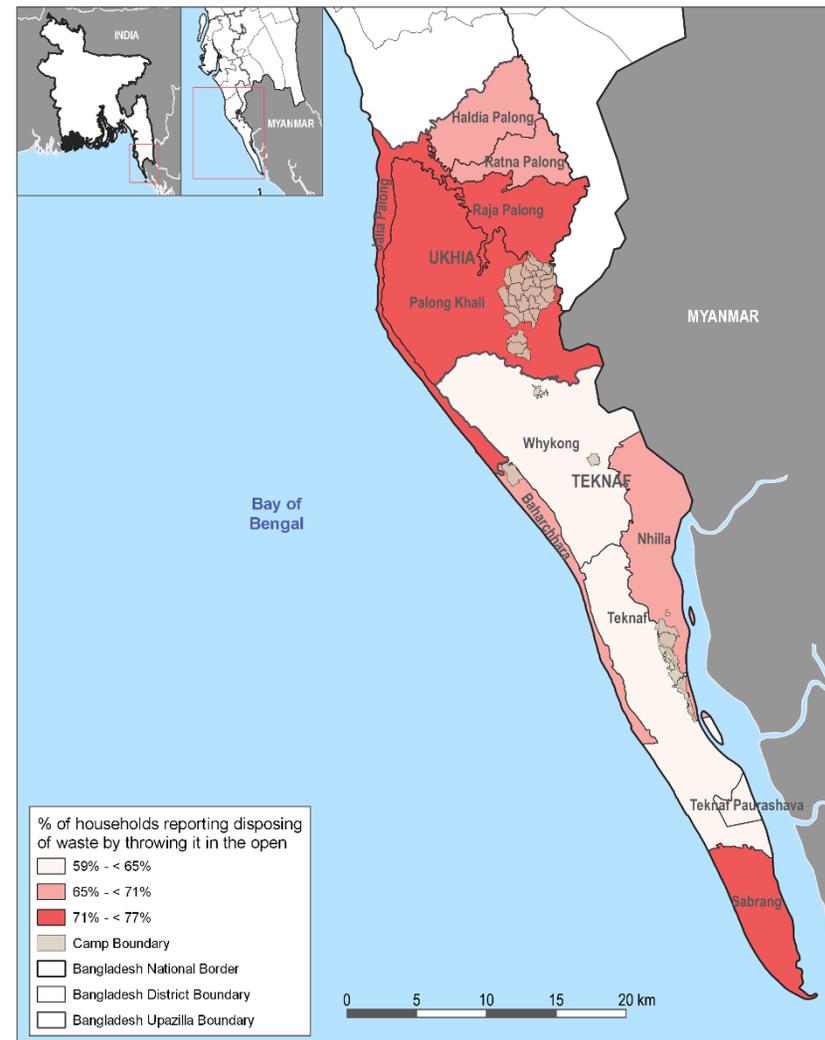


WASH

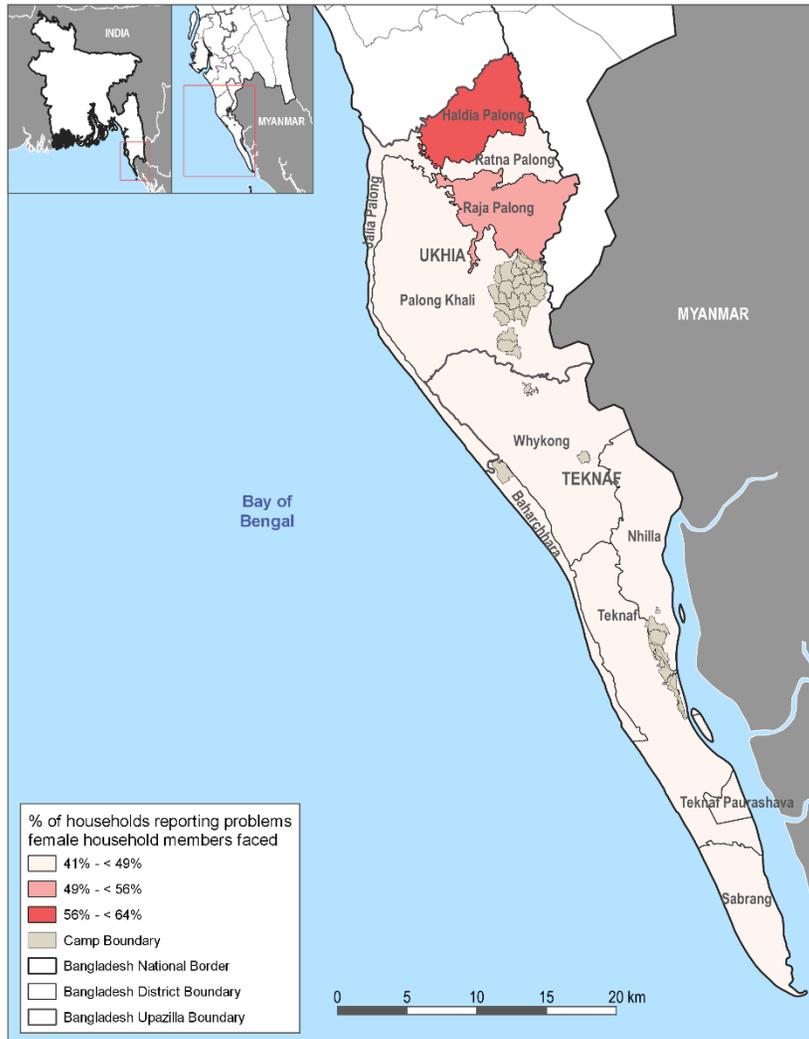
**Map 4** % of households reporting not having used an improved water source as their main drinking water source at the time of data collection, by union



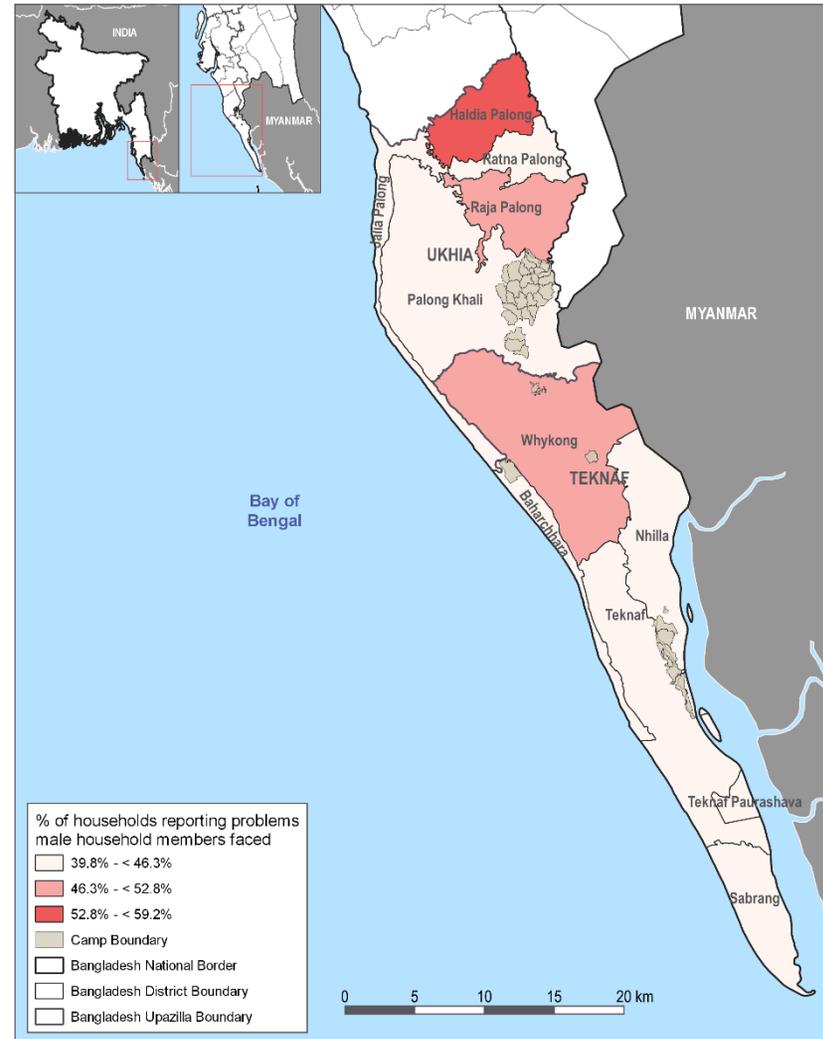
**Map 5** % of households reporting usually disposing of household waste by throwing it in the open, by union



**Map 6** % of households with female members reporting problems related to latrines females in their households faced at the time of data collection, by union

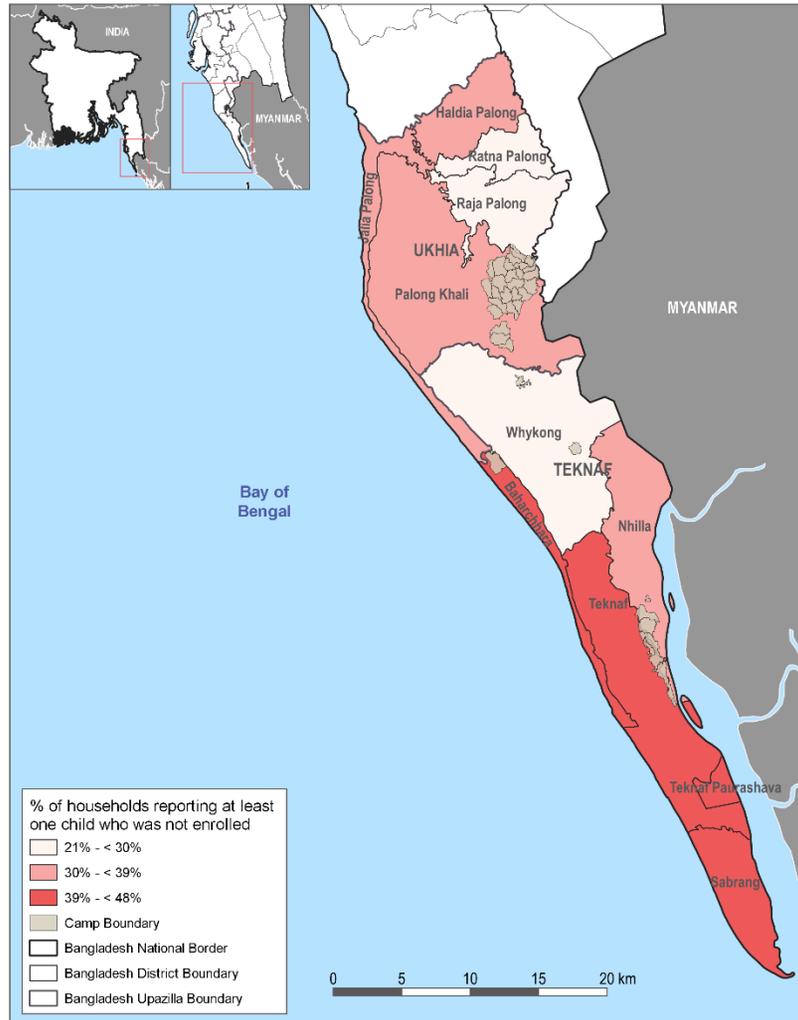


**Map 7** % of households with male members reporting problems related to latrines males in their households faced at the time of data collection, by union

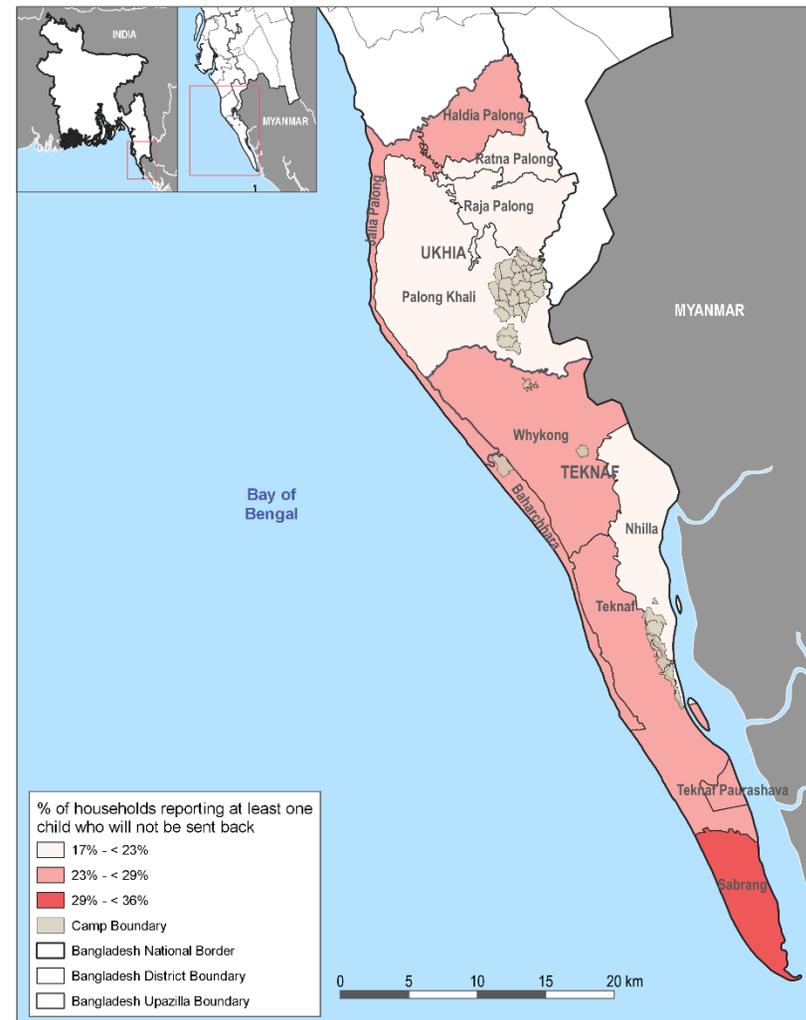


Education

**Map 8** % of households with school-aged children reporting at least one school-aged child as not having been enrolled in formal schools before schools closed in March 2020 due to the COVID-19 outbreak, by union (margin of error: +/- 11%)

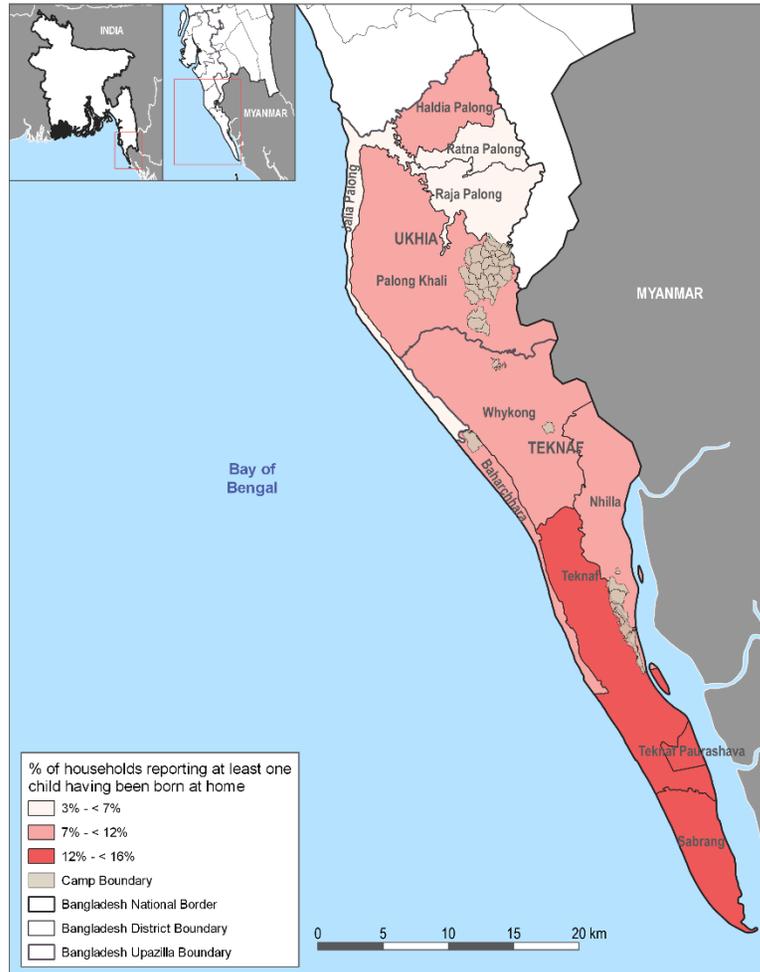


**Map 9** % of households with school-aged children reporting at least one school-aged child that will not be sent back to schools once they will re-open, by union (margin of error: +/- 11%)



Health and Nutrition

**Map 10** % of households reporting at one child under the age of 2 having been born at home



**Map 11** % of households with children aged 6-59 months reporting at least one child as not having been screened for malnutrition by community nutrition volunteers or nutrition facility staff since the start of Ramadan (margin of error: +/- 17%)

