COX'S BAZAR, BANGLADESH

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

Rohingya Refugees

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ISCG | Inter Sector Coordination Group

## COORDINATED BY:

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## TECHNICAL CONTRIBUTIONS:

HELVETAS BANGLADESH

REACH Informing more effective humanitarian action

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IOM • OIM NPM Needs and Population Monitoring THE UN MIGRATION AGENCY

ACAPS - NPM ANALYSIS HUB COX'S BAZAR - BANGLADESH

WFP

UNHCR The UN Refugee Agency

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# EXECUTIVE SUMMARY

Over the last four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Periodic outbreaks of violence led to large exoduses of refugees in particular in 1978, between 1991 and 1992, and in other short waves prior to August 2017.[1] 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.[2, 3]

With limited access to regular income and livelihood opportunities, the Rohingya refugee population in the 34 camps is highly reliant on humanitarian assistance.[4] While the crisis is now in its fifth year, prospects of return of refugees to Myanmar continue to be uncertain.[5] At the same time, structural factors, including a lack of formal education in camps, insufficient water, sanitation and hygiene (WASH) provisions, and weak shelter infrastructure continue to challenge the response.[6]

Moreover, large camp areas are located in hilly, formerly forested areas that are highly vulnerable to landslides and flash-flooding during the monsoon season, as witnessed most recently, in August 2021, during a large flood event that affected more than 80,000 individuals.[7] Camps are further affected by fires that spread easily between the tightly constructed shelters, as also seen earlier this year, in March 2021, when a large fire affected close to 50,000 individuals.[8]

Lastly, the outbreak of the COVID-19 pandemic and associated containment measures put in place in camps on 24 March 2020 severely restricted humanitarian access and service delivery to the highly aid-dependent refugee communities throughout much of 2020. With only a limited number of essential services having been provided and severely disrupted access to self-reliance activities and cash among the refugee community, pre-existing needs were exacerbated, in particular related to food security, health-seeking behaviour, education, and protection. Moreover, households' capacities to meet their needs and cope with service gaps, including recurring ones, such as monsoon-induced shelter damage, were considerably reduced. As a result, households increasingly turned towards more extreme coping strategies, with potential negative long-term impacts on household and individual well-being, in particular among the most at-risk populations.[9] A renewed lockdown, implemented in April 2021, may have further aggravated the situation.

[1] Zakaria, F. (2019), "Religion, mass violence, and illiberal regimes: Recent research on the Rohingya in Myanmar", *Journal of Current Southeast Asian Affairs,* 38(1), pp. 98 – 111.
[2] Compare https://data2.unhcr.org/en/situations/myanmar_refugees.
[3] Information as of the time of data collection (July-August 2021).
[4] World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA) – Cox's Bazar*, Bangladesh (April 2020) (Cox's Bazar, 2020). Available here (accessed 30 November 2021).
[5] 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); John Bryant & Oliver Lough, *With Myanmar's military back in full control, Rohingya refugees need long-term solutions* (February 2021). Available here (accessed 30 November 2021).
[6] Ibid.; WFP, 2020; ICG, 2019.
[7] ISCG, *Flash Update #5 On Monsoon Response Of 18 August 2021* (Cox's Bazar, 2021a). Available here (accessed 30 November 2021).
[8] ISCG, *Joint Humanitarian Response to Fire Incident in Rohingya Refugee Camps* (Cox's Bazar, 2021b). Available here (accessed 30 November 2021).
[9] Inter Sector Coordination Group (ISCG), *2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020*, Rohingya Humanitarian Crisis, April – December 2020 (Cox's Bazar, 2020a). Available here (accessed 30 November 2021); Government of The People's Republic of Bangladesh, Office of the Refugee Relief and Repatriation Commissioner, Restricted Programme in Light of COVID-19 (Letter No-749) (Cox's Bazar, 2020); ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Rohingya Refugees, May 2021* (Cox's Bazar, 2021c). Available here (accessed 30 November 2021).

Against this background, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across Rohingya refugee and 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 refugee 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. This report focuses on the findings relating to the Rohingya refugee component of the J-MSNA.

The J-MSNA targeted all Rohingya refugee households residing in the 34 camps in Ukhiya and Teknaf Upazilas (excluding any refugees having been relocated elsewhere). Sectors and topics covered included Food Security and Livelihoods, WASH, Shelter and Non-food items (NFIs), Site Management and Site Development (SMSD), 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 the UNHCR refugee registration database, using a stratified random sampling approach, with the camps as the strata. Results are representative of the population included in the sampling frame, i.e. households registered with phone numbers in the UNHCR refugee registration database and in areas with mobile reception, at the camp 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 2% margin of error. A total of 3,683 interviews were carried out between 12 July and 26 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 being biased towards men and possibly slightly better educated households, mobile reception being unequal across camps, and difficulties ensuring privacy during phone interviews, likely resulting in under-reporting of sensitive issues. 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

**Almost all households were found to have unmet multi-sectoral needs**, with 20% of households having been found to have extreme unmet needs, and 66% of households having been found to have severe unmet needs. Unmet needs were most commonly related to shelter and NFIs, as well as food security and livelihoods. However, extreme unmet needs most commonly concerned food security and livelihood outcomes, as well as (child) protection.

Generally, **households appear to have at least partially recovered from the COVID-19 outbreak and its secondary impacts, in particular on food security and livelihoods, and health-seeking behaviour**. Proportions of households similar to 2019 J-MSNA results were found to have an acceptable food consumption score (FCS) again, and also the proportion of individuals reportedly having required health care reported as having sought it at an NGO clinic in the 4 weeks prior to data collection increased to 72% again, after having dropped to 64% in 2019.[10]

Moreover, results show that the **coverage of some services has remained extensive. Almost all households (99.5%) reported having received food assistance** in the 30 days prior to data collection, **97% of households reported having received liquefied petroleum gas (LPG) refills** in the 3 months prior to data collection**, 97% of households with children aged 6 to 59 months (nearly 5 years) reported having had some form of contact with nutrition service providers** since the start of Ramadan (14 April 2021), and **88% of individuals reportedly having needed health care were reported as having sought it at an NGO clinic** in the 3 months prior to data collection. Additionally, in particular in relation to access to water, **positive trends** can be observed with an **increasing proportion of households having used piped water as their main water source (as reported by 54% in 2021, compared to 29% in 2019),** and a **decreasing proportion of households reportedly not having had enough water (as reported by 31% in 2021, compared to 56% of households in 2019).**

However, **with limited access to self-reliance activities, the refugee population in camps remains highly reliant on humanitarian assistance**. **Excluding the value of assistance received and consumed by households, 85% of households reported monthly per capita expenditures below the Minimum Expenditure Basket (MEB)**, i.e. likely not being able to meet their basic needs.[11] At the same time, **even including the value of assistance received and consumed by households, roughly one quarter of households were found to have monthly per capita expenditures below the MEB**, indicating that households may not always be able to meet their basic needs despite the assistance they receive.

As such, results also showed **needs and gaps in access to basic goods and services having remained across sectors. Not all households may be receiving shelter support when needed, and also among those having received support, it may not always have been sufficient.** Specifically, among households reportedly having improved/repaired their shelter in the 6 months prior to data collection, 29% did not report having received the materials

[10] 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.

[11] 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).

for the improvements/repair but having bought them, while 33% reported having received and bought materials. Large gaps were further reported in relation to access to **NFIs**, with **almost nine in ten (90%) households reporting having had insufficient NFIs.**

Similarly, despite blanket food distributions, **roughly half the households were found not to have an acceptable FCS**, likely linked to challenges preserving food items until the end of distribution cycles, especially with COVID-19 containment measures in place, limited food diversity and challenges accessing in particular fresh products.

Moreover, **one in five households (19%) were reportedly not using an improved water source** as their main source of drinking water, and **not all households perceived always having had access to enough water**. **Roughly four in ten households reported problems male or female household members faced related to latrines**, and **roughly 20% of households reported problems male or female household members faced related to bathing facilities.** Additionally, during FGDs with women, **insufficient distribution of menstrual hygiene kits, and issues of low quality** were frequently reported.

**Large gaps in access to education have also remained, in particular among older individuals and girls**. Adolescent girls may be most at risk of having ended their education early as a result of the COVID-19 outbreak. **While 18% of girls aged 15 to 18 were reportedly enrolled in learning facilities before they closed due to the COVID-19 outbreak in March 2020, only 15% had reportedly accessed home-based learning since the start of the 2021 school year until support for home-based learning stopped at the end of March 2021, and only 12% will reportedly be sent back once learning facilities will re-open**. **Younger children who were not enrolled in education pre-COVID-19 are likely to start their education later** than they would have, if learning facilities would not have been closed, as largely only previously enrolled children appear to have accessed home-based learning. Generally, the main reported barriers towards accessing an education were on the one hand, a **lack of opportunities for older students as well as other reasons for older students to drop out early**, such as marriage, and on the other hand **both remote and in-person education having been perceived as ineffective or of low quality**, while also **COVID-19 remained a concern in relation to in-person education**.

Furthermore, since the start of the COVID-19 outbreak, there has been an increase in reports of Gender Based Violence (GBV), petty crimes, inter- and intra-communal disputes, human trafficking, abduction, assault, and extortion.[12] Moreover, increases in violence against children have been reported, with the lockdown as the primary reason.[13] **Fear and feelings of insecurity may have been further exacerbated this year by the reduced Protection Sector footprint in camps between April and September 2021 in line with COVID-19 containment measures**, which was frequently reported as having prevented access to protection services among those wanting to access them. At the same time, an **over-reliance on *mahjis* and Camps-in-Charge (CiCs) as first points-of-contact to report at least cases of assault and abuse remained.**[14]

Lastly, while unmet **health** needs were generally low, **one third of households without unmet needs reportedly only met their needs through the adoption of negative coping strategies**, indicating that they may also not be able to meet their needs in the long run.

[12] ACAPS, *Secondary impacts of COVID-19: Potential consequences of the May 2021 containment and risk mitigation measures* (Cox's Bazar, 2021). Available here (accessed 30 November 2021).
[13] Child Protection Sub-Sector, *Findings from the Child Protection Assessment in Rohingya Refugee Camps in Cox's Bazar* (Cox's Bazar, 2021).
[14] More information on the governance structures in the Rohingya camps and role of the mahjis is available here.

**Some households were found to be more likely than others to report gaps or challenges, or have unmet needs**. These households included **households with persons with disabilities, female-headed households, households without access to self-reliance activities, and large households or households with high dependency ratios**. Households with persons with disabilities, female-headed households, and households without access to self-reliance activities, were all particularly likely to report worse outcomes, as well as having adopted coping strategies to meet their needs. Large households were more likely to report assistance, in particular LPG and food assistance, as not having lasted the full distribution cycles.

Results clearly show that while some positive trends and extensive service provision can be observed, five years into the crisis, needs and service gaps have remained. As such, **additional information on the drivers behind persisting needs and gaps in access to basic services** may help effectively address those. Similarly, a more in-depth investigation for a **better understanding of barriers towards accessing protection services and the referral pathways households take** – also beyond the first point-of-contact – may help improve access to and use of protection services offered by humanitarian actors.

Lastly, given the practical limitations of this assessment, certain topics, such as access to menstrual hygiene materials, could not be covered within the household survey but some were covered within the qualitative survey component. Sensitive issues that were addressed, e.g. related to safety and security, may have been under-reported due to the methodological limitations. Therefore, **targeted assessments of such sensitive topics** with carefully designed methodologies and in-person data collection may help improve the understanding of issues around topics such as menstrual hygiene and safety and security to be able to better counter gaps and negative trends.

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## List of Acronyms

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

## Geographical Classifications

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

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# INTRODUCTION

Over the last four decades, Rohingya refugees have been fleeing in successive waves to Bangladesh from Rakhine State, Myanmar. Periodic outbreaks of violence led to large exoduses of refugees in particular in 1978, between 1991 and 1992, and in other short waves prior to August 2017.[15] 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.[16]

Already prior to displacement, the Rohingya faced challenges accessing basic services and meeting basic needs in Myanmar.[17] This is reflected in factors such as low educational attainment among the Rohingya refugees in Bangladesh both in absolute terms, and relative to the average in Myanmar.[18] Poverty in Rakhine State, where the Rohingya constituted one third of the population prior to the 2017 mass exodus, is nearly twice the national average of Myanmar, with households' levels of poverty likely having been further exacerbated during migration. High numbers of refugee children had never received any vaccinations in Myanmar, and recorded levels of acute malnutrition, child and maternal mortality in Rakhine State are all indicative of gaps in health outcomes among the population.[19]

With limited access to regular income and livelihood opportunities, the Rohingya refugee population in the 34 camps is highly reliant on humanitarian assistance.[20] While the crisis is now in its fifth year, prospects of return of refugees to Myanmar continue to be uncertain.[21] At the same time, structural factors, including a lack of formal education in camps, insufficient water, sanitation and hygiene (WASH) provisions, and weak shelter infrastructure continue to challenge the response.[22]

Moreover, large camp areas are located in hilly, formerly forested areas that are highly vulnerable to landslides and flash-flooding during the monsoon season, as witnessed most recently, in August 2021, during a large flood event that affected more than 80,000 individuals.[23] Camps are further affected by fires that spread easily between the tightly constructed shelters, as also seen earlier this year, in March 2021, when a large fire affected close to 50,000 individuals.[24]

Lastly, the outbreak of the COVID-19 pandemic and associated containment measures put in place in camps on 24 March 2020 severely restricted humanitarian access and service delivery to the highly aid-dependent refugee communities throughout much of 2020. With only a limited number of essential services having been provided and severely disrupted access to self-reliance activities and cash among the refugee community, pre-existing needs were

[15] Zakaria, F. (2019), "Religion, mass violence, and illiberal regimes: Recent research on the Rohingya in Myanmar", *Journal of Current Southeast Asian Affairs,* 38(1), pp. 98 – 111.
[16] Compare https://data2.unhcr.org/en/situations/myanmar_refugees.
[17] Rosenthal, G., *A brief and independent inquiry into the involvement of the United Nations in Myanmar from 2010 to 2018* (May 2019). Available here (accessed 30 November 2021).
[18] Davis, A. *et al.*, *Socioeconomic Characteristics of Rohingya Refugees from Myanmar living in Bangladesh, April 2020* (Washington, D.C. 2020). Available here (accessed 30 November 2021).
[19] Abishek, B. *et al.* (2018), "The Rohingya in Cox's Bazar: When the Stateless Seek Refuge", *Health and human rights* 20(2), 105.
[20] World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA) – Cox's Bazar*, Bangladesh (April 2020) (Cox's Bazar, 2020). Available here (accessed 30 November 2021).
[21] 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); John Bryant & Oliver Lough, *With Myanmar's military back in full control, Rohingya refugees need long-term solutions* (February 2021). Available here (accessed 30 November 2021).
[22] Ibid.; WFP, 2020; ICG, 2019.
[23] Inter Sector Coordination Group (ISCG), *Flash Update #5 On Monsoon Response Of 18 August 2021* (Cox's Bazar, 2021a). Available here (accessed 30 November 2021).
[24] ISCG, *Joint Humanitarian Response to Fire Incident in Rohingya Refugee Camps* (Cox's Bazar, 2021b). Available here (accessed 30 November 2021).

exacerbated, in particular related to food security, health-seeking behaviour, education, and (child) protection. Moreover, households' capacities to meet their needs and cope with service gaps, including recurring ones, such as monsoon-induced shelter damage, were considerably reduced. As a result, households increasingly turned towards more extreme coping strategies, with potential negative long-term impacts on household and individual well-being, in particular among the most at-risk populations.[25] 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 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 refugee 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 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.

[25] ISCG, *2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020*, Rohingya Humanitarian Crisis, April – December 2020 (Cox's Bazar, 2020a). Available here (accessed 30 November 2021); Government of The People's Republic of Bangladesh, Office of the Refugee Relief and Repatriation Commissioner, Restricted Programme in Light of COVID-19 (Letter No-749) (Cox's Bazar, 2020); ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA): Rohingya Refugees, May 2021* (Cox's Bazar, 2021c). 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 refugee populations to inform the 2022 Joint Response Plan (JRP);[26]
2. Provide an analysis of how refugee 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 refugee camps?
    a. How severe are these needs within and across sectors?
    b. What are the main drivers of need?
    c. What is the co-occurrence of needs?
2. How do sectoral and inter-sectoral 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' preferences and priorities for 2022?

## Scope and tool development

In line with the geographical coverage and population targeted by all previous as well as the 2022 JRP, the assessment targeted all Rohingya refugee households residing in the 34 camps in Ukhiya and Teknaf Upazilas (excluding any refugees having been relocated elsewhere). Sectors and topics covered included Food Security and Livelihoods, WASH, Shelter and Non-food items (NFIs), Site Management and Site Development (SMSD), 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 13 sections of closed-ended questions, covering basic household- and

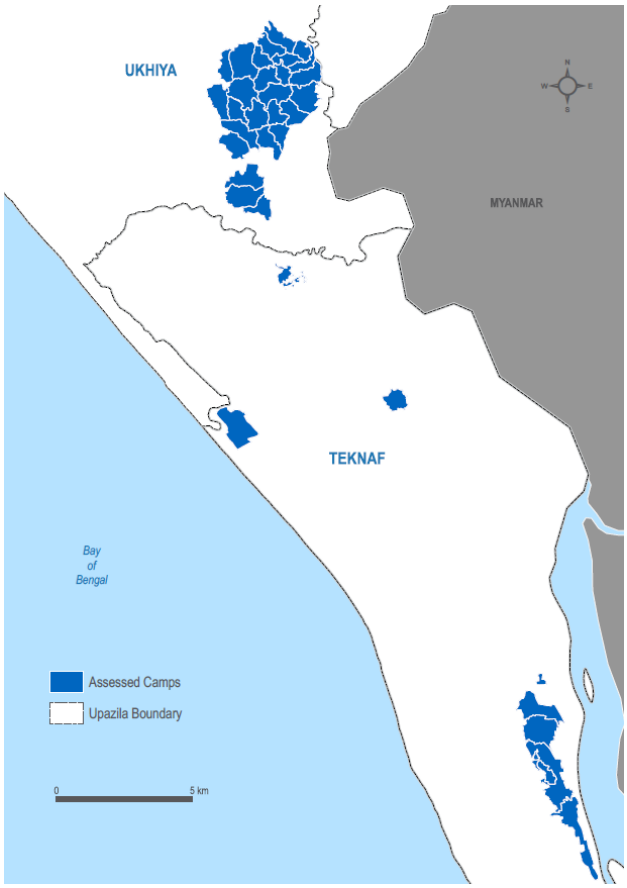
[26] A separate J-MSNA with the same objectives was simultaneously conducted in the host community.

individual-level information, as well as the sectors/topics outlined above. It was translated to Rohingya 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.

*Qualitative component*

The question route for the focus group discussions (FGDs) was developed by the MSNA TWG guided by 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 additional explanations and context around the quantitative results. The tool was translated to Rohingya prior to volunteer training and data collection. FGDs in the camps were conducted by Rohingya volunteers, with equal gender representation for volunteers and participants.

**Map 1** Assessed camps 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.[27] Target sample sizes were based on the most recent population figures available from UNHCR. Households were sampled from the UNHCR refugee registration database, including all registered refugee households, using a stratified random sampling approach, with the camps as the strata. Households were sampled with the aim of generating results representative at the camp 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 2% margin of error.

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 limited phone numbers available in the sampling frame from Nayapara and Kutupalong registered camps, these two camps were sampled and analysed as one stratum. With the two camps being assumed to be sufficiently similar in their characteristics and levels of service provision to justify treating them as one stratum, this allowed to still draw a random sample and therefore generate results that are representative of the households in those two camps registered with phone numbers in the database.

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 (4%), such as Bangladeshi households living within camp boundaries and vice versa; (2) non-response (66%), including non-functional phone numbers, households without mobile reception, or switched off phones; (3) non-consenting or child-headed households (6%), 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, 17% of respondents were female and 83% of respondents were male. Fifty-eight percent (58%) of female respondents and 6% 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 camps 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

[27] 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".

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, 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 26 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 3,683 households were surveyed across all 34 refugee camps. Achieved sample size at the camp level ranged from a minimum of 100 surveyed households (obtained in camp 4E) to a maximum of 141 surveyed households (as reached in camp 16).[28] Results are therefore representative at the camp level of all refugee households included in the sampling frame at a 95% confidence level and with a 10% margin of error. Overall results are representative of all refugee households included in the sampling frame at a 95% confidence level and with a 2% margin of error. They can further serve as a proxy of the entire camp population in the 34 camps Teknaf and Ukhiya Upazilas. Data collection was led by REACH and conducted by 6 teams of UNHCR enumerators, consisting of 12 to 13 enumerators each (77 enumerators in total).

Prior to data collection, enumerators underwent a three-day online training to familiarise themselves with the tool and data collection protocols.[29] 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.[30] 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 Family Counting Numbers (FCN) and location (camp and block numbers), where provided, it was attempted to verify that the correct households had been interviewed. In total, 53 of 3,736 completed interviews were deleted from the final dataset due to quality issues related to timing or duplicate respondent IDs that could not be corrected.

[28] A full list of completed interviews by camp is included in annex 1.
[29] The enumerator training agenda is included in annex 3.
[30] 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, 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 FGDs with 41 to 59 year-olds (2 with males, 2 with females), and 3 FGDs with 60+ year-olds (1 with males, 2 with females) were conducted.[31]

Data collection was led and conducted by ACAPS and NPM with a team of 11 Rohingya enumerators, in 19 camps. Prior to the training, the tool was discussed with and reviewed by the Rohingya 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 Rohingya, recorded and transcripts translated into English.

## Data analysis

Both sectoral and inter-sectoral analysis was conducted. However, the estimation of caseloads of households in need was beyond the scope of this assessment. Qualitative results and secondary data were used to contextualise quantitative findings. 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 sectoral and inter-sectoral 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 34 camps, results were weighted at the camp level during the basic descriptive analysis.

As part of the inter-sectoral analysis, the following analytical constructs were measured:

- **Living Standard Gap (LSG):** signifies an unmet need in a given sector, where the LSG severity score is 3 or higher.
- **Capacity Gap (CG):** signifies that negative and unsustainable coping strategies are used to meet needs. Households not categorised as having an LSG may be maintaining their living standards through the use of negative coping strategies.
- **Severity:** signifies the "intensity" of needs, using a scale that ranges from 1 (minimal/no need) to 4 (extreme needs)/4+ (extreme+ needs).

[31] A full list of completed FGDs is included in annex 2.

- **Magnitude:** corresponds to the overall number or percentage of households in need.
- The **Multi-Sectoral Needs Index (MSNI)** is a measure of a household's overall severity of humanitarian needs across sectors (expressed on a scale from 1 to [4/4+]), based on the highest severity of sectoral LSG severity scores identified in each household.

The analytical framework was inspired by the draft Joint Inter-Sector Analysis Framework (JIAF), an analytical framework being developed at the global level aiming to enhance the understanding of needs of affected populations. The framework measures a progressive deterioration of a household's situation towards the worst possible humanitarian outcome. For more information on the analytical framework, please refer to the assessment's concept note, as well as to annexes 1 to 3 of the factsheet.

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 there was an association between the household characteristics and indicator outcomes. Relationships were determined to be statistically significant for p-values ≤ 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.

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 Rohingya 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. Referral instructions and guidance were provided to all teams of enumerators.[32]

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 it was disseminated more widely.

## Challenges and limitations

Challenges and limitations of the assessment included:

- **Sampling frame:** As the sampling frame did not cover the entire camp population, results can be considered representative of the population included in the sampling frame. They are indicative of the camp population as a whole. Due to limitations in the sampling frame, Nayapara and Kutupalong camps were sampled and analysed as one stratum.
- **Remote data collection:** Due to restrictions on movement, access to camps, and face-to-face interviews as part of the COVID-19 containment measures, all household interviews were conducted over the phone. This created some challenges and limitations:

[32] The referral instructions are included in annex 4.

  - 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.
  - As phone ownership is more prevalent among men, a lower proportion of households with female respondents were reached than might have been reached during an in-person survey. However, the sampling approach still allowed to include 17% of female respondents, with 58% of them reportedly having replied on behalf of a female-headed household.
  - 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 camps, 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"). In addition, there may have been limitations with respondents not wanting to answer questions from Bangladeshi enumerators.
- **Perceptions:** Questions on household perceptions may not directly reflect the realities of service provision in refugee camps 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.

**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.**
- The **reduced Protection Sector footprint** in camps between April and September 2021, as a result of COVID-19-related preventative measures, as well as a sometimes potentially **limited understanding of protection and the different services offered by protection actors** among respondents, may **have impacted respondents' perceptions of the types of services available.**

# FINDINGS

## Multi-sectoral and priority needs

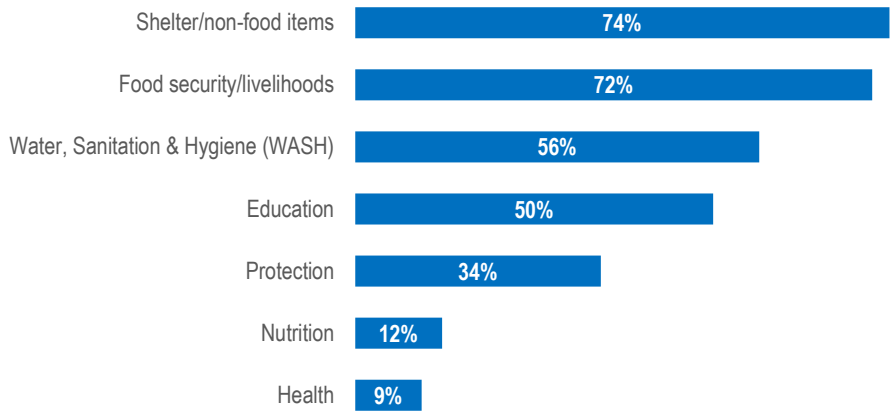
**Almost all households were found to have unmet multi-sectoral needs**. One in five households were found to have extreme needs, while two thirds were found to have severe needs. In total, 13% of households could not be classified, largely due to challenges among households replying to community-level protection-related questions (hence, often replying "Don't know"), and therefore an impossibility to identify the severity of protection as well as multi-sectoral needs for those households (Table 1).

**Table 1** % of households per severity phase

| | | |
|---|---|---|
| *Households in need* | 4 (Extreme) | 20% |
| | 3 (Severe) | 66% |
| | 2 (Stress) | 1% |
| | 1 (None/minimal) | <1% |
| | Not classified | 13% |

Unmet needs were found to be most commonly related to shelter and NFIs, as well as food security and livelihoods (Figure 1). However, extreme unmet needs most commonly concerned food security and livelihood outcomes (13% of households were found to have extreme unmet food security and livelihoods needs), as well as (child) protection (6% of households were found to have extreme unmet protection needs, and 4% of households were found to have extreme unmet education needs[33]).

**Figure 1** % of households with sectoral living standard gaps (LSG severity score > 2) among households with multi-sectoral needs (MSNI > 2)




As outlined in more detail in the chapter "Vulnerability", the proportion of households in need differed between different types of households, as well as at the camp level. The highest proportions of households with extreme needs were

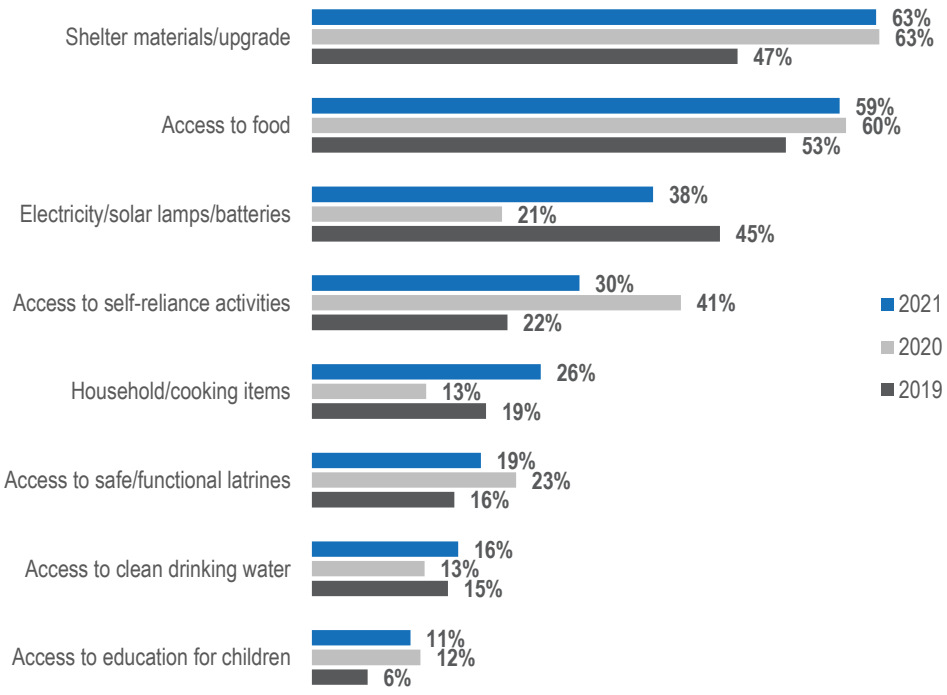
[33] Extreme education needs would indicate child protection relevant barriers preventing access to education, such as children up until the age of 18 not receiving an education due to marriage/pregnancy or because they are working outside the household.

found among households with persons with disabilities, female-headed households and households without access to self-reliance activities.

**The most commonly reported priority needs reflect the multi-sectoral findings, such that shelter and NFI-related needs as well as food security and livelihood-related needs were most frequently mentioned**, followed by WASH-related needs and access to education (Figure 2).

Shelter materials and access to food were reported among the top three priority needs by proportions of households similar to 2020 J-MSNA findings, indicating that those have remained high priority needs. On the other hand, access to self-reliance activities was mentioned by lower proportions of households again, after having increased in 2020. The same holds true, but to a lesser degree, for access to safe and functional latrines. Latrines/latrine maintenance had reportedly become more of an issue in 2020 due to the limited presence of humanitarian actors in camps in compliance with COVID-19 containment measures. As such, these results may be indicative of the issue having become slightly less prevalent again, with respondents in a few FGDs also having reported that – while still being an issue – latrine maintenance had improved. Instead, electricity and household/cooking items were reported by higher proportions of households again, after having decreased from 2019 to 2020 findings. Overall, these trends may be indicative of households having at least partially recovered from the COVID-19 outbreak and its secondary impacts on livelihoods observed last year, with the proportions of households reporting different priority needs – with the exception of shelter and food – being more similar to 2019 results again (also refer to next chapter "Recovery from COVID-19 and its secondary impacts" for more details) (Figure 2).

**Figure 2** % of households reporting top three priority needs for 2022, compared to 2019 and 2020 results[34]

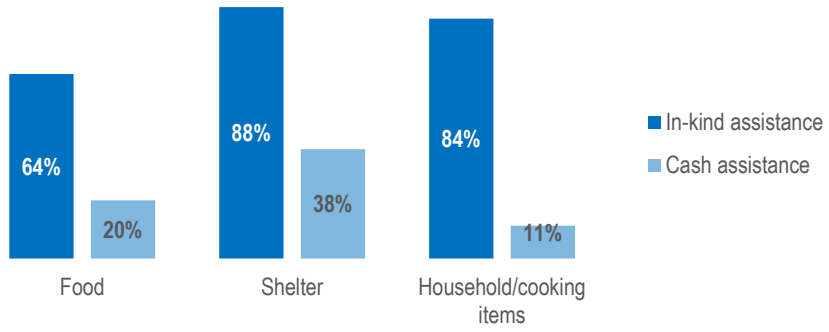



[34] ISCG, 2021c; ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA), Rohingya Refugees, Cox's Bazar, Bangladesh, September 2019* (Cox's Bazar, 2019). Available here (accessed 30 November 2021).

Generally, female respondents were significantly more likely than male respondents to report electricity/solar lamps/batteries (reported by 51% of female respondents, compared to 34% of male respondents),[35] household/cooking items (41% of female respondents, 21% of male respondents),[36] and clothing (11% of female respondents, 7% of male respondents)[37] among their top three priority needs. Male respondents were significantly more likely than female respondents to report access to self-reliance activities (20% of female respondents, 33% of male respondents),[38] shelter materials/upgrades (56% of female respondents, 65% of male respondents),[39] and access to food (55% of female respondents, 60% of male respondents)[40] among their top three priority needs.[41]

Related to the preferred modality of assistance, higher proportions of households reported preferring in-kind assistance than reported preferring cash assistance (Figure 3). Additionally, 17% of households reported preferring labour support as shelter assistance modality, 10% reported preferring vouchers for shelter materials, and 8% reported preferring a combination of shelter assistance modalities. Ten percent (10%) reported preferring mixed modality food assistance.

**Figure 3** % of households reporting preferred modalities of assistance to meet each need[42]




## Recovery from COVID-19 and its secondary impacts

The impact of COVID-19, in particular on food security and livelihoods, as well as health-seeking behaviour, observed in the 2020 J-MSNA appears to have partially reversed in the current assessment.

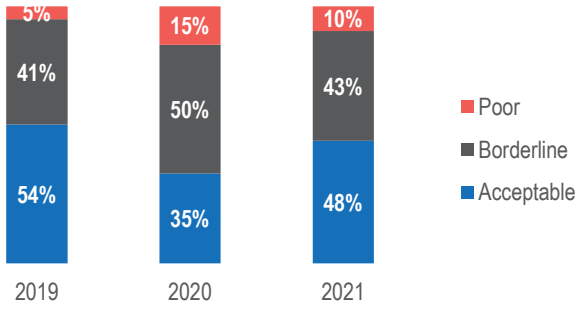
### *Food security and livelihoods*

Between 2019 and 2020, food consumption scores (FCS) found during the respective J-MSNAs had worsened notably, likely as a result of changes in the frequency of food distributions and the diversity of food packages to reduce the risk

[35] p-value ≤ 0.0001.
[36] p-value ≤ 0.0001.
[37] p-value ≤ 0.05.
[38] p-value ≤ 0.0001.
[39] p-value ≤ 0.0001.
[40] p-value ≤ 0.05
[41] Results for female respondents are representative with a +/- 4% margin of error (n = 801). Results for male respondents are representative with a +/- 2% margin of error (n = 2,879).
[42] 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: shelter materials, n = 2,308 – households could select multiple options; household/cooking items, n = 970 (results are representative with a +/- 4% margin of error). All households were asked about their preferred modality to receive food assistance.

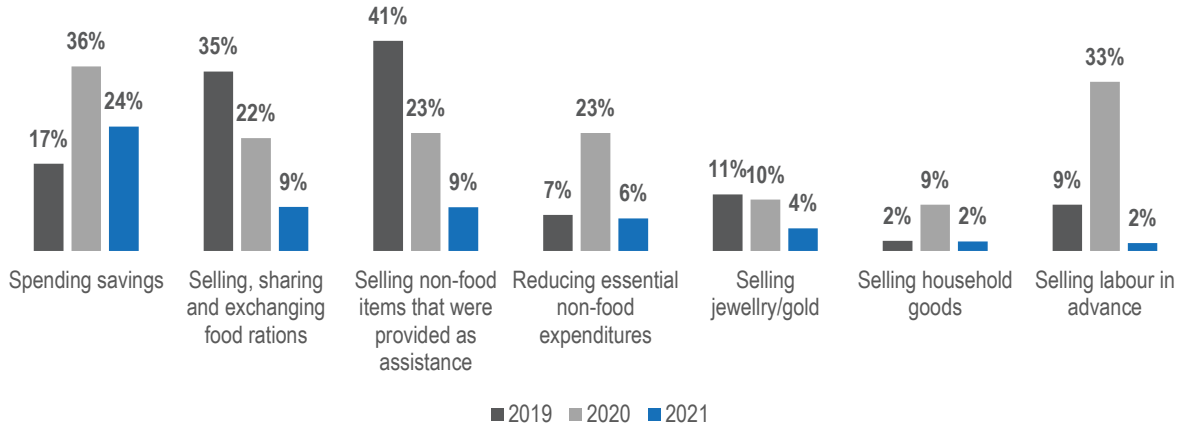
of spread of COVID-19 at the time of data collection in 2020.[43] This year, compared to 2020 J-MSNA findings, FCS were found to have improved again. **While roughly half the households remain without an acceptable FCS, similar proportions of households as in 2019 were now found to have an acceptable FCS again** (Figure 4).

**Figure 4** % of households by food consumption score[44]




Moreover, while 2020 J-MSNA results had indicated a potential erosion of coping capacities as a result of exacerbated needs and reduced levels of assistance,[45] also this trend appears to have at least partially reversed in the current assessment. Nevertheless, overall, **70% of households continued to report having exhausted or adopted livelihoods-based coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection. However, the proportion of households that reported having adopted or exhausted certain comparable coping strategies decreased again compared to 2020 J-MSNA findings.** For instance, the proportion of households having reported having spent savings as a coping strategy had increased from 17% in 2019 to 36% in 2020, and reportedly reduced to 24% again this year. Similar trends were found for the proportions of households reporting having reduced essential non-food expenditures, having sold household goods, or having sold labour in advance (Figure 5).

**Figure 5** % 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[45]



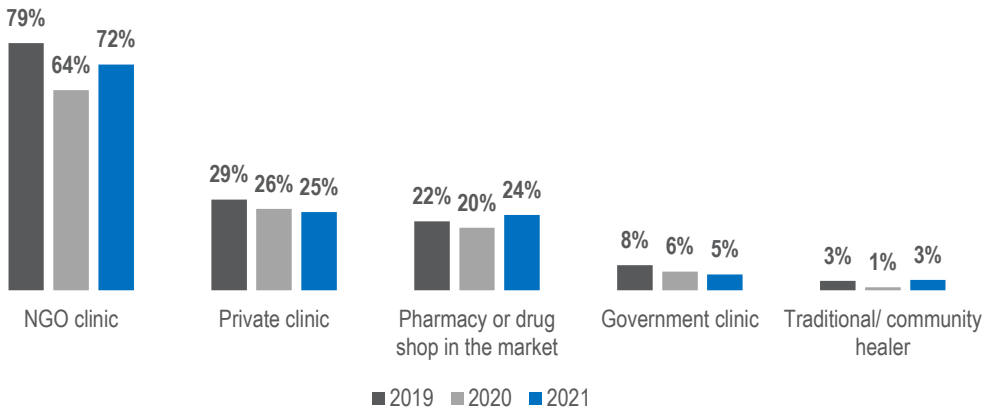

[43] ISCG, 2021c.
[44] The Food Consumption Score (FCS) is a composite score based on (1) dietary diversity; (2) food frequency; and (3) relative nutritional importance of nine weighted food groups. The FCS is recorded from a seven-day recall period. In Bangladesh, thresholds for FCS classifications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

At the same time, there is a continuous decrease in the proportion of households reportedly having sold, shared or exchanged both food and non-food assistance, as well as jewellery/gold (Figure 5). This may not necessarily be indicative of a reduced need among households to adopt those strategies, but may also be driven by a reduced availability or viability of these strategies. (27% of households reported selling jewellery/gold not to be available to them as a coping strategies, 25% of households reported selling productive assets or means of transport not to be available to them, 18% of households reported selling household goods not to be available to them, and 12% of households reported spending savings not to be available to them as a coping strategy). For instance, changes in food assistance provision, including a shift from in-kind to e-voucher food assistance and measures such as rice capping associated with lower rates when selling the assistance, may make selling food items less viable,[46] while selling other items may not be an option when households' own needs are not met (compare Figure 15).

### *Health-seeking behaviour*

During the 2020 J-MSNA, a negative trend in health-seeking behaviour was found. Specifically, the proportion of individuals needing treatment reportedly having sought it at an NGO clinic had dropped from 79% in 2019 to 64% in 2020. This drop was attributed to high levels of distrust and scepticism about the quality of health services among households that had already existed pre-COVID-19 and were further exacerbated following the COVID-19 outbreak.[47] This year, a reversal of this trend was found, with 72% of individuals reportedly needing treatment having been reported as having sought it at an NGO clinic again, which may be indicative of a restoration of the availability, accessibility and/or use of health services similar to 2019 levels (Figure 6).

**Figure 6** % of individuals reported as having had a health problem and needing to access treatment in the 4 weeks prior to data collection by treatment location and year[48]




[46] World Food Programme (WFP), *Refugee influx emergency vulnerability assessment (REVA 4) – Cox's Bazar*, Bangladesh (April 2021) (Cox's Bazar, 2021). Available here (accessed 30 November 2021); Food Security Sector (August 2021).
[47] ISCG, 2021c.
[48] The denominator for this indicator is all individuals having had a health problem and needing to access health care (n = 2,293). Households could select multiple options. 2019 and 2020 results: ISCG, 2019; ISCG, 2021c.

## Positive trends in access to services

Over the past three years, the coverage of some services, such as the provision of liquefied petroleum gas (LPG), blanket food distributions, and the coverage of nutrition and health services, has remained extensive. As outlined above, also the reported use of health services was extensive again. Moreover, some positive trends can be observed, such as an increase in the proportion of households reportedly having used piped water, and a decrease in the proportion of households reporting a lack of water.

### *Service provision that remained extensive*

**Almost all households (99.5%) had reportedly received food assistance in the 30 days prior to data collection. Other services that were reported has having been widely used included LPG provision, nutrition services, and health care.** In total, 97% of households reported having received LPG refills from humanitarian actors (Figure 7); 97% of households with children aged 6 to 59 months reported having had some form of contact with nutrition service providers (Figure 8),[49] as did 93% of households with pregnant or lactating women (PLW) (Figure 9);[50] and 88% of individuals who were reported as having had a health problem and needing to access health care in the 3 months prior to data collection were reported to have sought treatment at a clinic (Figure 10).[51]

**Figure 7** % of households reporting having received LPG refills from humanitarian actors in the 3 months prior to data collection

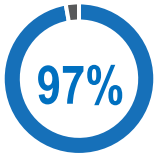
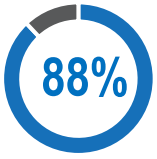



**Figure 8** % of households with children aged 6-59 months reporting having had some form of contact with nutrition service providers since the start of Ramadan (14 April 2021)[49]


**Figure 9** % of households with PLW reporting having had some form of contact with nutrition service providers for PLW during the current pregnancy or while breastfeeding[50]


**Figure 10** % of individuals reportedly having had a health problem and needing to access health care in the 3 months prior to data collection who were reported as having sought treatment at a clinic[51]



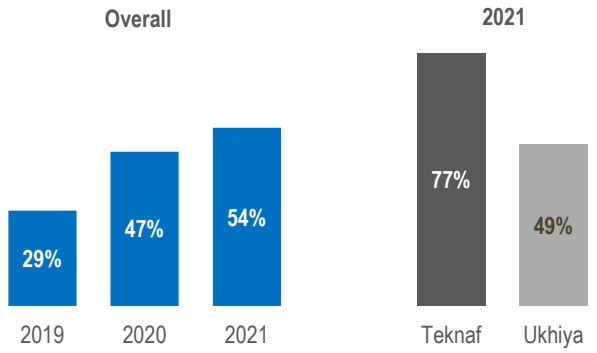

### *Positive trends in service provision*

**In particular, in relation to access to water, positive trends can be observed**. For instance, the proportion of households reportedly having used piped water as their drinking water source has increased from less than one third in 2019 to more than half the households in 2021, or up to 77% of households reportedly having used piped water in Teknaf and roughly half the households reportedly having used piped water in Ukhiya (Figure 11).

[49] The denominator for this indicator is all households with children aged 6-59 months (n = 2,154). This indicator considers any form of contact, including screening by nutrition facility staff or volunteers, involvement in the caregiver-led MUAC programme, having received blanket supplementary feeding, and having received messages related to infant and young child feeding practices.
[50] The denominator for this indicator is all households with PLW (n = 713). Results are representative with a +/- 4% margin of error. This indicator considers any form of contact, including screening by nutrition facility staff or volunteers, having received supplementary feeding, or iron and folic acid tablets, and having received messages related to infant and young child feeding practices.
[51] The denominator for this indicator is all individuals having had a health problem and needing to access health care (n = 4,019).

At the same time, the proportion of households reportedly not having had enough water at the time of data collection has decreased from 56% in 2019[52] to 31% in 2021.

**Figure 11** % of households reporting piped water as their main source of water used for drinking at the time of data collection, by year and by upazila[53]

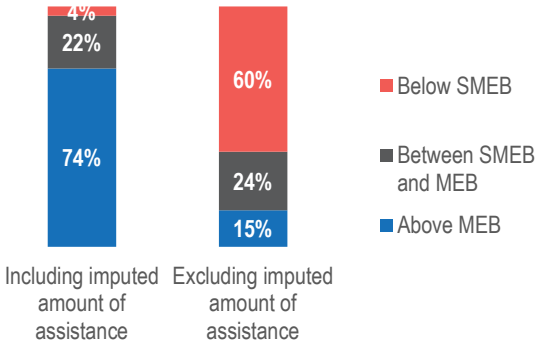



## Persisting needs and service gaps

**With limited access to self-reliance activities, the refugee population in camps remains highly reliant on humanitarian assistance and, as highlighted above, almost all households do have unmet multi-sectoral needs**.

Figure 12 shows the average monthly per capita expenditure, both including and excluding the reported value of assistance received and consumed by households, in relation to the Minimum Expenditure Basket (MEB) and the Survival Minimum Expenditure Basket (SMEB).[54]

**Figure 12** % of households by average monthly per capita expenditure in the 30 days prior to data collection in relation to the MEB




[52] ISCG, 2019.

[53] This question was a multiple choice question in 2019 and 2020, while only the one main source of drinking water was reported in 2021. As such, results are not directly comparable. They may, however, give an indication of a possible trend. Results for Teknaf are representative with a +/- 4% margin of error (n = 826). 2019 and 2020 results: ISCG, 2019; ISCG, 2021c.

[54] 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).

Results are clearly representative of the high aid dependency of the refugee community. Excluding the reported value of assistance received and consumed, i.e. considering only own household spending for the expenditure calculation, only 15% of households would have had a monthly per capita expenditure above the MEB, i.e. would potentially have been able to meet their basic needs. Almost two thirds of households (60%) would have had a monthly per capita expenditure below the SMEB, i.e. likely not even being able to meet their most basic survival needs. These results 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. Other assessments found only 4% to 8% of households having monthly per capita expenditures above the MEB, excluding humanitarian assistance.[55]

However, even including the reported value of assistance households had received and consumed, the monthly per capita expenditure remained below the MEB for roughly one quarter (26%) of households. **Thus, despite the assistance received, households may still not always be able to meet their basic needs.** This is also reflected in reported gaps in access to basic goods and services across sectors, which will be outlined in the following.

### *Shelter and NFIs*

**As in previous J-MSNAs, high proportions of households (72%) continued to report having had issues with their shelters** in the 6 months prior to data collection, most commonly shelters leaking during rain (as reported by 66% of households). At the same time, 36% of households continued to report not having made improvements or repairs to their shelters despite having reported shelter issues (Figure 13), most commonly because of insufficient shelter support and a lack of means to access materials otherwise. Specifically, during another survey covering camps 2E, 9, 15, 18 and 20, 84% of households reported not having received enough shelter materials in 2021,[56] while in the current assessment, among the 36% of households reportedly not having made needed improvements, 61% reported not having received any or sufficient shelter support from humanitarian organisations as the reason, and 39% reported a lack of money to pay for materials.[57]

**Figure 13** % of households reporting not having made improvements/repairs to their shelter despite having reported issues

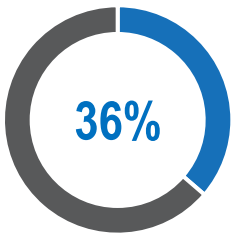
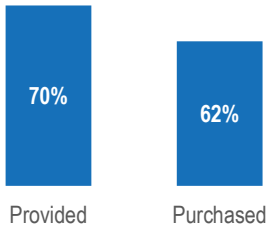



**Figure 14** % of households reporting source of shelter materials for shelter improvements/repairs among households reportedly having made shelter improvements/repairs in the 6 months prior to data collection[58]




[55] WFP, 2020; WFP, 2021.
[56] Ground Truth Solutions (GTS), *Preliminary findings: Round V response-wide perceptions survey with Rohingya aid recipients* (Cox's Bazar, 2021).
[57] The denominator for this indicator is households reportedly not having made any improvements (n = 2,045). This may include households having reported and not having reported shelter issues. Results are representative with a +/- 3% margin of error. Households could select up to 3 options.
[58] The denominator for this indicator is households reportedly having made improvements (n = 1,629). Results are representative with a +/- 3% margin of error. Households could select multiple options.

Overall, 44% of households reported having made improvements/repairs to their shelter in the 6months prior to data collection. Among households reportedly having improved or repaired their shelters, almost equal proportions of households reported having received the materials for improvement/repair from humanitarian organisations as reported having bought them themselves (Figure 14). Overall, 29% of households having made improvements/repairs did not report having received materials but having bought materials, while 33% of households having made improvements/repairs reported having received and purchased materials.[54] Similarly, participants in half the FGDs reported shelters being damaged and needing shelter materials, in particular bamboo and tarpaulins, to repair their shelters. **These results are indicative of shelter material support not reaching all households that/when they need it, while also not always being sufficient, with households buying materials in addition.**

Moreover, **12% of households reported having had to pay or exchange goods/labour to live in their current shelters**. This compares to 10% of households having reported so during the 2019 and 2020 J-MSNAs.[59] While this increase of two percentage points from previous years may be within the margin of error of the results, i.e. not represent a true increase but rather be explained by the limited precision of the results, **a slight increasing trend in the proportion of households having to make rent payments is also possible**. Initially, refugees may have only had to pay rent to first build their shelter but as they are staying longer than expected, regular rent payments may be increasing.[60] A recent shelter assessment that found 13% of refugee households to be paying rent in cash to stay in their shelters also reported rent payments as having emerged as one of the prominent forms of engagement between the refugee and the host community.[61] Moreover, relocation of households from outside newly built fences onto host community land inside the camp boundaries may be one of the reasons for driving increasing rent payments.[56]

Similarly, while most participants in the FGDs reported not having to make rent payments, in one FGD, it was reported that while people were not currently paying rent, they had to buy land to build their shelters initially. In a few FGDs, participants reported paying rent both in cash and by providing (a share of) their assistance. An inability to pay rent may lead to fights with landowners or even lead to eviction.

> *"When we don't give [the landowners] bottles of oil when they ask, they dig the base of the mountains below our shelters at night so that the shelters fall down when it rains."* – FGD with men, ages 25-40

**Almost nine in ten households (86%) were found to have unmet NFI needs**. Most commonly, households reported having had insufficient fans, shoes, torches/batteries or solar lamps, and clothing (Figure 15).[62] Among households having reported household/cooking items among their top three priority needs for 2022, most commonly, kitchen sets, mosquito nets, blankets, and fans, were reported as needed (Figure 15). Therefore, while **generally most frequently fans, shoes, and torches/batteries or solar lamps, may be insufficient, among those considering household/cooking items to be among their top three priority needs, kitchen sets, mosquito nets, blankets and fans are most urgently needed** (while clothing was reported by 8% of households among their top three priority needs, and electricity/solar lamps/batteries was reported by 38% among their top three priority needs for 2022).

Similarly, in 12 FGDs (6 with women and 6 with men), participants expressed a need for solar panels and fans to be able to cope with heat inside shelters, which is especially important for women who spend more time inside shelters than men. Moreover, a lack of light was recurrently reported as an issue, preventing people from carrying out basic

[59] ISCG, 2019; ISCG, 2021c.
[60] Shelter/NFI Sector (Reports from the HLP Technical Forum, reported 28 October 2021.
[61] Shelter/NFI Sector, IOM NPM & REACH, *Shelter Standard Assessment* (Cox's Bazar, 2021). Available here (accessed 30 November 2021);
[62] 'Sufficient NFIs' meant that all household members' basic needs were generally met in relation to the NFIs' quality, quantity, and functionality.

activities, such as cooking, eating, praying, studying or personal hygiene, at night without torchlight. However, in line with what was reported as priority needs, the items most frequently reported as needed (considered urgent needs) included sleeping mats, blankets, mosquito nets, pillows, and cooking utensils. **Most participants reported that they had received NFIs once, when they had first arrived, without any additional distributions since. As a result, the items they currently have are often broken, consumed, or difficult to use.**

**Figure 15** % of households reporting having had insufficient NFIs at the time of data collection, by NFI[62]

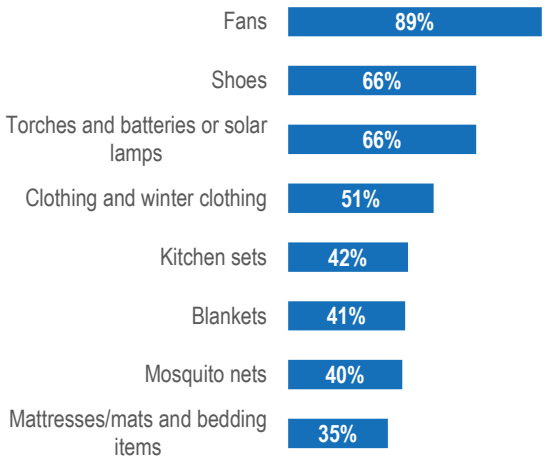
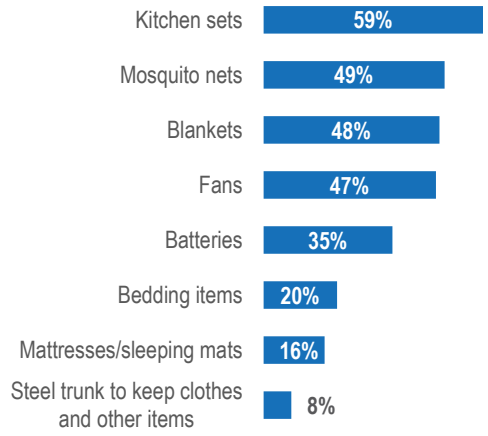



**Figure 16** % of households reporting top 3 household/cooking items needed most, by need (of households which reported household/cooking items as a priority need)[63]




**Lastly, even though almost all households had reportedly received LPG refills, roughly half of those having received refills (53%) reported that the refills had not always lasted the full refill cycle.[64] The most commonly reported alternative source of cooking fuel remained firewood**, which does not only have implications in relation to living standards and potential health risk. It may also negatively impact on environmental sustainability and has implications for fire safety, in particular in the camp context where tightly constructed shelters allow fires to quickly spread.

During the FGDs, thankfulness for LPG distributions was expressed, but participants also reported the distributed LPG to be insufficient. In nine FGDs, issues related to LPG were reported, including an increase in the time between distributions and difficulties carrying LPG refills to shelters (especially for women and older people). LPG distribution points closer to blocks were suggested.

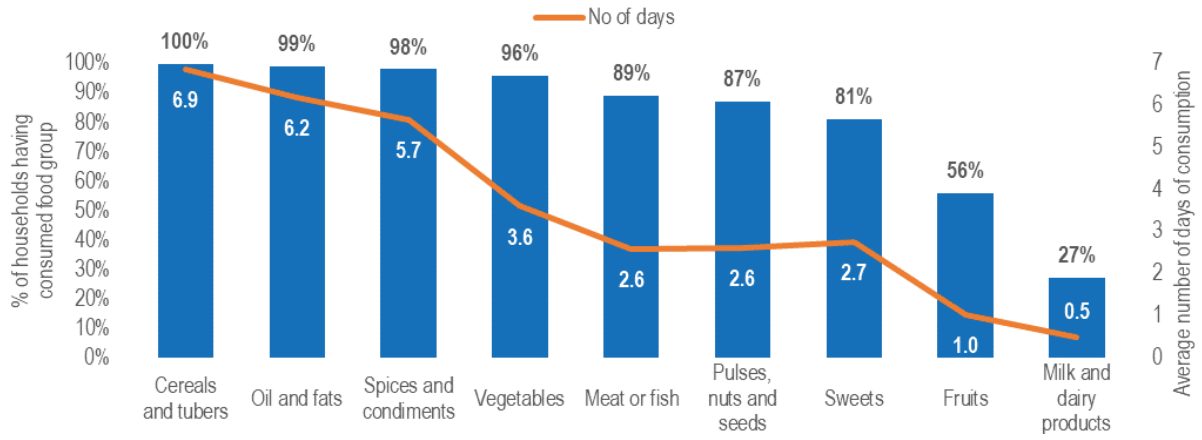
> *"Previously, they used to provide gas on time. Now, they changed the schedule and we are facing a gas shortage. Sometimes, it takes 50 days to get gas. Some people who relocated to other camps still get gas cylinders from our camp and they sell their gas cylinders and go back, but the officials think that we, the people of our camp, sell the gas cylinders. You should report about this misunderstanding."* – FGD with men, ages 25-40

[63] The denominator for this indicator is households having reported household/cooking items among their top three priority needs (n = 969). Results are representative with a +/- 4% margin of error. Households could select up to three options.
[64] The denominator for this indicator is households reportedly having received LPG refills (n = 3,575).

### *Food security & livelihoods*

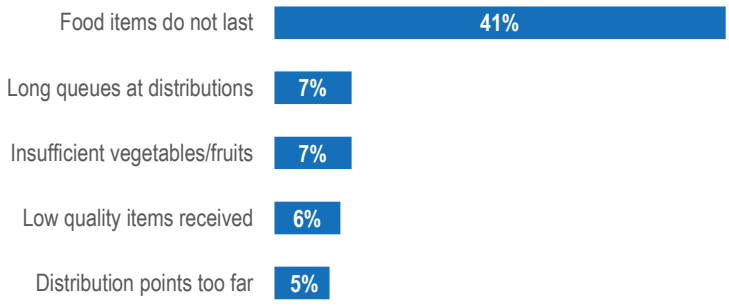
As outlined above, despite FCS having improved compared to 2020 J-MSNA results, still **roughly every second household was found not to have an acceptable FCS.** The extensive coverage of food assistance is mainly reflected in households reportedly consuming cereals and tubers on an almost daily basis, while gaps in FCS appear to be driven by more irregular consumption of other food groups, ranging from an average consumption of roughly every second day for vegetables, over roughly every third day for meat or fish, and pulses, to once a week or less than once a week for fruits and dairy products (Figure 17).

**Figure 17** % of households reporting having consumed each food group in the 7 days prior to data collection, and average reported number of days each food group was consumed in the 7 days prior to data collection




**Roughly half the households (47%) reported having faced challenges with their food assistance in the 3 months prior to data collection, most commonly items not having lasted** (Figure 18). Items most commonly reported as not lasting until the next distribution included rice, oil, onions, chili and eggs.

**Figure 18** % of households reporting having faced challenges related to food assistance in the 3 months prior to data collection (top 5)




**While being grateful for the received assistance, and in particular food assistance, participants in all FGDs raised issues around the quality, quantity and variety of food assistance.** Participants in most FGDs reported not always having enough food, especially in large households and households with many adults. Moreover, a lack of

choice, while always receiving the same food items, was reported. Green vegetable and fresh fruits were among the most requested food items.

Other problems reported in the FGDs included receiving low quality or rotten food and an inability to safely store food until the next distribution. Moreover, challenges adding new family members to or replacing lost family cards, resulting in households missing out on rations, reportedly compounded food access problems.

> *"They should change potatoes, chillies, and onions as they rot easily. They provide us with these things for a month, but we can't keep them even for a week. […] I don't have anything to eat now as everything rotted."* –FGD with women, ages 25-40

> *"We are thankful to God for the things we are receiving from NGOs, but there are many rats in our shelters and they destroy everything. They destroy the plastic containers [that hold] the rice. They eat the rice. We struggle with the rats. Also, it is very hot in our shelters and we don't have fans. Our children feel too hot in the shelter."* –FGD with women, ages 25-40

As in 2020, food access problems may have been compounded by measures put in place to comply with COVID-19 containment regulations, including a transition from value to commodity vouchers with pre-packaged rations, low preference of some food items in the food basket, and difficulty to preserve items until the end of the cycle, with food rations also having been purchased again on a monthly basis since June 2021.[65]

As such, **accessing or paying for food also remained the most commonly reported reason for having adopted livelihoods-based coping strategies**, as reported by 89% of those reportedly having adopted coping strategies in the 30 days prior to data collection.[66]

### *WASH*

Despite the positive trends in access to water outlined above, 19% of households (or 22% of households in Ukhiya, and 8% of households in Teknaf)[67] were reportedly still using shallow tubewells as their main source of drinking water at the time of data collection. Moreover, roughly one in ten households (or 12% of households in Ukhiya, and 10% of households in Teknaf)[63] continued to report not having had enough drinking water at the time of data collection, and roughly every second household (or 42% of households in Ukhiya, and 50% of households in Teknaf)[63] reported adopting coping strategies throughout the year to adapt to a lack of water. Most commonly, households reported adapting to a lack of water by fetching water from a source further away than the usual one (as reported by 35% of households). Issues related to water reported during the FGDs included water not being available all day, long queues, and not having the right containers to carry water. Moreover, some participants mentioned safety concerns for females when walking to water collection points. **Thus, even though access to water reportedly has improved, some challenges persisted, while one in five households were reportedly not using an improved water source, and not all households perceived always having access to enough water.**

[65] WFP, 2021.
[66] The denominator for this indicator is households reportedly having adopted any coping strategy (n = 2,581).
[67] Results for Ukhiya are representative with a +/- 2% margin of error (n = 2,857). Results for Teknaf are representative with a +/- 4% margin of error (n = 826).

While the proportion of households reportedly having used a flush or pour/flush toilet at the time of data collection has also increased compared to 2019, the same holds true for the proportion of households reportedly having used a pit latrine without a slab or platform (Figure 19). Moreover, **roughly four in ten households reported problems male or female household members faced related to latrines.** Most commonly, a lack of latrines, long waiting times or overcrowding was reported, followed by latrines being unclean or unhygienic, and latrines being too far (Figure 20).

**Figure 19** % of households reporting sanitation facility the household usually uses[68]

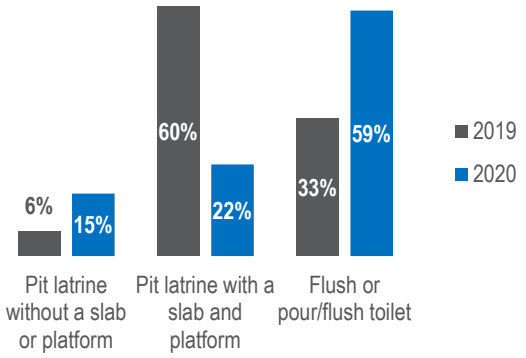
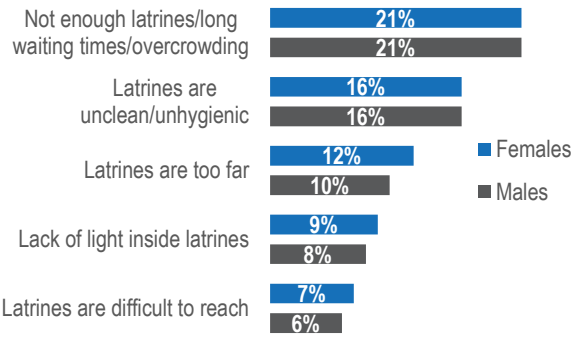



**Figure 20** % of households with female or male individuals reporting problems related to latrines females/males in their households faced at the time of data collection[69]




**Similarly, 21% of households reported problems female household members faced related to bathing facilities, and 16% of households reported problems male household members faced**, most commonly a lack of bathing facilities, long queues and overcrowding (as reported by 11% of households as a problem female household members faced, and by 9% of households as a problem male household members faced), and bathing facilities being too far (9% and 6%).

In line with the household survey results, issues related to latrines and bathing facilities reported during the FGDs included damaged or non-functional latrines, facilities being far away and difficult to reach at night, overcrowded facilities and lack of privacy (especially for women and girls), long queues, some of which may also pose protection-related concerns. In a few FGDs, participants reported wealthier households or households with space having built bathing facilities or latrines in their shelters, in particular so girls do not have to use public facilities.

Despite almost all households having reported having had soap in the household survey, **insufficient soap was reported in 11 of 20 FGDs.** At the same time, among households having reported access to hygiene items among their top three priority needs for 2022 in the household survey (1%), soap was the most frequently reported item needed.

As interviews were conducted remotely, access to menstrual hygiene items could not be assessed during the household survey. However, **in most FGDs with women, participants reported not having sufficient menstrual hygiene kits, and that the pads distributed were of poor quality, and not distributed often enough.**

[68] This question was a multiple choice question in 2019, while only one sanitation facility usually used was reported in 2021. As such, results are not directly comparable. They may, however, give an indication of a possible trend. 2019 results: ISCG, 2019.

[69] 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 = 3,663; households with males, n = 3,620). Households could select up to 5 options.

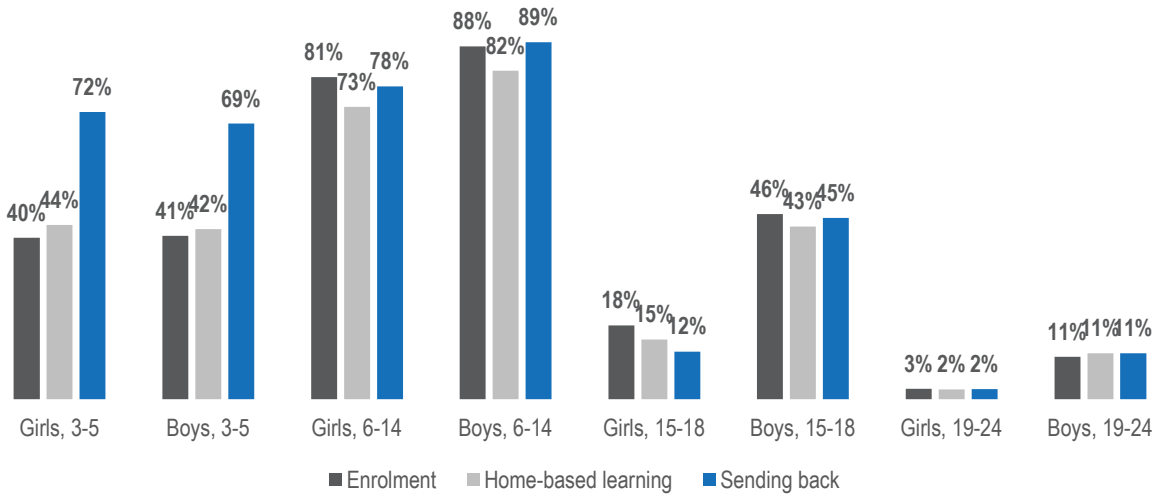
*"We wash used pads and dry them. We reuse them. But, when we put them in the bags, the rats damage them. We are facing difficulties with pads."* – FGD with women, ages 25-40

*"We are using torn clothes." […] "We clean our old clothes and use them during our menstruation."* – FGD with women, ages 25-40

### *Education*

**Large gaps in access to education have remained, in particular among older individuals and girls.** Among the 6 to 14 year-olds, between 80% and 90% of both boys and girls were reportedly enrolled in learning facilities before the COVID-19 outbreak, had accessed home-based learning, and will reportedly be sent back to learning facilities once they will re-open. However, due to a lack of learning opportunities or education support in camps for older individuals, in line with past J-MSNA results,[70] those proportions were considerably lower among older age groups (Figure 21).

**Figure 21** % of children aged 3-24 reported as having been enrolled in learning facilities before learning facilities closed in March 2020 (pre-COVID-19), having regularly accessed home-based learning since the start of the 2021 school year until support for home-based learning stopped at the end of March 2021, and that will reportedly be sent back once learning facilities will re-open[71]




**In particular girls aged 15 to 18 may have dropped out of their education as a result of the COVID-19 outbreak.** FGD participants reported adolescents, and in particular adolescent girls, to be at highest risk of not returning to learning facilities due to cultural norms.

[70] ISCG, 2019; ISCG, 2021c.

[71] The denominator for this indicator is all individuals in the specified gender and age groups (girls, 3-5, n = 1,088; boys, 3-5, n = 1,173; girls, 6-14 years, n = 2,570, boys, 6-14 years, n = 2,606, girls, 15-18 years, n = 860, boys, 15-18 years, n = 757, girls, 19-24 years, n = 1,368, boys, 19-24 years, n = 1,159). Results for girls and boys aged 3-5 as well as boys and girls aged 19-24 are representative with a +/- 3% margin of error. Results for boys and girls aged 15-18 are representative with a +/- 4% margin 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.

> *"Schools are closed due to the coronavirus. Now, our girls have become adolescents. Rohingya girls don't go outside after puberty because people will say bad things about them if they do."* – FGD with women, ages 25-40

A corresponding trend is also reflected in the household survey results. While 18% of girls aged 15 to 18 were reportedly still enrolled in learning facilities pre-COVID-19, only 15% had reportedly accessed home-based learning, and only 12% will reportedly be sent back (Figure 21), indicating individuals having dropped out of learning over the course of learning facility closures.

At the same time, results appear to show that **only those previously enrolled in learning facilities also accessed home-based learning**, with the proportion of children reportedly having accessed home-based learning being similar to reported pre-COVID-19 enrolment rates. **As a result, children aged 3 to 5 may start their education later than they would have if learning facilities were not closed**. Specifically, among children aged 3 to 5, the proportions of boys and girls who will reportedly be sent back were almost twice the proportions of boys and girls of the same age group who were previously enrolled or reported as having accessed home-based learning (Figure 21).

The top five challenges reported related to home-based learning were: not having been enrolled in learning facilities pre-COVID-19, marriage/pregnancy, home-based learning not being effective, a lack of guidance and children being too old to participate. The top three reported reasons for not sending children back were marriage/pregnancy, not having been enrolled pre-COVID-19, and children being too old. On the other hand, the most commonly expected challenges when sending children back was the risk of infection with COVID-19 on the way to or at learning facilities, followed by a lack of qualified teaching staff and children having fallen too far behind on learning (Table 2).

Despite most FGD participants saying that they would send their children back to learning facilities, once they will re-open, in most FGDs with men, participants reported poor quality of teaching and education in learning centres. They reported that they would prefer sending their children to private tutors due to the lack of a grading system at the learning facilities.

> *"Adolescents engaged in other things, such as jobs or business, will not go to school. Adolescents who lost their dream will not go to school. All of us lost our dreams when we fled Myanmar. [Some of us] are somehow still dreaming. That is why we will go to school. It is difficult for us here. We don't have educational opportunities. Parents cannot support us financially for our education because they don't have work here. If they get some work in NGOs, it is just for a few days. A camp is a place with dangerous conditions. People are engaged in dangerous things. The teachers who are hired in [some humanitarian organisations] are not graduates of class 10. They are not qualified enough to teach children, so children are not learning. We are just suffering in the camp like prisoners."* – FGD with men, ages 18-24

Similarly, during another survey covering camps 2E, 9, 15, 18 and 20, 55% of households reported education services to be very bad, and 32% reported them to be bad, while only 3% reported them to be good or very good. More than 80% of households reported the quality of education services to have become worse over the 12 months prior to data collection for that survey.[72]

[72] GTS, 2021.

In some FGDs, also practical challenges, such as a lack of uniforms, books, and bags, as well as bad roads, making it difficult to access learning facilities were raised. However, generally, drawing from both the household survey and the FGDs, **the main reported barriers towards accessing an education were on the one hand, as outlined above, a lack of opportunities for older students as well as other reasons for older students to drop out early, such as marriage. On the other hand, both remote and in-person education were perceived as ineffective or of low quality, while also COVID-19 remained a concern in relation to in-person education.**

**Table 2** Reported challenges towards benefitting from home-based learning, reasons for not sending children back to learning facilities once they will re-open, and expected challenges when sending them back

| % of households with children aged 3-24 reporting challenges girls and boys aged 3-24 in the household faced towards benefitting from or reasons they could not do any home-based learning (top 5)[73] | | % of households with at least one girl or boy aged 3-24 that will reportedly not be sent back to learning facilities once they will re-open reporting main reasons for not sending them back (top 3)[74] | | % of households with at least one girl or boy aged 3-24 that will reportedly be sent back to learning facilities once they will re-open reporting expecting challenges once children will be sent back (top 3)[75] | |
|---|---|---|---|---|---|
| **Girls** | **Boys** | **Girls** | **Boys** | **Girls** | **Boys** |
| • Not enrolled in education pre-COVID-19/never enrolled **(17%)**<br>• Marriage and/or pregnancy **(16%)**<br>• Home-based learning is not effective/children have fallen behind on learning **(7%)**<br>• Lack of guidance from learning facilitators **(6%)**<br>• Children too old to participate **(6%)** | • Not enrolled in education pre-COVID-19/never enrolled **(14%)**<br>• Home-based learning is not effective/children have fallen behind on learning **(8%)**<br>• Marriage **(8%)**<br>• Lack of guidance from learning facilitators **(8%)**<br>• Children too old to participate **(5%)** | • Marriage and/or pregnancy **(34%)**<br>• Not enrolled in education pre-COVID-19/never enrolled **(28%)**<br>• Children are too old now **(23%)** | • Not enrolled in education pre-COVID-19/never enrolled **(29%)**<br>• Children are too old now **(24%)**<br>• Marriage **(18%)** | • Risk of infection with COVID-19 on the way or at learning facility **(11%)**<br>• Lack of qualified teaching staff **(3%)**<br>• Children have fallen too far behind on learning **(3%)** | • Risk of infection with COVID-19 on the way or at learning facility **(11%)**<br>• Lack of qualified teaching staff **(4%)**<br>• Children have fallen too far behind on learning **(3%)** |

Lastly, when asked to provide suggestions to make it more likely for children to return to learning facilities, FGD participants suggested **providing education beyond the elementary level up until grade 10, introducing a grading system, improving the quality of teaching, following the Myanmar curriculum and hiring Rohingya who were teachers in Myanmar, as well as having separate learning facilities for boys and girls.**

### *Protection*

Likely linked to the above, the most commonly reported unmet need of children in the community was education (as reported by 23% of households as not being met). This was followed by a lack of safe areas for playing (15%), food

[73] The denominator for this indicator is households with girls or boys aged 3-24 (households with girls, n = 3,146; households with boys, n = 2,901). Households could select up to 5 options.
[74] The denominator for this indicator is households with at least one girl or boy aged 3-24 that will reportedly not be sent back (households with at least one girl that will reportedly not be sent back, n = 2,177; households with at least one boy that will reportedly not be sent back, n = 1,553). Results for households with at least one boy that will reportedly not be sent back are representative with a +/- 3% margin of error. Households could select up to 5 options.
[75] The denominator for this indicator is households with at least one girl or boy aged 3-24 that will reportedly be sent back (households with at least one girl that will reportedly be sent back, n = 1,861; households with at least one boy that will reportedly not be sent back, n = 2,162). Results for households with at least one girl that will reportedly be sent back are representative with a +/- 3% margin of error. Households could select up to 5 options.

(9%), and safety and security in general (6%). Despite challenges and limitations linked to the collection of sensitive data (compare Box 1), in particular over the phone, likely leading to under-reporting and decreased accuracy of the finding, more than one in ten households also reported areas considered unsafe by community members (15% of households reported areas considered unsafe by girls and women, and 11% of households reported areas considered unsafe by boys and men), most commonly markets and when travelling to different facilities. Moreover, 7% of households considered it to be unsafe for adult men or adult women to move around camps at night.

**In most FGDs, the safety and security situation was reported to have worsened during the 12 months prior to data collection. However, some participants also said they could not discuss issues of safety and security out of fear of negative consequences.** Problems that were reported in some FGDs included experiencing violence when travelling through host community areas, fear of being arrested or fined by the police when leaving shelters at night, cases of abduction and robbery, and fear of shelters being set on fire at night or while being away.

> *"We are really worried about the kidnapping currently happening in the camp. One of my neighbours was kidnapped by some people and later he was released for ransom. People are being kidnapped even in broad daylight. We were under security threat in Myanmar, and we are living in the same conditions here. I do not know what will happen to our community."* – FGD with men, ages 60+

> *"We cannot tell you about that [safety and security]. We would not be able to stay here if we talk about that."* – FGD with men, ages 41-59

> *"I don't feel safe to share [about safety and security]. They will come and kill us if I do."* – FGD with women, ages 41-59

**Since the start of the COVID-19 outbreak, there has been a reported increase in reports of GBV, petty crimes, inter- and intra-communal disputes, human trafficking, abduction, assault, and extortion.[76] Moreover, increases in violence against children have been reported, with the lockdown as the primary reason.[77]** For most of 2020, these increase in protection issues had already been compounded by the limited presence of protection actors in camps in line with COVID-19 containment measures, and an increased presence of criminal groups with heightened levels of control.[78] Also this year, **fear and feelings of insecurity may have been further exacerbated by the reduced Protection Sector footprint in camps between April and September 2021 in line with COVID-19 containment measures.** In fact, services or staff not having been available due to COVID-19 was the most commonly reported reason for community members not having been able to access protection services or report safety or security incidents when needed (Figure 22). Other reasons for not accessing protection services included (past) problems not having been resolved to households' satisfaction (14%), a lack of trust in the available services (9%), and language barriers (6%).[79]

[76] ACAPS, *Secondary impacts of COVID-19: Potential consequences of the May 2021 containment and risk mitigation measures* (Cox's Bazar, 2021). Available here (accessed 30 November 2021).
[77] Child Protection Sub-Sector, *Findings from the Child Protection Assessment in Rohingya Refugee Camps in Cox's Bazar* (Cox's Bazar, 2021).
[78] ACAPS,2021.
[79] The denominator for this indicator is households having reported community members wanting to access protection services and not having been able to (n = 96). Results are representative with a +/- 10% margin of error.

**At the same time, an over-reliance on actors other than humanitarian protection actors to report incidents remained.** As already found in previous years,[80] the most commonly reported points-of-contact to refer cases of assault or abuse to were *mahjis* and Camps-in-Charge (CiCs) (Figure 23).

**Figure 22** % of households having reported community members not having been able to access protection services reporting unavailability of services/staff due to COVID-19 as the reason[79]

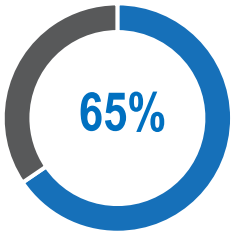
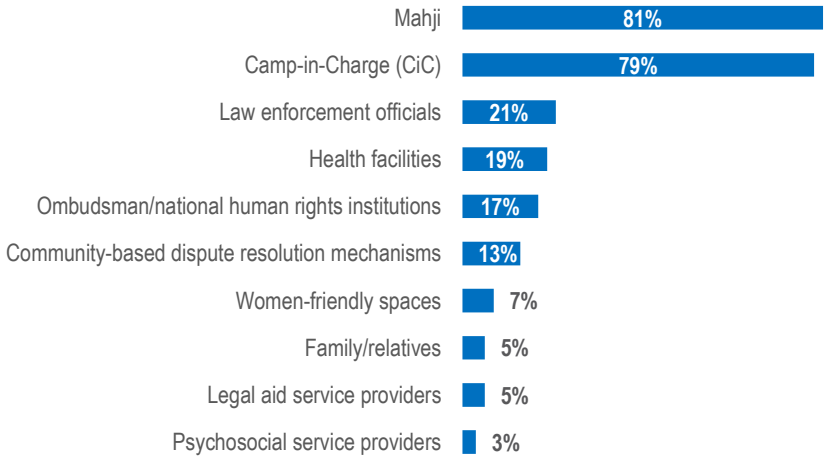



**Figure 23** % of households reporting where they would send a friend for care and support in case of assault or abuse, by point-of-contact[81]




While health facilities, psychosocial service providers, ombudsmen/national human rights institutions, women-friendly spaces/multi-purpose women centres, family/relatives/guardians, curators or authorised legal representatives would be considered more appropriate for the referral of protection cases than other points-of-contact, only 42% of households reported that they would send a friend who had been assaulted or abused to any of these points-of-contact. This compares to 58% of households that did not report any of these points-of-contact as somewhere they would send a friend who had been assaulted or abused.

Similarly, most FGD participants said they would report issues related to safety and security first to *mahjis*, then to head *mahjis*, and then to the CiCs, while issues of violence against women or girls would mostly be kept private, but also sometimes be brought to *mahjis*. Men, in particular, said they would rarely consult NGOs on issues related to safety and security, as they felt NGOs were often unable to help. Similarly, another survey covering camps 2E, 9, 15, 18 and 20 found that 68% of households would not report a sensitive issue to a humanitarian organisation.[82] These results may in part be linked to Protection actors not having had access to camps while COVID-19 lockdown measures were in place. At the same time, *mahjis* or CiCs may often only be the first point-of-contact, who may then still refer cases onwards to humanitarian protection actors. However, this **strong reliance on the *mahji* system may sometimes be concerning, as *mahjis* have occasionally been reported to intervene violating basic protection principles**. In the past, there have been allegations of corruption, favouritism, abuse of power, and inappropriate conflict resolution relating to the *mahji* system, which may have been further exacerbated as *mahjis* have increasingly filled gaps left by humanitarian protection actors in camps during successive lockdowns.[83]

[80] ISCG, 2021c.
[81] Households could select multiple options.
[82] GTS, 2021.
[83] IOM, ACAPS and REACH, *Vulnerabilities in the Rohingya refugee camps* (Cox's Bazar, 2019). Available here (accessed 30 November 2021); United Nations High Commissioner for Refugees (UNHCR), *Rohingya Refugee Response – Bangladesh, Factsheet – Protection (as of June 2020)* (Cox's Bazar, August 2020). Available here (accessed 30 November 2021); UNHCR and REACH, *Settlement and Protection Profiling: Round 6, November 2019* (Cox's Bazar, 2020). Available

### *Health*

**While unmet health needs were generally low, 30% of households without unmet needs reportedly only met their needs through the adoption of negative – i.e. in the long run unsustainable – coping strategies**, including paying for health care or adopting livelihoods-based coping strategies to access or pay for health care. In a context in which households cannot access regular income-generating activities, paying for treatment may not be feasible for them in the long run without foregoing other needs, taking on debt, etc. Nevertheless, also during the FGDs, participants reported that those who can afford it and are able to obtain the necessary permissions would prefer to visit hospitals outside the camps.

> *"People along with the* majhi *go to the CiC for permission, so that they can go to Cox's Bazar for proper treatment. It is really difficult to get permission from the CiC. Some NGO staff came and made a list of people with physical challenges, but they never helped these people. They just make lists. If someone is seriously injured, such as has a broken leg, community leaders raise funds for him, so that he can get proper treatment from Nila or Teknaf hospital."* – FGD with men, ages 25-40

**Forty-four percent (44%) of households reported having experienced or expecting experiencing barriers when needing to access health care**, most commonly long waiting times or overcrowding (as reported by 24% of households), the specific medicine, treatment or service needed being unavailable (21%), or perceiving not receiving the correct medication (11%). This was also confirmed during the FGDs, in which participants reported long waiting times, health services being too far away, and not receiving proper consultations as issues. Participants further raised short opening hours as an issue, as well as being mistreated in health centres and not receiving medicine from the health posts but having to buy it outside. However, in two FGDs with women, participants also reported that recently, hospitals had become more accessible for pregnant women and they were receiving a decent service.

> *"The hospitals don't provide adequate medicine to us [the Rohingya], but when local [Bangladeshi] villagers visit [on their way home] from work in the evening, they are provided with piles of medicine strips."* – FGD with men, ages 25-40

> *"We don't get proper medical treatment here. We have different types of sickness such as blood pressure and pain in the body. They don't check us well. They shout at us if we say anything. Sometimes, after waiting too long in the queue, they tell us to come back another day. Even if we tell them we are very sick, they scold us and tell us to come back another day."* – FGD with women, ages 25-40

> *"They decide on their own and they sell the things they have and go for treatments. If someone doesn't have things to sell, then there is no option for that person except dying with sickness."* – FGD with women, ages 25-40

here (accessed 30 November 2020); Amnesty International, *Let us speak for our rights: Human rights situation of Rohingya refugees in Bangladesh* (London, 2020). Available here (accessed 30 November 2021).

## Vulnerability[84]

**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)).

**Table 3** % of households with extreme unmet needs (MSNI score = 4), by type of household, including sample size and level of precision at a 95% confidence level

| Household type | Subset | % of households | Sample size | Precision at a 95% confidence level |
|---|---|---|---|---|
| By gender of head of household (p-value ≤ 0.01) | Female | 26% | 616 | 4% |
| | Male | 19% | 3,064 | 2% |
| By household size (p-value ≤ 0.05) | Large | 22% | 2,233 | 2% |
| | Small | 18% | 1,450 | 3% |
| Households with and without persons with disabilities (p-value ≤ 0.01) | With | 27% | 252 | 7% |
| | Without | 20% | 3,431 | 2% |
| Households with and without access to self-reliance activities (p-value ≤ 0.001) | With | 18% | 2,636 | 2% |
| | Without | 25% | 1,047 | 3% |
| By highest level of education in the household (p-value ≤ 0.05) | No formal education | 22% | 543 | 5% |
| | Some primary | 22% | 1,447 | 3% |
| | Primary and above | 18% | 1,688 | 3% |

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 or households with high dependency ratios tend to be more economically vulnerable. Previous studies, for instance, found those households to be more likely to borrow money, in particular to cover health-related costs. This is especially the case if household size is compounded by other vulnerabilities, e.g. for large female-headed

[84] For more information, also refer to the factsheet (pp. 6-10).

households. They are moreover more likely to report received assistance, in particular LPG refills and food, as being insufficient for the household.[85]

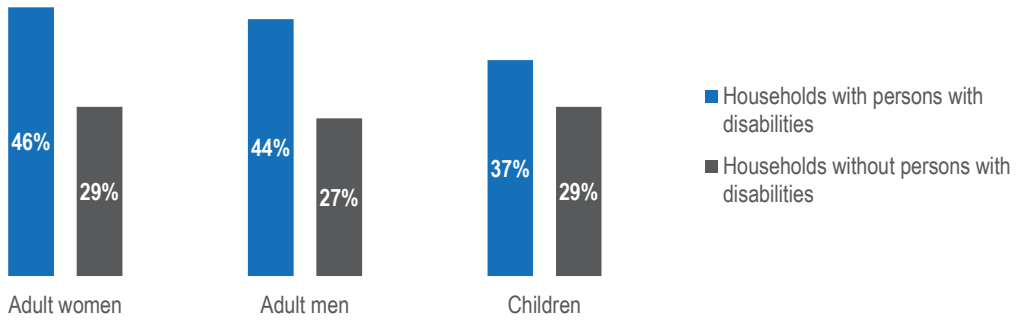
These patterns of vulnerability were also reflected in the current assessment, such that particularly households with persons with disabilities, female-headed households, and households without access to self-reliance activities were found to have worse outcomes, resulting in those households being significantly more likely to have extreme needs than households without persons with disabilities, male-headed households, and households with access to self-reliance activities. Moreover, large households were found to be significantly more likely than small households to have extreme needs, as were less educated households compared to better educated households (Table 3).

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

### *Households with persons with disabilities*

Households with persons with disabilities were significantly more likely than households without persons with disabilities to report challenges moving around camps (Figure 20).

**Figure 24** % of households with adult women, adult men, or children, reporting that adult women (p-value ≤ 0.0001), adult men (p-value ≤ 0.0001), or children (p-value ≤ 0.05) in their household faced challenges moving around camps at the time of data collection[86]

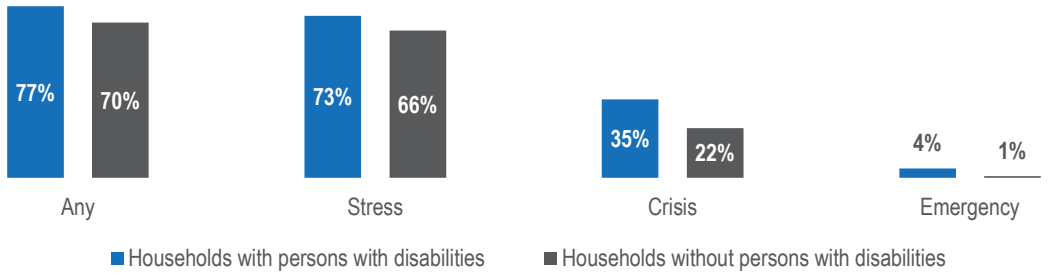



**Likely in part at least as a result of such challenges, across sectors, households with persons with disabilities were often more likely than households without persons with disabilities to report challenges accessing services or facilities, and therefore more likely to have unmet needs.** This included households with persons with disabilities having been significantly more likely than households without persons with disabilities to report challenges related to latrines[87] and bathing facilities,[88] as well as challenges related to their food assistance.[89] They were further significantly more likely than households without persons with disabilities to report expecting challenges when needing to access health care,[90] as well as to have unmet LPG needs.[91] Lastly, households with persons with disabilities were

[85] 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, 2021c; WFP, 2021.
[86] Households were asked to report mobility challenges for all target groups (adult women, adult men, children) present in the household.
[87] Challenges female household members faced: p-value ≤ 0.0001; challenges male household members faced: p-value ≤ 0.01.
[88] Challenges female household members faced: p-value ≤ 0.0001; challenges male household members faced: p-value ≤ 0.001.
[89] p-value ≤ 0.0001.
[90] p-value ≤ 0.05.
[91] p-value ≤ 0.05.

significantly more likely than households without persons with disabilities to report challenges accessing information,[92] and providing feedback or complaints[93] (for more details, refer to the factsheet, pp. 6-7).

**Figure 25** % 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 ≤ 0.05), or stress- (p-value ≤ 0.05), crisis- (p-value ≤ 0.0001), emergency-level (p-value ≤ 0.0001) coping strategies)[94]




**Facing greater challenges accessing services may make households with persons with disabilities more likely to resort to coping strategies, including more negative ones than households without persons with disabilities might resort to.** Specifically, significantly higher proportions of households with persons with disabilities than households without persons with disabilities reported having adopted livelihoods-based coping strategies, in particular crisis-level ones (Figure 25).

**Figure 26** % of individuals reported by households with and without persons with disabilities as having had a health problem and needing to access health care in the 3 months prior to data collection (p-value ≤ 0.0001)

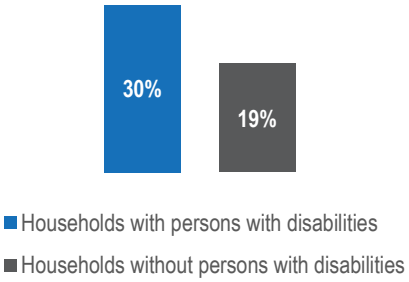



**Figure 27** % of households with and without persons with disabilities and without unmet needs reporting having adopted negative coping strategies to meet their health needs (p-value ≤ 0.0001)[95]

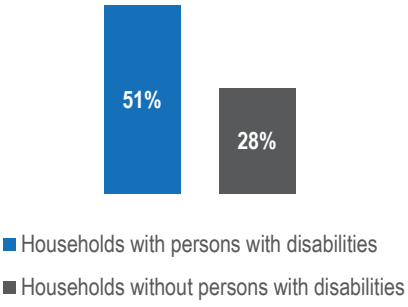
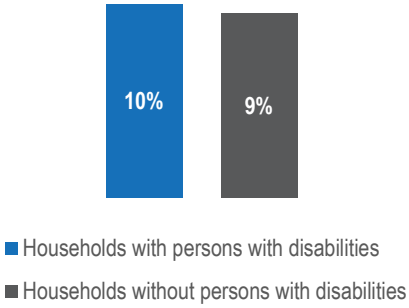



**Figure 28** % of households with and without persons with disabilities with unmet health needs




[92] p-value ≤ 0.001.
[93] p-value ≤ 0.0001.
[94] 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.
[95] The denominator for this indicator is households without unmet health needs (n, households with persons with disabilities = 223 - results are representative with a +/- 7% margin of error; n, households without persons with disabilities = 3,091 - results are representative with a +/- 2% margin of error).

Similarly, a significantly higher proportion of households with persons with disabilities than households without persons with disabilities reported adopting coping strategies to adapt to a lack of water.[96] While most commonly households reported coping by fetching water from a source further away than the usual one, households with persons with disabilities in addition reported at higher proportions than households without persons with disabilities relying on a less preferred water source for purposes other than drinking, as well as for drinking. Households with persons with disabilities might face greater challenges fetching large amounts of water from sources further away, and therefore be more likely to rely on other coping strategies in addition. As such, also these results may be indicative of **households with persons with disabilities being more likely than households without persons with disabilities to be driven to rely on more negative coping strategies.**

Lastly, while households with persons with disabilities were significantly more likely than households without persons with disabilities to report at least one household member as having required health care in the 3 months prior to data collection (Figure 26), they were not significantly more likely to have unmet health care needs (Figure 27). However, they were significantly more likely to report having adopted negative coping strategies to meet their needs (Figure 28). **Thus, while households with persons with disabilities may largely be able to meet their health needs, they may often do so by adopting coping strategies, possibly eroding their capacities to meet other needs, as well as to cope with future shocks.**

**Figure 29** % of girls, boys (p-value ≤ 0.05), and all children (p-value ≤ 0.05) aged 6-18 reported by households with and without persons with disabilities as having been enrolled in learning facilities before learning facilities closed in March 2020 (pre-COVID-19)[97]

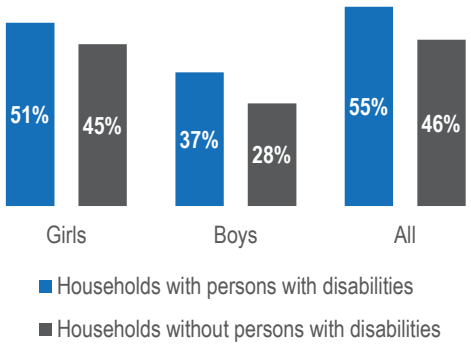
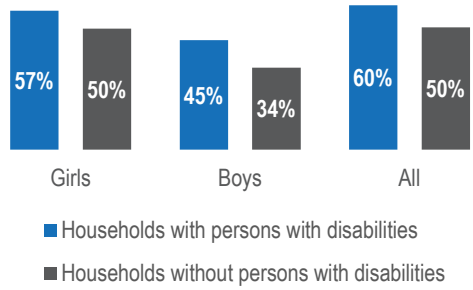



**Figure 30** % of girls, boys (p-value ≤ 0.01), and all children (p-value ≤ 0.05) aged 6-18 reported by households with and without persons with disabilities as having regularly accessed home-based learning since the start of the 2021 school year until support for home-based learning stopped at the end of March 2021[97]




Having greater (health care) needs and reduced capacities to meet (other) needs may also have a negative impact on children in the household. Most notably, significantly larger proportions of households with persons with disabilities than households without persons with disabilities reported school-aged (ages 6-18) boys as not having been enrolled in learning facilities pre-COVID-19 (Figure 29), and as not having regularly accessed home-based (Figure 30). Households with persons with disabilities may have a reduced adult workforce, if adult household members with disabilities cannot work. At the same time, persons with disabilities may have greater support needs, which are also usually covered by family members, further reducing the available workforce. **As a result, children, especially boys,**

[96] p-value ≤ 0.05.

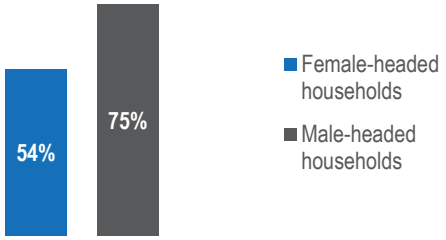
[97] The denominator for this indicator is households with children aged 6-18 in the specified gender groups (households with persons with disabilities: girls, n = 151 – results are representative with a +/- 8% margin of error; boys, n = 145 – results are representative with a 9% margin of error; all, n = 189 – results are representative with a +/- 8% margin of error; households without persons with disabilities: girls, n = 1,834 – results are representative with a +/- 3% margin of error; boys, n = 1,816 – results are representative with a +/- 3% margin of error; all, n = 2,410 – results are representative with a +/- 2% margin of error).

**may be at an increased risk in households with persons with disabilities of being sent to earn an income**.[98] Possibly also linked, children not staying with the household, separated children, and married children, were reported at higher proportions in households with persons with disabilities than in households without persons with disabilities.

### *Female-headed households*

With largely male household members having been reported as having been involved in self-reliance activities, a significantly lower proportion of female-headed households than male-headed households reported household members having been involved in self-reliance activities in the 30 days prior to data collection (Figure 31).

**Figure 31** % of female- and male-headed households reporting households members having been involved in self-reliance activities in the 30 days prior to data collection (p- value ≤ 0.0001)




**As such, female-headed households may have less economic capacity to meet their needs than male-headed households, likely leading to female-headed households often being more likely to have unmet needs.** For instance, while also being significantly more likely to report challenges related to their food assistance,[99] female-headed households were significantly more likely than male-headed households to have unmet food security and livelihoods needs.[100] They were further significantly[101] more likely to report shelter issues. At the same time, among households having implemented shelter repairs, while being equally likely as male-headed households to report having received the shelter materials for the improvements/repairs from humanitarian organisations, female-headed households were significantly less likely than male-headed households to report having purchased materials (for more details, refer to the factsheet, p. 8).[102]

**Moreover, female-headed households may face greater challenges than male-headed households interacting with humanitarian actors**. For instance, female-headed households were significantly more likely than male-headed households to report not having been able to access enough clear information on the types of assistance available to them (Figure 32).

**In addition, while the reported over-reliance on *mahjis* and CiCs as points-of-contact for the referral of cases of assault or abuse was high among all respondents, this was particularly true for female respondents**. Female respondents were significantly less likely than male respondents to report that they would refer someone who had been

[98] REACH, *Age and Disability Inclusion Needs Assessment – Rohingya Refugee Response* (Cox's Bazar, 2021). Available here (accessed 30 November 2021); Child Protection Sub-Sector, 2021.
[99] p-value ≤ 0.0001.
[100] p-value ≤ 0.01.
[101] p-value ≤ 0.01.
[102] p-value ≤ 0.01.

assaulted or abused to "recommended" points-of-contact, including health facilities, psychosocial service providers, ombudsmen/national human rights institutions, women-friendly spaces/multi-purpose women centres, family/relatives/guardians, or curators or authorised legal representatives, leaving them more reliant on less "recommended" points-of-contact (Figure 33).

**Figure 32** % of female- and male-headed households reporting not having been able to access (receive and understand) enough clear information on at least one type of services / assistance in the 6 months prior to data collection (p- value ≤ 0.0001)

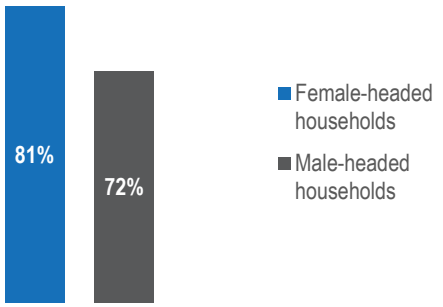
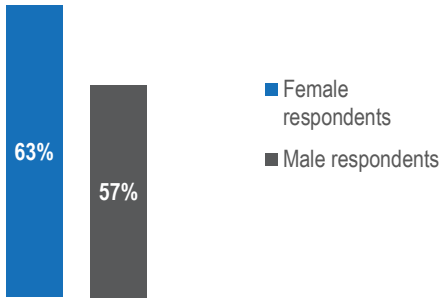



**Figure 33** % of female and male respondents not naming any of the "recommended" points-of-contact as a point-of-contact where they would send a friend for care and support in case of assault or abuse (p- value ≤ 0.01)




**Facing greater challenges meeting their needs may make female-headed households more likely than male-headed households to adopt coping strategies to meet their needs.** Specifically, female-headed households were significantly more likely than male-headed households to report having adopted livelihoods-based coping strategies. Overall, 79% of female-headed households reported having adopted livelihoods-based coping strategies due to a lack of money to meet their basic needs in the 30 days prior to data collection, compared to 68% of male-headed households[103] (for more details, refer to the factsheet, p. 9).

### *Households without access to self-reliance activities*

Already the 2020 J-MSNA found households without access to cash to be more likely than households with access to cash to have worse FCS.[104] This trend persisted in the current assessment, with **households without access to self-reliance activities having been found to have been significantly more likely to have worse FCS than households with access to self-reliance activities**.[105] Households without access to self-reliance activities were further significantly more likely than households with access to self-reliance activities to report challenges related to their food assistance,[106] as well as to report not having made shelter repairs/improvements despite having reported shelter issues (for more details, refer to the factsheet, pp. 9-10).[107]

Again, having less economic capacity to meet their needs, households without access to self-reliance activities were significantly more likely than households with access to self-reliance activities to report having adopted livelihoods-based coping strategies due to a lack of money to meet their basic needs in the 30 days prior to data collection. With the scope of self-reliance activities generally being limited and the reported adoption of livelihoods-based coping

[103] p-value ≤ 0.0001.
[104] ISCG, 2021c.
[105] p-value ≤ 0.0001.
[106] p-value ≤ 0.0001.
[107] p-value ≤ 0.0001.

strategies being common among all households, **households without access to self-reliance activities may be pushed towards more extreme coping strategies, having been in particular significantly more likely than households with access to self-reliance activities to report having adopted crisis-level coping strategies** (for more details, refer to the factsheet, p. 10).[108]

On the other hand, **having access to self-reliance activities may to some degree deprive young men of education**, as they may be more likely to work, and with household poverty being one of the main perceived driving forces for reported increases in child labour.[109] As such, households with access to self-reliance activities were significantly more likely to report at least one male household member aged 3-24 as not having been enrolled in education before learning facilities were closed due to the COVID-19 outbreak, as not having regularly accessed home-based learning since the start of the 2021 school year until support for home-based learning stopped, and that will not be sent back.[110]

### *Large households/households with a high dependency ratio*

In line with past assessments**, large households were found to be more likely to report assistance being insufficient for the household.** Being more likely to report LPG refills not to have lasted the full refill cycle, large households were found to be significantly more likely than small households to have unmet LPG needs (Figure 34).

They were further found to be significantly more likely than small households to report challenges related to their food assistance,[111] in particular reporting at higher proportions items not to have lasted until the next distribution (Figure 35).

**Figure 34** % of large and small households with unmet LPG needs, by household size (p-value ≤ 0.0001)

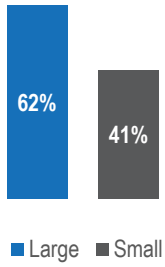



**Figure 35** % of large and small households reporting food items not to have lasted until the next distribution as a challenge with their food assistance in the 3 months prior to data collection

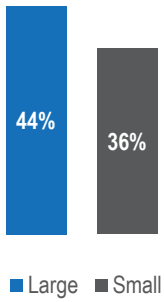
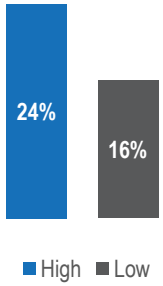



**Figure 36** % of households with a high and low dependency ratio reporting household members reportedly having had a health problem and needing to access health care in the 3 months prior to data collection for whom treatment was not sought at a clinic (p-value ≤ 0.05)[112]



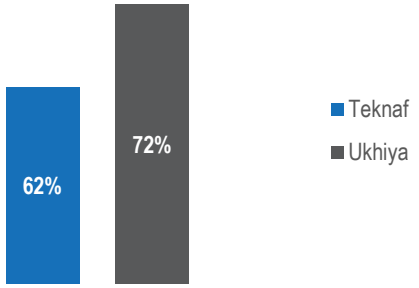

[108] p-value ≤ 0.0001.
[109] Child protection sub-sector, 2021.
[110] Pre-COVID-19 enrolment: p-value ≤ 0.01; home-based learning: p-value ≤ 0.05; sending back: p-value ≤ 0.01.
[111] p-value ≤ 0.001.
[112] The denominator for this indicator is all individuals having had a health problem and needing to access health care (n, high dependency ratio = 201 - results are representative with a +/- 7% margin of error; n, low dependency ratio = 1,836 - results are representative with a +/- 3% margin of error).

Lastly, households with a high dependency ratio were significantly more likely than households with a low dependency ratio to report at least one individual needing treatment in the 3 months prior to data collection for whom treatment was not sought at a clinic (Figure 36).

### *Differences between camps in Teknaf and Ukhiya*[113]

**Some services appear to have a lower coverage in camps in Teknaf than in camps in Ukhiya.** For instance, among households reportedly having made shelter improvements/repairs, households in Teknaf were significantly less likely than households in Ukhiya to report having received the materials for the improvements/repairs from humanitarian organisations (Figure 37). Moreover, significantly larger proportions of households in Teknaf than households in Ukhiya reported having had to make rent payments to stay in their current shelter in the 6 months prior to data collection.[114] Lastly, 95.9% of households in Teknaf reported having received LPG refills, compared to 97.5% of households in Ukhiya. While this difference is very small, as LPG distributions are generally widespread, it was significant, indicating that also in this case, coverage in Teknaf is slightly lower than in Ukhiya (also see maps in annex 6).[115]

**Figure 37** Among households in Teknaf and Ukhiya reportedly having made shelter improvements/repairs in the 6 months before data collection, % reporting that they received shelter materials from humanitarian organisations (p-value ≤ 0.01)[116]




Moreover, as already found in the 2020 J-MSNA,[117] **availability, access or use of NGO clinics is lower in camps in Teknaf than in camps in Ukhiya**. Among households having reported household members having had a health problem and needing to access health care, lower proportions of individuals in Teknaf than in Ukhiya were reported as having sought treatment at NGO clinics, while higher proportions were reported as having sought treatment in private clinics (Figure 38). As a result, higher proportions of households in Teknaf than in Ukhiya with at least one individual reportedly having accessed health care reported having paid for health services (Figure 39). In addition, higher proportions of households in Teknaf than in Ukhiya with individuals reportedly having needed treatment reported barriers having prevented individuals from accessing health care when needed (Figure 36). They particularly reported at higher proportions long waiting times for services/overcrowding, not having received the correct medication, the specific medicine, treatment or service needed not having been available, and a lack of functional health facilities nearby (also see maps in annex 6).

[113] Mapped results for the indicators described in this section can be found in annex 6. Results for Teknaf are representative with a +/- 4% margin of error (n = 826), and results for Ukhiya are representative with a +/- 2% margin of error (n = 2,857), unless stated otherwise.
[114] p-value ≤ 0.0001.
[115] p-value ≤ 0.05.
[116] The denominator for this indicator is all households having made improvements/repairs (n, Teknaf = 318 – results are representative with a +/- 6% margin of error; n, Ukhiya = 1,311 – results are representative with a +/- 3% margin of error.)
[117] ISCG, 2021c.

**Figure 38** % of individuals reported by households in Teknaf and Ukhiya as having had a health problem and needing to access treatment in the 3 months prior to data collection, by treatment location[118]

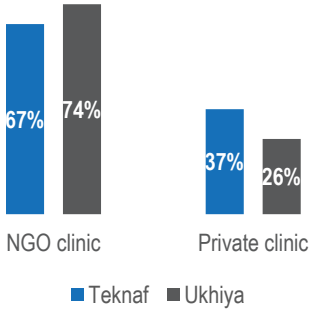



**Figure 39** % of households in Teknaf and Ukhiya with at least one individual reportedly having accessed health care in the 3 months prior to data collection reporting having paid for health services (p-value ≤ 0.05)[119]

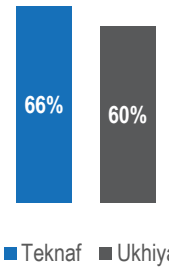
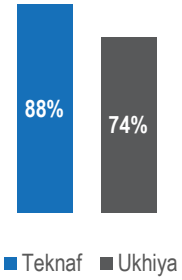



**Figure 40** % of households in Teknaf and Ukhiya with at least one individual reportedly having needed health care in the 3 months prior to data collection but did not seek any treatment at a health facility or hospital reporting barriers that prevented them from accessing the health care they needed (p-value ≤ 0.01)[120]




**There also appear to be differences at the upazila and camp level in access to water and sanitation facilities.** While households in Teknaf were significantly more likely than households in Ukhiya to report not having had enough water at the time of data collection (Figure 41), households in Ukhiya were significantly more likely than households in Teknaf to report not having used an improved water source (Figure 42). Households in Ukhiya were also significantly more likely than households in Teknaf to report problems related to sanitation facilities (Figure 43) (also see maps in annex 6).

**Figure 41** % of households in Teknaf and Ukhiya reporting not having had enough water for at least one purpose at the time of data collection (p-value ≤ 0.01)

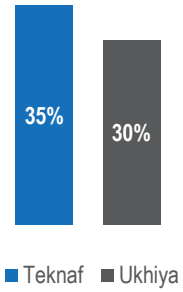



**Figure 42** % of households in Teknaf and Ukhiya reporting not having used an improved water source as their main source of water used for drinking at the time of data collection (p-value ≤ 0.0001)

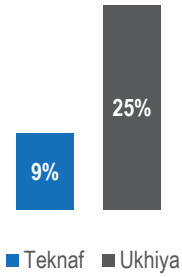
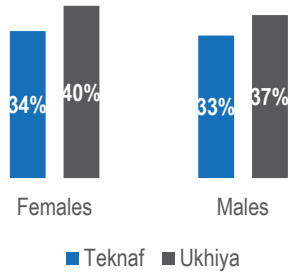



**Figure 43** % of households in Teknaf and Ukhiya with female or male household members reporting problems related to latrines females (p-value ≤ 0.01) or males (p-value ≤ 0.05) in their households faced at the time of data collection




[118] The denominator for this indicator is all individuals having had a health problem and needing to access health care (n, Teknaf = 895 – results are representative with a +/- 4% margin of error; n, Ukhiya = 3,124 – results are representative with a +/- 2% margin of error).
[119] The denominator for this indicator is all households with at least one individual having accessed health care (n, Teknaf = 423 – results are representative with a +/- 5% margin of error; n, Ukhiya = 1,482– results are representative with a +/- 3% margin of error).
[120] The denominator for this indicator is all households with at least one individual needing but not having accessed health care (n, Teknaf = 73 – results are representative with a +/- 12% margin of error; n, Ukhiya = 267– results are representative with a +/- 6% margin of error).

**Lastly, protection concerns appear slightly more prevalent in camps in Teknaf than in camps in Ukhiya**. While the differences at the upazila level were small, still significantly higher proportions of households in camps in Teknaf than households in camps in Ukhiya reported the safety and security situation to have deteriorated in the 12 months prior to data collection (Figure 44). Similarly, the proportions of households having reported areas considered unsafe by boys and men in the community were significantly higher in Teknaf than in Ukhia (Figure 45), as were the proportions of households having reported needing protection support (Figure 46). At the camp level (see maps in annex 6), those differences were more pronounced, ranging from 0% of households having reported a deterioration in the safety and security situation in camp 13 to 23% having reported so in camp 1W; from 1% of households having reported areas considered unsafe by boys and men in camp 22 to 20% of households having reported so in camp 14; from 5% of households having reported areas considered unsafe by girls and women in camp 4 to 29% of households having reported so in camp 15; and from 22% of households having reported needing protection services in camp 2W to 93% having reported so in camp 14, and with patterns in terms of the relative distribution of results across camps being similar across the four indicators.

**Figure 44** % of households in Teknaf and Ukhiya reporting the safety and security situation in their neighbourhood and area of residence to have deteriorated compared to the previous 12 months (p-value ≤ 0.05)

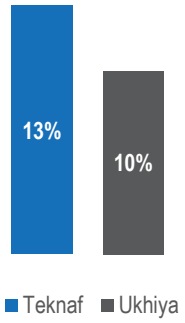



**Figure 45** % of households reporting areas considered unsafe by boys and men in the community at the time of data collection (p-value ≤ 0.05)

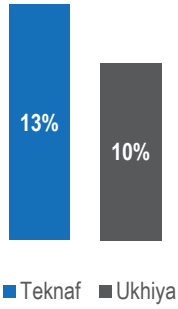
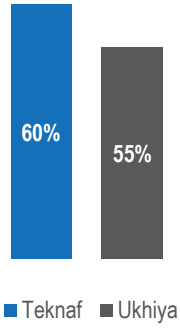



**Figure 46** % of households reporting needing protection services or support (p-value ≤ 0.05)



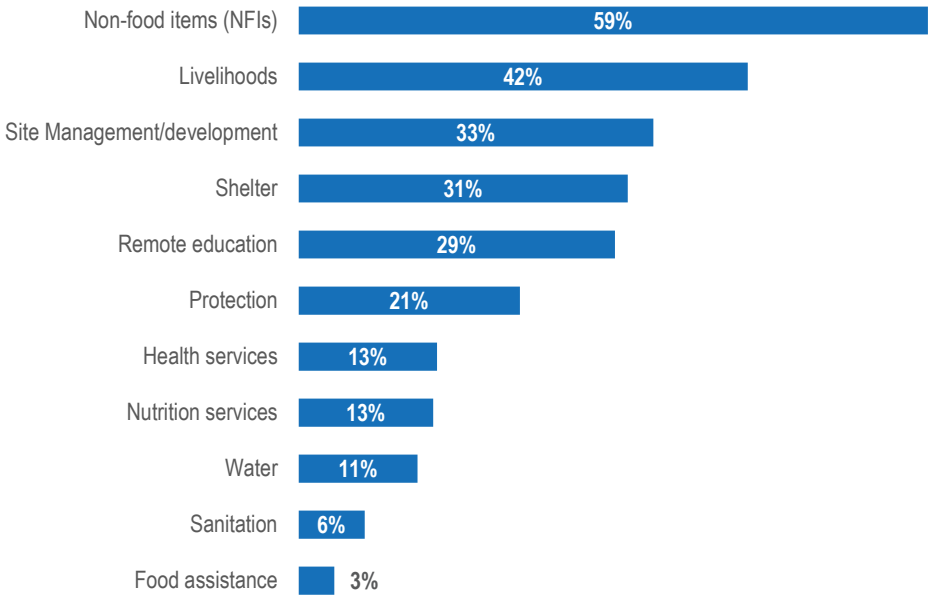

## Communication with Communities

**Roughly three in four households (74%) were reportedly unable to access enough clear information on the types of assistance available to them in the 6 months prior to data collection.** Types of assistance about which households most frequently reported not having received enough clear information included NFIs and livelihoods, followed by site management, shelter, remote education and protection services (Figure 47).

In addition, 18% of households reported having faced problems when accessing (receiving and understanding) information in the 6 months prior to data collection, most commonly aid workers not sharing or disclosing information (as reported by 8% of households). Similarly, during another survey camps 2E, 9, 15, 18 and 20, 86% of households reported not being able to ask aid providers about the available aid.[121]

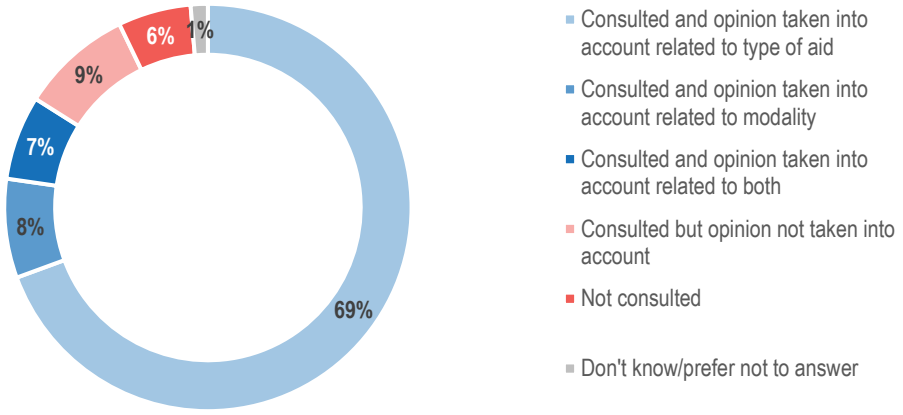
[121] GTS, 2021.

**Figure 47** % of households reporting not having been able to access (receive and understand) enough clear information, by type of service




While 84% of households reported 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, **15% of households reported either not having been consulted or having been consulted but feeling that their opinions had not been taken into account** (Figure 48).

**Figure 48** % of households 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



The above findings are contrary to results from another survey covering camps 2E, 9, 15, 18 and 20, during which 82% of households reported that their feedback was not considered by humanitarian organisations when providing aid.[122] Similarly, **participants in most FGDs reported not feeling included in decision-making and not feeling heard by humanitarian actors**. In some cases, the reduced presence of humanitarian actors due to COVID-19 was reported as potentially having negatively impacted upon community inclusion. Most male participants reported that humanitarian assistance was not provided according to their needs and that even if they were consulted, their opinions were not taken into account.

**In addition, 9% of households reported facing 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 4% of households). Again, the survey covering camps 2E, 9, 15, 18 and 20, on the other hand, found 85% of households having provided feedback reporting that their issues were not resolved, indicating that challenges related to feedback or complaints may have been under-reported during the current assessment. These differences between survey results may be due to methodology, the social desirability bias outlined above as well as the remote nature of the survey, increasing the likelihood of sensitive issues being under-reported.[123]

**During the FGDs, the first points-of-contact for feedback and complaints were largely reported to be *mahjis* or head *mahjis*, followed by CiCs. Only a minority of participants said they would report to humanitarian organisations.** At the same time, a lack of trust towards *mahjis* was reported, and issues of bribery when addressing feedback and complaints raised. Bribery and discrimination were also reported as an issue when accessing services, e.g. health services (1 FGD), and in relation to the distribution of humanitarian assistance or volunteer opportunities (5 FGDs).

> *"When I go to the majhi and ask for an NGO job, he demands BDT 5,000 or 10,000[124] and says that he will have to give the money to the NGO. So those who are able to pay can be a volunteer, and those who are not able to pay can't. The people who work as daily labourers for NGOs have to pay BDT 50 per day. They get paid BDT 350 and they have to pay him [the mahji] BDT 50 daily."* – FGD with men, ages 25-40

[122] Ibid.
[123] GTS, 2021.
[124] BDT 1 = USD 0.011648545 (XE currency converter, as of 18 November, 2021).

# CONCLUSION

Approximately 900,000 Rohingya refugees continue to reside in camps in Cox's Bazar District, Bangladesh. The crisis has now entered its fifth year, and a return of refugees to Myanmar continues to be uncertain. As such, there is a continued need for up-to-date information on the needs and vulnerabilities of all affected populations. At the same time, renewed COVID-19 containment measures put in place in April 2021, and related restricted service provision in camps, as well as recurring disasters, such as flooding and fires, are likely to have impacted on pre-existing needs and service gaps. 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 Rohingya refugee populations residing in all 34 camps in Teknaf and Ukhiya Upazilas (excluding any refugees having been relocated elsewhere), and was implemented through the ISCG's MSNA TWG.

Almost all households were found to have unmet multi-sectoral needs, with 20% of households having been found to have extreme unmet needs, and 66% of households having been found to have severe unmet needs. Unmet needs were most commonly found to be related to shelter and NFIs, as well as food security and livelihoods. However, extreme unmet needs most commonly concerned food security and livelihood outcomes, as well as (child) protection.

Generally, households appear to have at least partially recovered from the COVID-19 outbreak and its secondary impacts, in particular on food security and livelihoods, and health-seeking behaviour. Moreover, results show that the coverage of some services, such as blanket food distributions, LPG provision, and nutrition and health services, has remained extensive. Additionally, in particular in relation to access to water, positive trends can be observed across 2019, 2020 and 2021 J-MSNA results.

However, with limited access to self-reliance activities, the refugee population in camps remains highly reliant on humanitarian assistance. Excluding the value of assistance received and consumed by households, 85% of households reported monthly per capita expenditures below the MEB, i.e. likely not being able to meet their basic needs, while compared to other assessments, these results may still be optimistic estimates. At the same time, even including the value of assistance received and consumed by households, roughly one quarter of households were found to have monthly per capita expenditures below the MEB, indicating that households may not always be able to meet their basic needs despite the assistance they receive.

As such, results also showed needs and gaps in access to basic goods and services having remained across sectors. Not all households may be receiving shelter support when needed, and also among those having received support, it may not always have been sufficient. Large gaps were further reported in relation to access to NFIs, with almost nine in ten households reporting having had insufficient NFIs.

Similarly, blanket food distributions may be reaching all households. However, still, only roughly half the households were found to have an acceptable FCS, likely linked to challenges preserving food items until the end of distribution cycles, especially with COVID-19 containment measures in place, limited food diversity and challenges accessing in particular fresh products.

Moreover, one in five households (19%) were reportedly not using an improved water source, and not all households perceived always having had access to enough water. Roughly 40% of households reported problems male (37%) or female (38%) household members faced related to latrines, and roughly 20% of households reported problems male (16%) or female (21%) household members faced related to bathing facilities. Additionally, during FGDs with women, insufficient menstrual hygiene kits, and issues of quality were frequently reported.

Large gaps in access to education have also remained, in particular among older individuals and girls. Adolescent girls may be most at risk of having ended their education early as a result of the COVID-19 outbreak, while younger children who were not enrolled in education pre-COVID-19 are likely to start their education later than they would have would learning facilities not have closed, as largely only previously enrolled children appear to have accessed home-based learning. Generally, the main reported barriers towards accessing education were on the one hand, a lack of opportunities for older students as well as other reasons for older students to drop out early, such as marriage, and on the other hand both remote and in-person education having been perceived as ineffective or of low quality, while also COVID-19 remained a concern in relation to in-person education.

With increases in reports of protection incidents since the start of the COVID-19 outbreak, fear and feelings of insecurity may have been further exacerbated this year by the reduced Protection Sector footprint in camps between April and September 2021 in line with COVID-19 containment measures, which was frequently reported as having prevented access to protection services among those wanting to access them. At the same time, an over-reliance on *mahjis* and CiCs as first points-of-contact to report at least cases of assault and abuse remained.

Lastly, while unmet health needs were generally low, one third of households without unmet needs reportedly only met their needs through the adoption of negative coping strategies, indicating that they may also not be able to meet their needs in the long run.

Some households were found to be more likely than others to report gaps or challenges, or have unmet needs. These households included households with persons with disabilities, female-headed households, households without access to self-reliance activities, and large households or households with high dependency ratios. Households with persons with disabilities, female-headed households, and households without access to self-reliance activities, were all particularly likely to report worse outcomes, as well as having adopted coping strategies to meet their needs. Large households were more likely to report assistance, in particular LPG and food assistance, as not having lasted the full distribution cycles.

Results clearly show that while some positive trends and extensive service provision can be observed, five years into the crisis, needs and service gaps have remained. As such, additional information on the drivers behind persisting needs and gaps in access to basic services may help effectively address those. Similarly, a more in-depth investigation for a better understanding of barriers towards accessing protection services and the referral pathways households take – also beyond the first point-of-contact – may help improve access to and use of protection services offered by humanitarian actors.

Lastly, given the practical limitations of this assessment, certain topics could not be covered within the household survey. Sensitive issues that were addressed, e.g. related to safety and security, may have been under-reported due to the methodological limitations. Therefore, targeted assessments of such sensitive topics with carefully designed

methodologies and in-person data collection may help improve the understanding of issues around topics such as menstrual hygiene and safety and security to be able to better counter gaps and negative trends.

# ANNEXES

## Annex 1: Household surveys completed per camp

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

| Upazila | Camp | Total number of households | Targeted minimum number of surveys | Completed number of surveys |
|---|---|---|---|---|
| Ukhiya | Camp 1E | 8,485 | 95 | 113 |
| | Camp 1W | 8,372 | 95 | 114 |
| | Camp 2E | 6,109 | 95 | 124 |
| | Camp 2W | 5,484 | 94 | 104 |
| | Camp 3 | 8,052 | 95 | 102 |
| | Camp 4 | 7,062 | 95 | 109 |
| | Camp 4 Extension | 1,728 | 91 | 100 |
| | Camp 5 | 5,540 | 94 | 106 |
| | Camp 6 | 4,878 | 94 | 101 |
| | Camp 7 | 8,295 | 95 | 112 |
| | Camp 8E | 6,250 | 95 | 107 |
| | Camp 8W | 6,613 | 95 | 116 |
| | Camp 9 | 7,200 | 95 | 104 |
| | Camp 10 | 6,320 | 95 | 108 |
| | Camp 11 | 6,177 | 95 | 110 |
| | Camp 12 | 5,343 | 94 | 110 |
| | Camp 13 | 8,815 | 95 | 108 |
| | Camp 14 | 6,605 | 95 | 108 |
| | Camp 15 | 10,550 | 95 | 117 |
| | Camp 16 | 4,486 | 94 | 141 |
| | Camp 17 | 3,860 | 94 | 111 |
| | Camp 18 | 6,104 | 95 | 114 |
| | Camp 19 | 4,921 | 94 | 116 |
| | Camp 20 | 1,575 | 91 | 113 |
| | Camp 20 Extension | 1,925 | 92 | 133 |
| Teknaf | Camp 21 | 3,893 | 94 | 119 |
| | Camp 22 | 4,290 | 94 | 109 |
| | Camp 23 | 2,396 | 92 | 104 |
| | Camp 24 | 5,815 | 94 | 105 |
| | Camp 25 | 1,582 | 91 | 108 |
| | Camp 26 | 8,985 | 95 | 108 |
| | Camp 27 | 3,255 | 93 | 108 |
| | Kutupalong/Nayapara Registered Camps | 7,575 | 95 | 121 |
| **Total** | | **188,540** | **3,105** | **3,683** |

## Annex 2: Focus group discussions completed by age and gender group

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

| Age group | Number of FGDs with men | Number of FGDs with women | Total |
|---|---|---|---|
| 18-24 | 3 | 3 | 6 |
| 25-40 | 4 | 3 | 7 |
| 41-59 | 2 | 2 | 4 |
| 60+ | 1 | 2 | 3 |
| **Total** | **10** | **10** | **20** |

## Annex 3: 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 |
|---|---|---|---|
| **Day 1, 4 July 2021 (Sunday)** | | | |
| 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 |
| **Day 2, 5 July 2021 (Monday)** | | | |
| 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 | | |

| Date &Time | Session | Objectives | Facilitator |
|---|---|---|---|
| 10:45 – 11:15 am | Shelter (camps) / CwC (HC) | Ensure everyone has a very good understanding of each question and its rationale. | REACH/sectors |
| 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 |
| **Day 3, 6 July 2020 (Tuesday)** | | | |
| 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 |
| **Day 4, 7 July 2020** | Pilot data collection (8:30 am – 4:30 pm) | Pilot data collection | REACH |
| **Day 5, 8 July 2020** | Pilot review (online, 8:30 am – 5:30 pm) | Pilot data collection and review, clarification of any open questions | REACH |

## Annex 4: Referral mechanism

The following instructions were provided to enumerators as guidance to the referral process. A list of names and contact details of the relevant protection actors was shared with field coordinators and team leaders.

### Referral – For interviews in camps only

**What to do if you come across an urgent protection concern in the process of the survey:**

- Contact the Protection Focal Point in a timely manner (have contacts ready) or the GBV or Child Protection Focal Point if relevant.
- Do not investigate the situation.
- Reassure the individual.
- If the protection concern involves an adult, ensure you get informed consent before referring to focal points. If consent is not given, provide the contact of the Protection Focal Point and the hotline number (16670), inviting the person to reach out to either of the contacts, if and when needed.
- If the incident involves a child, contact the child protection focal point, seeking the child's informed consent, if the child is capable to provide.
- Stay with the individual until help arrives, if needed/wished.
- If a person discloses personal information of a protection issue in the interview, ask consent to refer them to get further help – and **follow up on this promise if consent is obtained.**

**If the household is child-headed or indicates any other protection concern**, the household should be referred to the appropriate protection focal point – if it **consents** (or if child-headed and the child has not yet reached intellectual maturity, always refer):

1. Confirm that the household consents for REACH/UNHCR to contact a protection actor on their behalf and then ask for the following information (if not provided at the start of the interview):
    a. Name of respondent
    b. Household FCN
    c. Block number
    d. Preferred modality of contact (in-person or phone) – if phone, phone number they would like to be contacted on
2. After ending the interview inform your team leader about the case.
3. **For team leader:** After knowing about the case, call the relevant protection actor (see Excel sheet for general protection, child protection and GBV protection focal points in all camps) and provide them:
    a. Name of respondent
    b. Household FCN
    c. Block number
    d. Preferred modality of contact – and if phone, phone number

### রেফারেল - শুধুমাত্র ক্যাম্পে সাক্ষাত্কারের জন্যঃ

**জরিপের প্রক্রিয়াতে জরুরি ভিত্তিতে সুরক্ষা সম্পর্কিত কোনও কিছুর মুখোমুখি হলে, কী করবেন**

- সময়মতো সুরক্ষা বা প্রোটেকশন ফোকাল পয়েন্টের সাথে যোগাযোগ করুন (মোবাইল নম্বর দেয়া আছে) অথবা জিবিভি বা শিশু সুরক্ষা সম্পর্কিত ফোকাল পয়েন্টের সাথে যোগাযোগ করুন যদি প্রয়োজন হয়।
- সুরক্ষা সম্পর্কিত পরিস্থিতি তদন্ত করবেন না।
- যার সুরক্ষা প্রয়োজন সে ব্যক্তিকে আশ্বাস দিন।
- যদি সুরক্ষা সম্পর্কিত বিষয়টি কোনও প্রাপ্তবয়স্কের সাথে হয়ে থাকে তবে ফোকাল পয়েন্টের কাছে রেফার করার আগে আপনি যে ঐ ব্যক্তি থেকে সম্মতি পেয়েছেন তা নিশ্চিত করুন। যদি সম্মতি না দিয়ে থাকে তবে সুরক্ষা ফোকাল পয়েন্ট এবং হটলাইন নম্বর (16670) এর যোগাযোগ করুন, প্রয়োজন হলে, তখন ঐ ব্যক্তিকে যোগাযোগগুলির যে কোনও একটিতে পৌঁছানোর জন্য আমন্ত্রণ জানান।
- যদি ঘটনাটি কোনও শিশুর সাথে হয় তাহলে শিশু সুরক্ষা সম্পর্কিত ফোকাল পয়েন্টের সাথে যোগাযোগ করুন তবে অবশ্যই শিশুটির সম্মতি গ্রহন করবেন।
- যদি আপনার প্রযোজন বা ইচ্ছা করে তাহলে সহোযোগিতা না পৌঁছানো পর্যন্ত ঐ ব্যক্তি বা শিশুটির সাথে থাকুন

- যদি কোনও ব্যক্তি সাক্ষাৎকারের সময় সুরক্ষা সম্পর্কিত ইস্যুটিতে ব্যক্তিগত তথ্য প্রকাশ করে তবে তাদের আরও সহায়তা পাওয়ার জন্য রেফার করুন বা ফলো আপ করুন, **শুধুমাত্র তখনই করবেন যদি তারা সম্মতি দেয়।**

যদি পরিবারটি "শিশু নেতৃত্বাধীন পরিবার" (কোনও প্রাপ্তবয়স্ক প্রতিনিধি না থাকে) হয় অথবা পরিবারটি আপনাকে কোনও সুরক্ষা উদ্বেগের বিষয়ে বলে, তবে পরিবারটিকে যথাযথ সুরক্ষা ফোকাল পয়েন্টের কাছে রেফার করতে হবে। - যদি পরিবারটি সম্মতি দেয় (বা যদি শিশু নেতৃত্বাধীন এবং শিশুটি এখনও মেচিউর বা পরিপক্কতায় পৌঁছেছে না, উল্লেখ করুন):

১। নিশ্চিত করুন যে পরিবারটি তাদের পক্ষে রিচ/ইউএইচসিআরকে যথাযথ সুরক্ষা ফোকাল পয়েন্টের কাছে রেফার করার জন্য সম্মতি দিয়েছে এবং তারপরে নিম্নলিখিত তথ্য জিজ্ঞাসা করুন (যদি সাক্ষাত্কারের শুরুতে সরবরাহ না করা হয়):
ক। উত্তরদাতার নাম
খ। পরিবারের এফসিএন
গ। ব্লক নম্বর
ঘ। যে উপায়ে যোগাযোগ করলে তিনি স্বাচ্ছন্দ্যবোধ করবেন। (কোনও ব্যক্তি এসে বা ফোনে) - যদি ফোনে হয় , তাহলে কোন ফোন নম্বরে তাদের যোগাযোগ হবে জেনে নিন।

২। সাক্ষাত্কার শেষ করার পরে বিষয়টি **টিম লিডারকে** জানান।
৩। **টিম লিডার এর জন্যঃ** জরিপকারীর কাছ থেকে কেসটি জানার পর যথাযথ সুরক্ষা ফোকাল পয়েন্টের কাছে ফোন করুন (এক্সেল সীট দেখে ক্যাম্প অনুযায়ী সাধারণ সুরক্ষা (জেনেরাল সুরক্ষা), শিশু সুরক্ষা (সিপি) এবং লিঙ্গ-ভিত্তিক সহিংসতা (জিবিভি) সুরক্ষা ফোকাল পয়েন্টে এর নম্বর দেখুন) এবং নিচের তথ্যগুলো তাদের সরবরাহ করুন:

ক। উত্তরদাতার নাম
খ। পরিবারের এফসিএন
গ। ব্লক নম্বর
ঘ) যে উপায়ে যোগাযোগ করলে তিনি স্বাচ্ছন্দ্যবোধ করবেন।

# Annex 5: Partners involved in the assessment

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

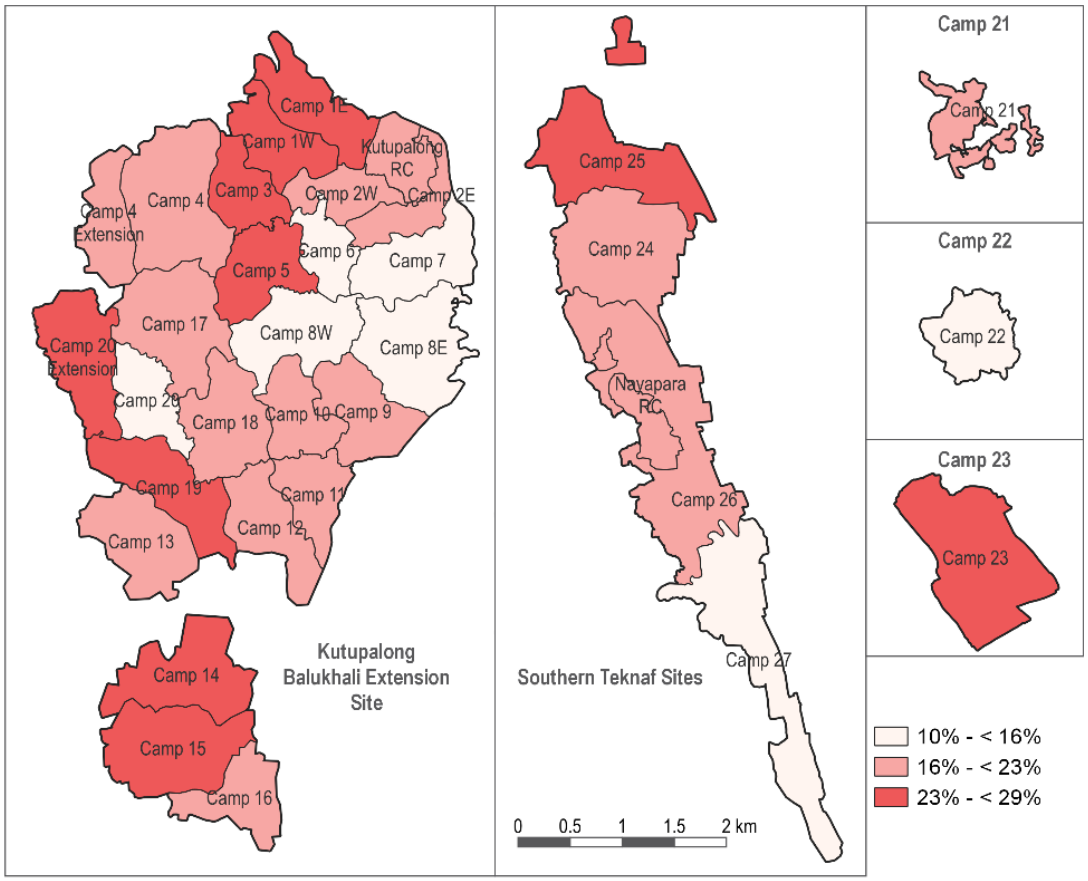
| Stage of the assessment | Partners involved |
|---|---|
| Research design | MSNA TWG, led by the ISCG and comprised of ACAPS, IOM NPM, WFP VAM, UNHCR and REACH |
| Tool design | Sectors, MSNA TWG |
| Enumerator training | Sectors, REACH |
| Data collection | UNHCR, Prottyashi, Helvetas, REACH |
| Data 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

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

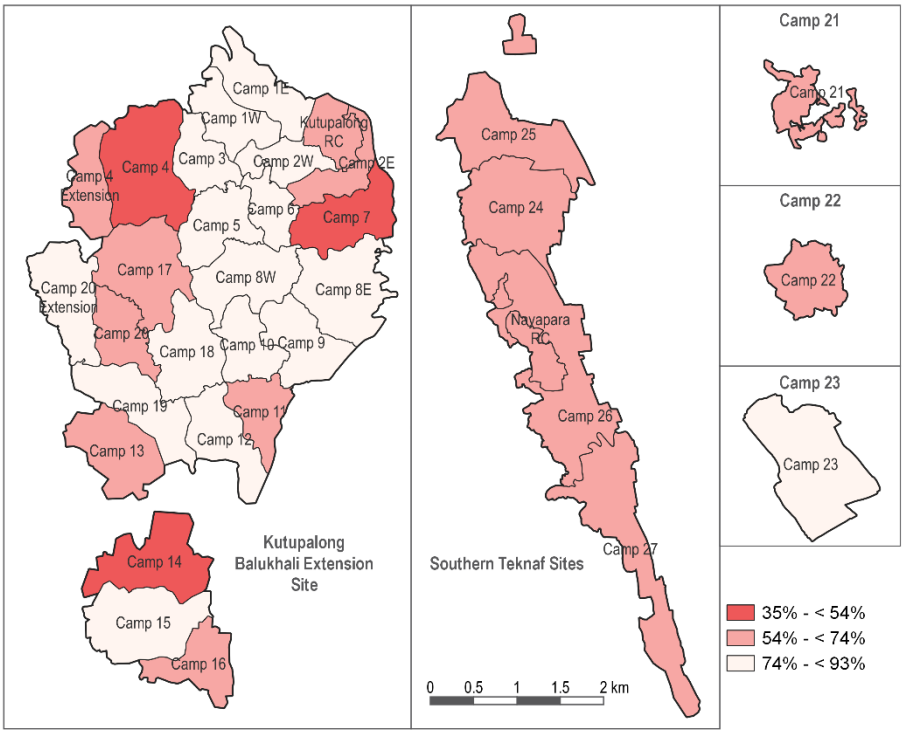
## *Extreme needs*

**Map 2** % of households with extreme unmet needs (LSG = 4), by camp

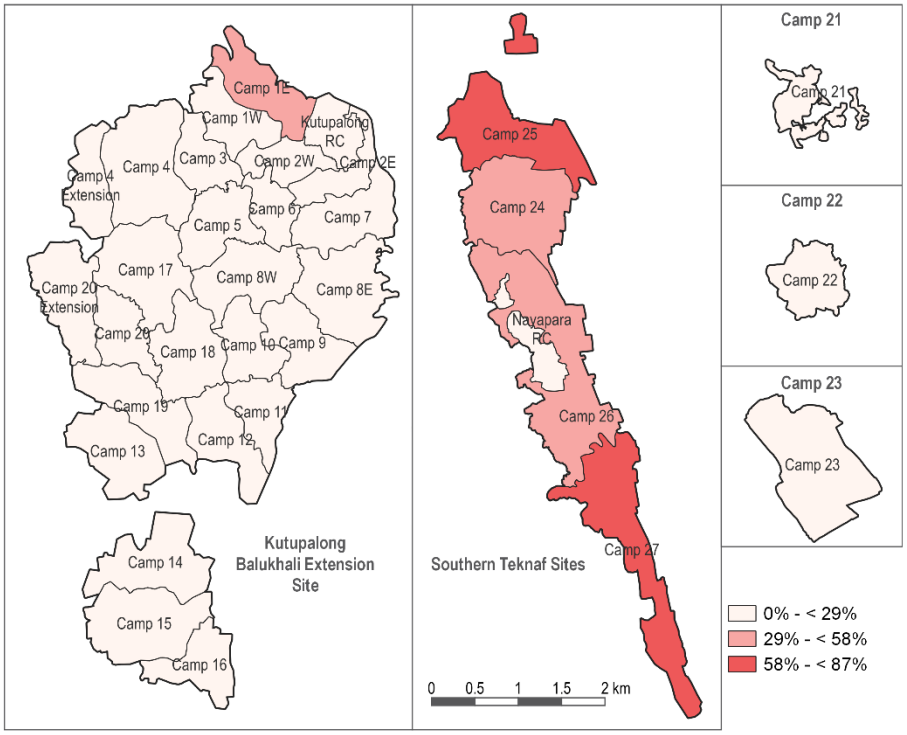


## *Shelter & NFIs*

**Map 3** Among households reportedly having made shelter improvements/repairs, % reporting having received the materials from humanitarian organisations, by camp (margin of error: +/- 18%)

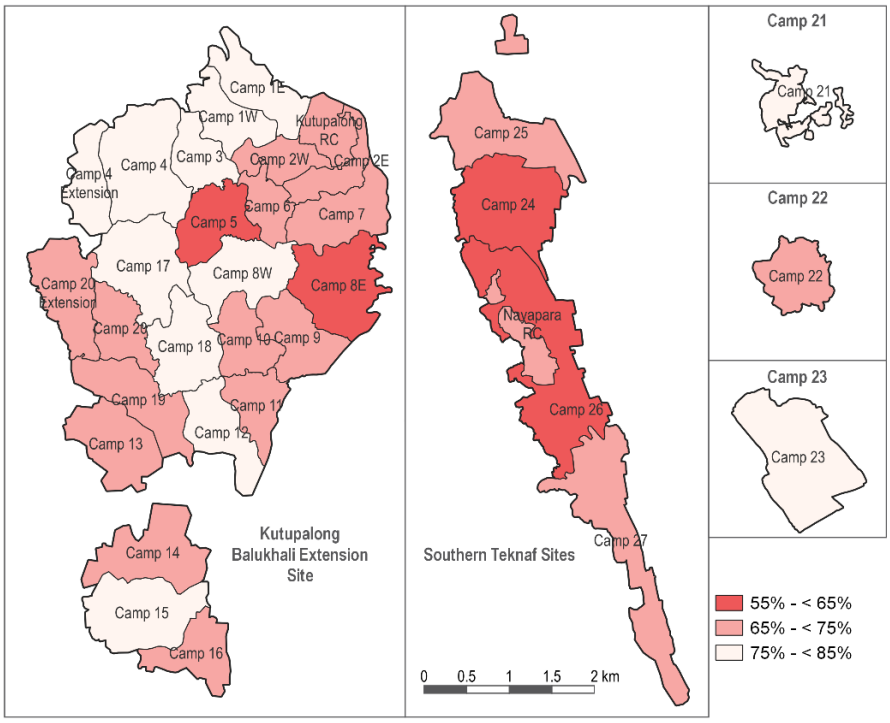



**Map 4** % of households reporting having had to pay or exchange goods/labour to live in their current shelter in the 6 months prior to data collection, by camp

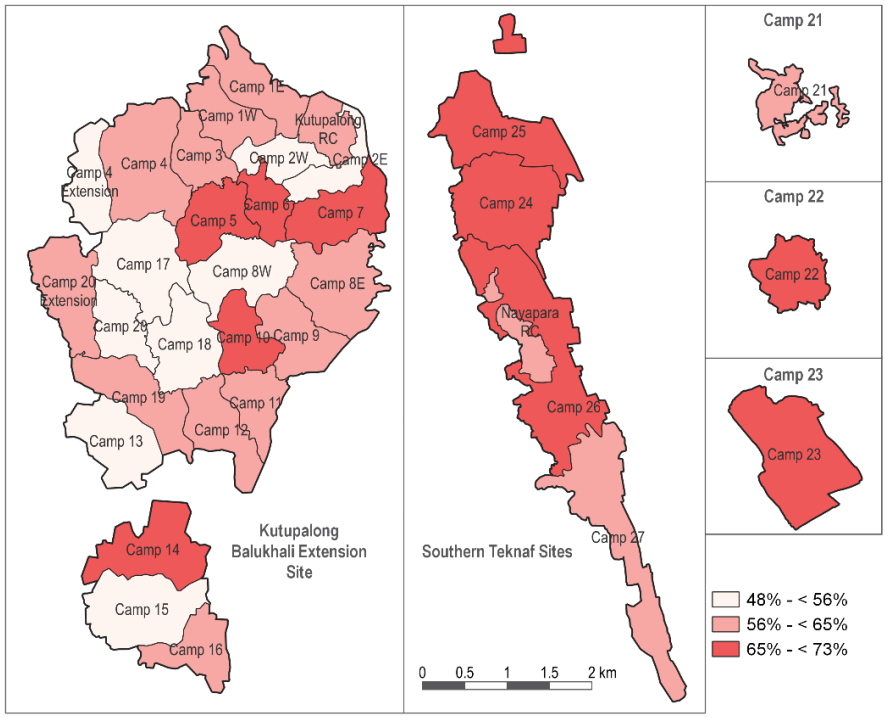


## *Health*

***Map 5*** % of individuals reportedly having had a health problem and needing to access treatment reported as having sought treatment at an NGO clinic in the 3 months prior to data collection, by camp (margin of error: +/- 11%)

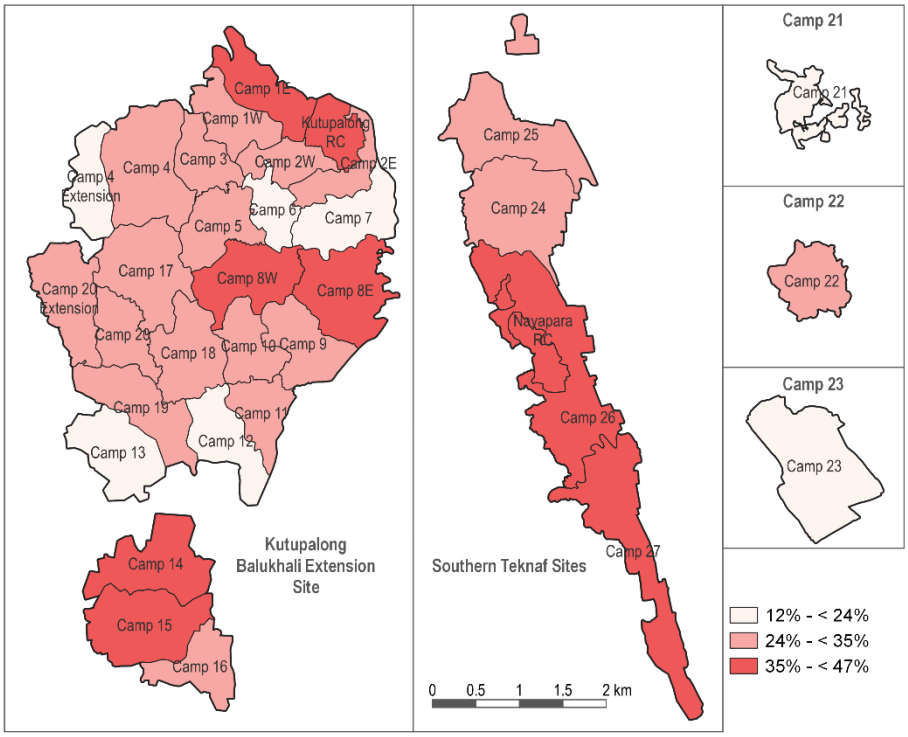



***Map 6*** % of households with at least one individual reportedly having accessed health care in the 3 months prior to data collection reporting having paid for health services, by camp (margin of error: +/- 15%)

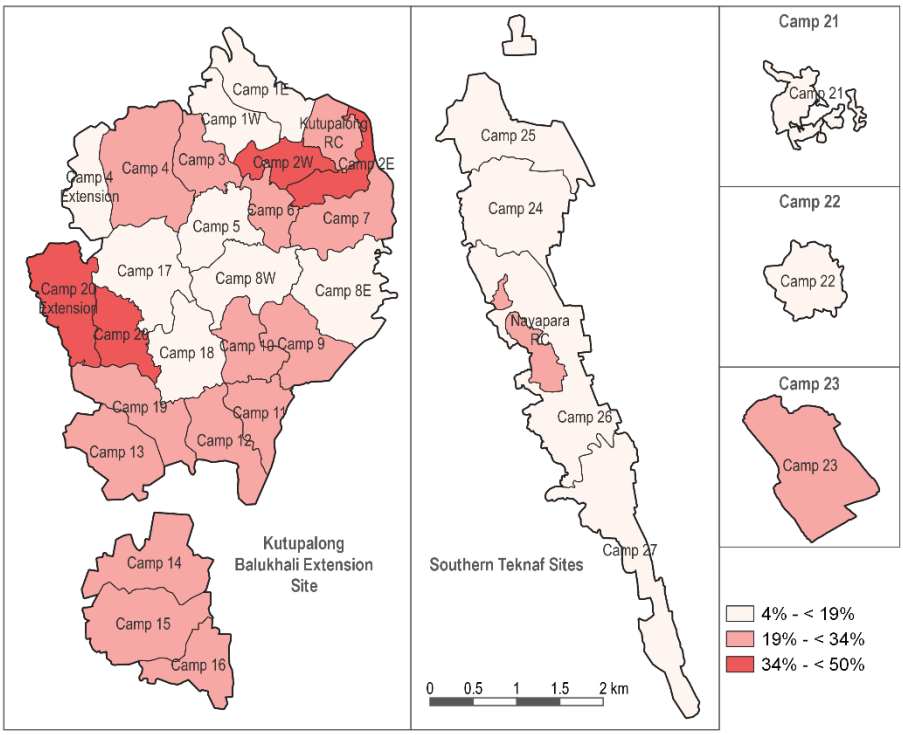


## *WASH*

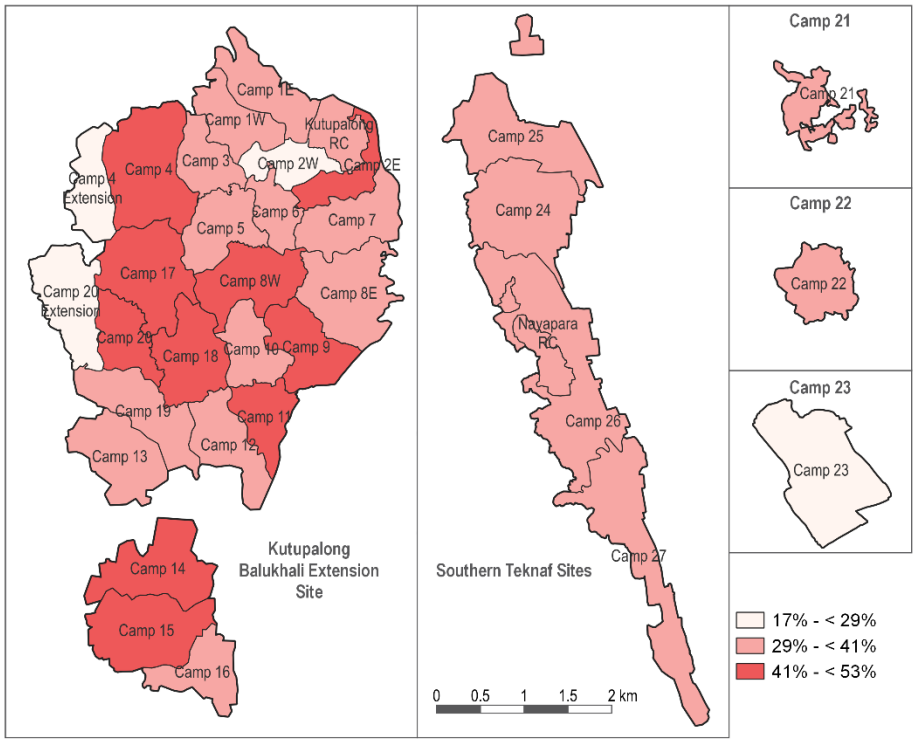
**Map 7** % of households reporting not having had enough water for at least one purpose at the time of data collection, by camp



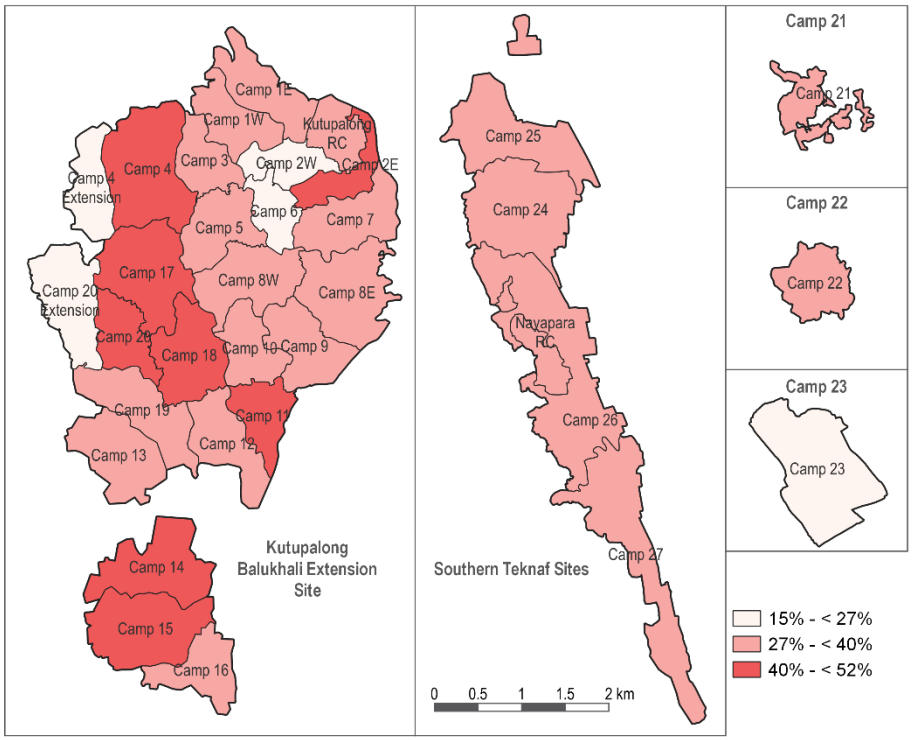

**Map 8** % of households reporting not having used an improved water source as their main source of water used for drinking at the time of data collection, by camp



**Map 9** % of households with female household members reporting problems related to latrines females in their households faced at the time of data collection, by camp

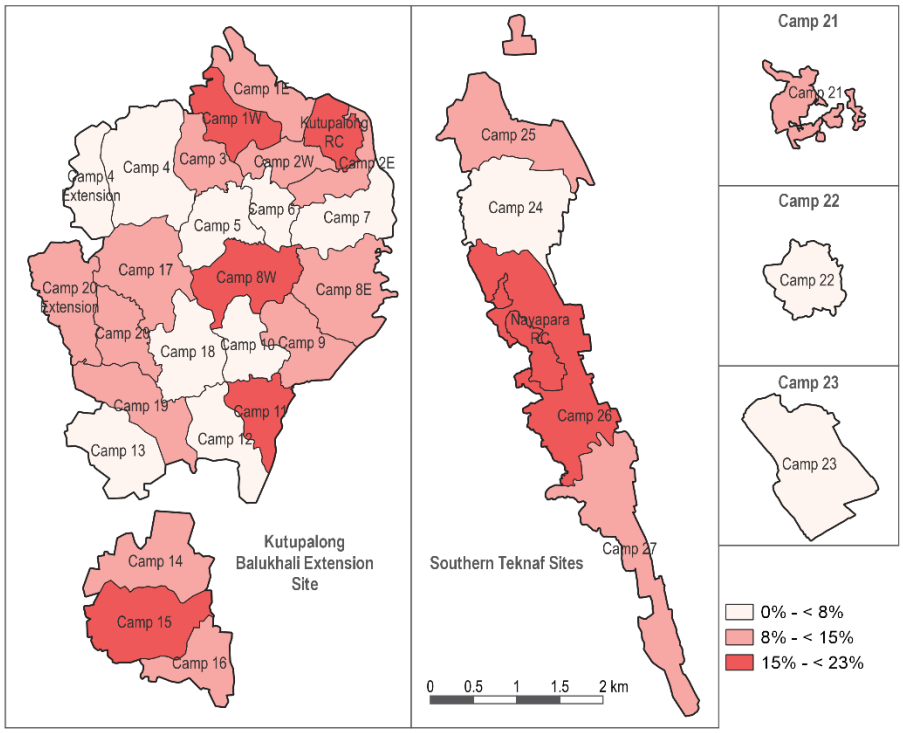



**Map 10** % of households with male household members reporting problems related to latrines males in their households faced at the time of data collection, by camp

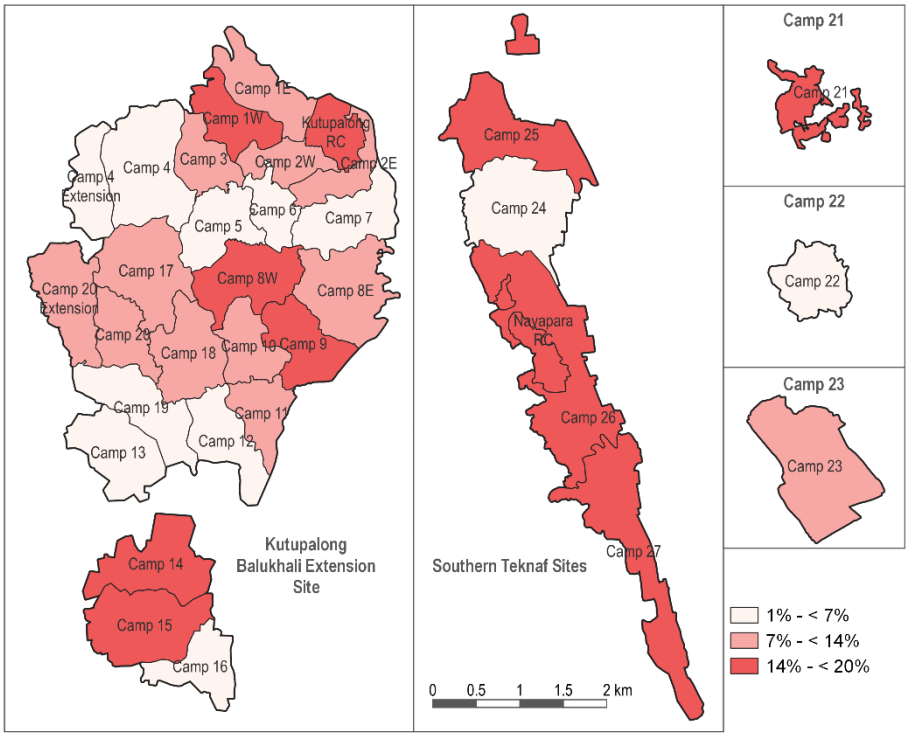


## *Protection*

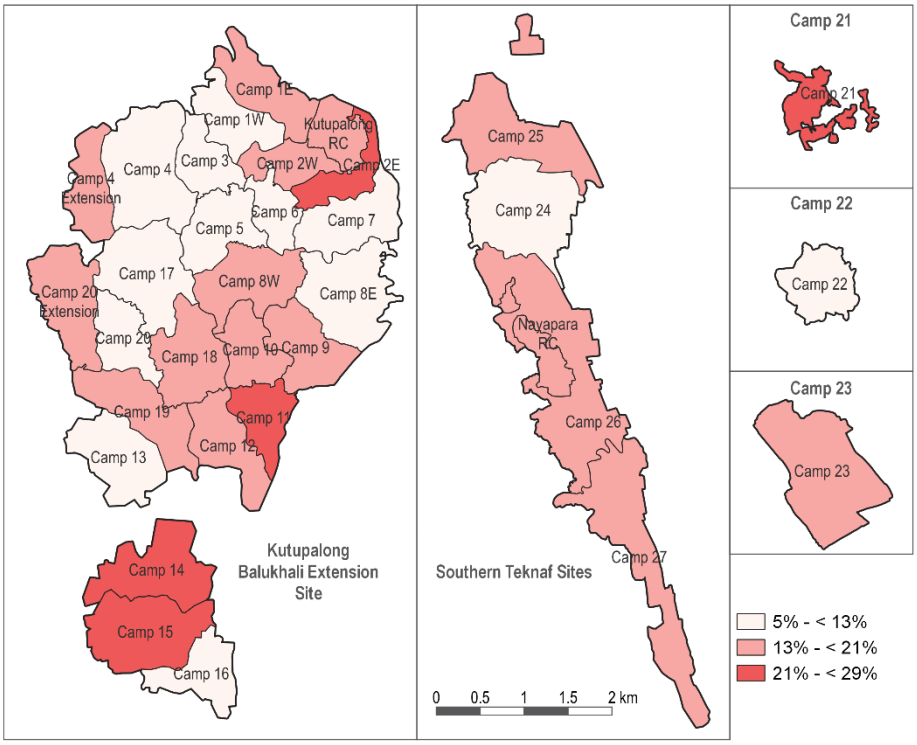
**Map 11** % of households reporting the safety and security situation in their neighbourhood and area of residence to have deteriorated compared to the previous 12 months, by camp




**Map 12** % of households reporting areas considered unsafe by boys and men in the community at the time of data collection, by camp



**Map 13** % of households reporting areas considered unsafe by girls and women in the community at the time of data collection, by camp




**Map 14** % of households reporting needing protection services or support, by camp