BANGLADESH

Considering age and disability in the Rohingya response

Life in congested refugee camps is challenging for the 866,457 stateless Rohingya refugees struggling to meet their basic needs (UNHCR 12/2020). For people with disabilities and older people1 living in the camps, such challenges are amplified. People with disabilities and older people struggle to access essential services such as latrines, water points, health centres, and aid distributions because of hilly and flood-prone terrain and a lack of adapted facilities and inclusive interventions. Social stigma is a major barrier preventing access to essential services and participation in community activities and decision-making processes. Exclusion and isolation also greatly restrict access to information or feedback and complaint mechanisms. For individuals requiring mental health and psychiatric care, specialised assistance is limited and there are few qualified professionals available to address the scale of these needs in the camps (ISCG 09/19; ADH, CDD, ASB 2017; DFID 01/2019).

Many people with disabilities and older people rely on the support of their caregivers to meet their basic needs. This requirement for around-the-clock care impacts an entire household's ability to meet its needs. Data collected in 2019 and 2020 indicates that households in the camps with at least one disabled member are among the most economically vulnerable, which has since been worsened by COVID-19 (ISCG 09/19; WFP 04/2020; ACAPS 04/10/2020). Information gaps about disability prevalence and a lack of detailed sex, age, and disability disaggregated data across the humanitarian response impacts the ability to scale up disability-inclusive practices, adjust implementation to support households with people with disabilities and older people, and measure reach and effectiveness.

COVID-19 and the accompanying containment and risk mitigation measures put in place in March 2020 have worsened an already challenging situation. People with disabilities and older people are at greater risk of contracting COVID-19 as they face difficulties in maintaining basic hygiene measures such as handwashing – because of both the lack of accessible handbasins, sinks, or water pumps, as well as the physical constraints of performing the necessary motions for handwashing. Maintaining physical distancing is also difficult because of the additional support needed from caregivers (WHO 03/2020).

People with disabilities may also have underlying health conditions that put them at greater risk of experiencing severe symptoms of COVID-19, and older people are an at-risk group for the virus. People with disabilities and older people also face barriers to accessing appropriate healthcare because of difficulties with transportation, disruptions to services, and – in some cases – compounding social stigma attached to disabilities and to contracting COVID-19.

People with vision, hearing, and intellectual impairments face communication difficulties and barriers to accessing public health information, including problems with fully understanding information about COVID-19 (WHO 03/2020; key informant interview 07/2020).

The primary and secondary impacts of COVID-19 and the associated measures on people with disabilities and older people in the camps are still not fully understood, partly because of data collection challenges and restricted camp access. Many planned data collection efforts were put on hold to comply with containment and risk mitigation measures but have since resumed (key informant interview 07/2020). Remote data collection posed challenges related to representativeness, as phone access among the Rohingya is not consistent and those who have phones struggle with poor network connectivity and are unable to charge their phones regularly (Humanitarian Alternatives 11/2020). Access to phones is limited for people with disabilities and older people (especially women), further marginalising them and resulting in inaccurate findings (UN Women, CARE, Oxfam 05/2020; ACAPS 08/06/2020). Data collection via phone also excludes people with disabilities with special communication needs.

This report evaluates existing data on the Rohingya refugee response. It highlights the key challenges and constraints faced by people with disabilities and older people in accessing essential services and explores how COVID-19 and related containment and risk mitigation measures have affected humanitarian programming for people with disabilities and older people. It also identifies information gaps and challenges linked to disability prevalence in the camps.

1 Questions on household disability prevalence often do not include the Washington Group Short Set of Questions on Disability. Individuals requiring support from another person to complete daily activities are addressed as a group within the response. As a result, data is often collected for people with disabilities and older people together.

KEY FINDINGS

- **COVID-19 has both highlighted and worsened pre-existing challenges** faced by people with disabilities and older people in accessing support and essential services.
- **Disability is often stigmatised, and disabilities hidden or misunderstood** among the Rohingya. This affects access to essential services and community participation.
- **The response is missing essential baseline data and standard use of the Washington Group questions** to collect data on people with disabilities.
- Where data collection is conducted by proxy (through caregivers), additional training for people collecting the data is critical in order to adjust the interview process, so that questions reflect the nuanced experiences of people with different physical and intellectual disabilities.
- **A deeper understanding about the interplay between compounding vulnerabilities and disability is lacking**, as is an understanding of how intra-household dynamics and cultural and social barriers affect the participation of people with disabilities and older people in decision-making, community life, and access to essential services.
- People with disabilities and older people face difficulty accessing essential services because of physical distances and lack of adapted infrastructure. Many require additional support from household or community members to access these services.
- **Many older people with special needs who experience physical limitations may not consider themselves disabled.** Detailed data on humanitarian access specifically for older people (separate from people with disabilities) is limited.
- There is insufficient data on how children with disabilities are affected by child labour and child marriage.
- There is insufficient data on gender-based violence towards women with disabilities and older women in the camps.
- Current distance learning mechanisms used for Rohingya children with disabilities are not adequately reported.

METHODOLOGY

This secondary data review focuses on the Rohingya refugee camps in Cox's Bazar and combines publicly available secondary data with 11 key informant interviews conducted with age and disability experts working on the humanitarian response. The interviews took place between 1 July–30 August 2020 with experts from the UN, national NGOs, INGOs, and the International Red Cross and Red Crescent Movement.

Limitations

This review is designed to provide a contextual overview of the key challenges and constraints faced by people with disabilities and older people that have been worsened by COVID-19. As a secondary data review, it is limited by the lack of existing data on people with disabilities and older people in the Rohingya response. There is insufficient disaggregated data to differentiate between people with disabilities and older people, as the two populations are often grouped together in data collection. As a result, their experiences are often conflated, and they are reported about as a unit. Age itself is not a disability and older people may not consider themselves to be a person with disabilities (ADH, CDD, ASB 2017).

The experts involved in the key informant interviews had limited access to the affected population at the time of the interviews because of COVID-19 containment and risk mitigation measures and faced difficulties with data collection.

LANGUAGE, CULTURAL BELIEFS, AND STIGMA

Disability is a broad term encompassing many types of long-term physical, mental, intellectual, or sensory impairments with varying levels of severity. When interacting with various barriers, these impairments may hinder full, equal, and effective participation in society (UN 03/2007). People with disabilities are a heterogeneous group of individuals with unique and varying needs and challenges, and discussing disability using blanket terms fails to address the nuances that exist in the experiences of people with different disabilities (DFID 01/2019). To understand the experiences of people with disabilities in the Rohingya camps, it is necessary to understand how disability is discussed and viewed in Rohingya society.

The Rohingya believe that some illnesses, diseases, and disabilities are caused by supernatural entities such as spirits and demons (jinn). Rohingya frequently refer to possessions by spirits as an explanation for mental health conditions, and it is a commonly held belief that jinns cause paralysis. It is said that if a jinn attacks a new-born child, they may develop a mental or physical disability. Traditional healers and religious leaders are often consulted rather than medical professionals if a child is born with a disability (UNHCR 2018; BBC Media Action, TWB 10/10/2019). Spirituality is a common and important source for addressing health concerns and trauma within the Rohingya community. The link between spiritual and physical healing and the way medicine is approached by the Rohingya has not been sufficiently studied however, and is poorly understood by the wider humanitarian community (The New Humanitarian 30/07/2018).

Discussing mental health or intellectual disabilities is difficult for the Rohingya as there is limited vocabulary to appropriately refer to mental health conditions (BBC Media Action, TWB

10/10/2019). The terms used to describe emotions, feelings, and thoughts have been adopted from other languages (mainly Urdu), and a range of mental health conditions are referred to using general terms that carry negative social connotations – such as 'faul', which means 'madness' or 'lunacy'. It is easier to discuss physical disabilities with the Rohingya (UNHCR 2018; BBC Media Action, TWB 10/10/2019).

People with physical disabilities also face discrimination and exclusion. Both people with physical disabilities and older people have expressed feelings of rejection and sadness because of limited interaction with the community as a result of their physical isolation. People with intellectual and developmental disabilities are also likely to experience similar isolation and exclusion because of social stigma (UNHCR 2018).

DISABILITY PREVALENCE IN THE CAMPS

Data on people with disabilities that is disaggregated by administrative location, sex, age, and type of disability is not readily available across the response and is not commonly included in larger sector-specific or multi-sector reports, despite the 2020 Joint Response Plan requirements (IOM et al. 03/03/2020). Many of these reports include overall disability prevalence without detailing sex, age, or disability types (ACAPS 04/2019). The collection, analysis, and use of disaggregated data on people with disabilities are essential to inclusive humanitarian action, to ensure at-risk groups are identified and that humanitarian programming is responsive to the risks, barriers, and needs of people with disabilities and considers their capacities (CBM, IDA, HI 12/2019).

There is no widely accepted figure of disability prevalence among Rohingya refugees, neither at the individual nor the household level. Prevalence at the household level in the refugee camps ranges from 3%–14% depending on the assessment (ISCG 07/2020; REACH 11/2019; REACH, UNHCR 07/2019). A recent UNHCR registration exercise (UNHCR 31/10/2020) found that approximately 1% of individuals in the refugee camps are people with disabilities – a stark contrast to the 5% reported by REACH (11/2019). Many assessments also combine different population groups, such as people with disabilities, people with chronic illnesses, and older people (ISCG 12/03/2020; key informant interview 07/2020).

Quantitative data collection exercises often use different methodologies in assessments, and sometimes use different questionnaires in different rounds of the same assessment type (ACAPS 04/2019). Questionnaire design also impacts the way questions can be interpreted and the way answers are provided. For example, a joint Government of Bangladesh and UNHCR registration exercise (UNHCR 31/10/2020) relied on 'yes' or 'no' questions to estimate the proportion of people with disabilities in the camps, finding that 1% of refugees were people with disabilities. Binary questions have limitations that do not reflect the complexities of living with a disability and may exclude individuals with certain types of disabilities. Disability data is also commonly collected by proxy, such as through a household representative. Proxies may be hesitant to discuss disabilities within the household because of the social stigma attached to disability in the Rohingya community, and may not adequately provide the full range of challenges, needs, or preferences experienced or expressed by people with disabilities (REACH 05/2019; key informant interview 07/2020).

INCLUSION OF PEOPLE WITH DISABILITIES AND OLDER PEOPLE IN HUMANITARIAN ASSISTANCE

To understand the direct and indirect impact of COVID-19 and the accompanying containment and risk mitigation measures on people with disabilities and older people, it is important to understand the barriers they faced prior to the pandemic. Accessibility is a precondition to meaningful participation in and access to services by people with disabilities and older people. This means considering accessibility in all aspects of humanitarian interventions and planning adjustments, including budgets, to ensure equal access in areas such as transportation, sign language interpretation, or distribution and use of assistive devices (CBM, IDA, HI 12/2019).

Lack of adapted infrastructure

The lack of adapted infrastructure for people with disabilities and older people in the camps means they struggle to move easily both within and outside shelters and face difficulties accessing healthcare facilities and distribution points (ISCG 09/2019; DFID 01/2019; BBC Media Action, TWB 13/01/2020). Steps at the entrances of structures and shelters are common and are a barrier to entry for people with disabilities and older people, including entry to their own homes and essential facilities (ISCG 07/2020; DFID 01/2019). People with disabilities with assistive devices, such as wheelchairs and walkers, struggle to manoeuvre across uneven floors, through narrow entranceways, and in congested spaces. Inside shelters, the floors are typically lined with natural earth and mats and are as uneven as the terrain they are built on (key informant interview 07/2020). Sleeping on the floor is common in most shelters. This is difficult for people with some types of physical disabilities and older people because of the movement required to lie down and get back up (DFID 01/2019).

In Jadimura camp, handpumps at water points were found to be labour-intensive to use – especially if not built with extended handles – and likely pose challenges for people with disabilities and older people when pumping water. For some people with disabilities and older people, some water container designs are difficult to use, such as buckets and aluminium pitchers. In contrast, narrow jerrycans with thinner handles on top can be carried while using a crutch or other mobility device (DFID 01/2019). A WASH baseline assessment

(REACH 04/2018) and a WASH follow-up assessment (REACH 05/2019) found that the use of disability-inclusive water containers was low across the response.

The primary barrier to accessing latrines is the lack of adapted latrines, which includes accessible light switches, wide and barrier-free entrances (with ramps where appropriate) to allow for assistive devices, colour contrasts so that people with visual impairments can easily identify the latrines, accessible handles and handrails, and sufficient space to accommodate a wheelchair with the door closed and to enable caregivers to assist with access or personal care (DFID 01/2019; key informant interview 07/2020; REACH 04/2018). There have been reports of people with disabilities and older people being kept away from latrines or water points by their families because they are considered to take too much time using the facilities (WASH Sector, ISCG, ADWG 05/2020).

Access and physical distance from essential services

Given the high reliance on both food and non-food distributions in the camps, equal access to distribution sites is essential. Many distribution points are not appropriately adapted to the needs of people with disabilities and older people, however (key informant interview 07/2020; BBC Media Action, TWB 13/01/2020). Long waiting times at distribution points, transportation issues because of heavy loads, and the distance of distribution sites from shelters are among a number of barriers reported by the general Rohingya population (UNHCR 25/11/2020; ISCG 04/2020; ACAPS, REACH 12/2019). These issues are aggravated for people with disabilities and older people who require additional support to access distribution points and often find it difficult to carry food, water, and other relief items home (key informant interview 07/2020). Difficulties carrying relief items (including heavy staple ingredients such as rice and pulses) are compounded by distance and terrain, with many distribution points located too far away for people with disabilities and older people to reach on their own (key informant interview 07/2020; UN Women, CARE, Oxfam 05/2020; WFP 04/2020; DFID 01/2019).

Existing food insecurity has been worsened by the pandemic and the accompanying containment and mitigation measures, with the proportion of households with acceptable Food Consumption Scores (FCS) decreasing by 19% and the proportion of households with poor FCS increasing by 10%. Households with disabled members were more likely to report having to adopt food-based coping strategies, such as relying on less preferred/less expensive food, borrowing from friends and family, and reducing portion size and/or the number of meals a day (ISCG 07/2020).

During the monsoon season, weather events such as windstorms, heavy rains, slope failure (landslide and soil erosion), and flooding impact the ability of households to travel within and between camps to access assistance. COVID-19 and related mitigation and containment measures have reduced access to basic goods and services because of restrictions on movement for both humanitarian organisations and refugees. During the lockdown period that began in March 2020, site development partners were unable to complete their regular pre-monsoon infrastructure reinforcements of bridges and pathways or slope failure mitigation initiatives. As a result, accessing essential services and assistance, including distributions, became even more challenging and dangerous during monsoon season (ACAPS 20/08/2020). A new requirement was put in place for people to collect assistance alone instead of in small groups (UN Women, CARE, Oxfam 05/2020). This measure, implemented to avoid crowding, has worsened challenges faced by people with disabilities and older people because they often need assistance to access distribution sites (ISCG 07/2020; HelpAge International 07/2020; key informant interview 07/2020). Support mechanisms such as a free porter system and the distribution of tote bags were introduced or scaled up (WFP 04/2020), but there have been reports of porters charging a fee or running away with assistance items (NPM 09/2020; ACAPS, IOM 25/08/2020). New methods of distribution have also resulted in heavier packages for people to carry.

Physical tasks – such as carrying/pumping water or travelling long distances along challenging terrain to reach facilities or services – are difficult for people with disabilities and older people. This is a key factor hindering access to WASH and other essential services (DFID 01/2019). Most water points in the camps are within 200 metres of individual shelters; however, refugees have reported spending a significant amount of time (more than 30 minutes) to access functional water points, suggesting that distances are longer or there is difficult terrain (DFID 01/2019; WASH Sector 08/2018; REACH 30/10/2018; IOM 09/2018; UNHCR 2015).

Accessing healthcare is also challenging for people with disabilities and older people because of the lack of physically accessible or adapted healthcare facilities, particularly for people who cannot easily leave their homes (DFID 01/2019; key informant interview 07/2020). For many people with disabilities and older people who could not access camp clinics prior to COVID-19 because of distances or difficult terrain, the pandemic and related restrictions made it harder for them to access medicine and health services (Health Sector 19/05/2020; key informant interview 07/2020). Key informants also noted that physical support provided to people with disabilities was stopped at the height of COVID-19-related restrictions. They suggested that as a result, people with disabilities and older people were more likely to struggle with mental health issues because the movement restrictions had worsened isolation.

Communication and access to Information

People with difficulty communicating may not understand COVID-19 or other messaging if communication tools are not adapted accordingly (SKUS 18/07/2020). Even prior to the pandemic, reduced exposure to mass media and to awareness-raising initiatives reduced the ability of people with disabilities and older people in the camps to fully understand

information shared by the humanitarian response. When the pandemic struck, they were less informed of preventative hygiene/social measures for COVID-19 (WASH Sector, ISCG, ADWG 05/2020). A lot of messaging in the camps occurs via microphones, tomtoms (electronically powered rickshaws), information signs/boards, and posters, limiting its reach to people with access to public spaces and leaving out those who cannot readily access these spaces – including people with disabilities and older people. It is especially difficult for such messaging to reach people with compounding vulnerabilities, such as women with disabilities (ACAPS, IOM 27/04/2020). The lack of alternative communication methods from frontline actors in the camps is a barrier for people with disabilities with communication constraints (ACAPS, IOM 31/05/2020). COVID-19 has also had an unexpected impact on some people with disabilities: for example, lip reading was one of the most common forms of communication for people with hearing disabilities, which has become difficult since masks are used to mitigate the spread of the virus.

Social inclusion and protection

The Rohingya are exposed to numerous and ongoing protection risks, such as sexual and gender-based violence, psychological distress or trauma, human trafficking, and child labour and marriage (Frontline Negotiations 15/07/2020). Many of these were heightened by COVID-19 and the accompanying containment and risk mitigation measures, which resulted in increased tensions within households, between Rohingya communities, and between the Rohingya and the host community (ISCG 04/2020; UN Women, CARE, Oxfam 05/2020). Restrictions also negatively affected humanitarian access and protection programming (Frontline Negotiations 15/07/2020). People with disabilities are especially vulnerable and require additional protection considerations (key informant interview 07/2020). Globally, girls and young women with disabilities are ten times more likely to experience gender-based violence than those without disabilities, and girls with intellectual disabilities are particularly vulnerable to sexual violence (UNFPA 07/2018). The social and economic disadvantages in camp contexts are a compounding factor for existing vulnerabilities, and Rohingya girls and women with disabilities are likely more vulnerable to gender-based violence.

The lack of social inclusion of people with disabilities because of stigma has been identified as a possible reason for the increased risk for young people with disabilities of being trafficked, either for sexual or other forced labour (UNFPA 07/2018). Community participation plays a large role in protection; an individual's interaction with their surrounding social system affects mental health and wellbeing while simultaneously providing a support network that acts as a protection mechanism (DFID 01/2019). People with disabilities and older people tend to face barriers to community participation however, removing an important element of social protection for an already at-risk demographic (DFID 01/2019; key informant interview 07/2020).

COMPOUNDING VULNERABILITIES

People with disabilities and older people can experience multiple vulnerabilities simultaneously, resulting in compounding vulnerabilities. Each experience is different, and some people with disabilities and older people are more vulnerable or experience more or different physical and social barriers than others. This is a result of a multitude of individual and household factors, such as the type of disability, age, environment, gender, socio-economic status, or the characteristics of their household. In the Rohingya context, children, adolescents, adult women, and older people with disabilities are at higher risk of being excluded from humanitarian assistance than male people with disabilities of working age (WASH Sector, ISCG, ADWG 05/2020).

Households with people with disabilities or with members that have additional needs (such as chronic illnesses) may also face compounding vulnerabilities. It is important not to conflate vulnerabilities at the individual and household levels, however (ACAPS 04/10/2020). Households with people with disabilities and/or members with chronic illnesses, such as older people, generally incur higher costs because of additional medical expenses (ISCG 07/2020). Data collected in 2019 in the camps indicated that households containing at least one member (aged five and above) who required assistance to complete daily activities were more likely to report not making improvements to their shelter, despite reporting the need to do so, because of financial hardship (ISCG 07/2020; ISCG 09/2019; BBC Media Action, TWB 13/01/2020). The temporary halt to activities carried out by Shelter Sector partners because of COVID-19 resulted in a 100% increase in shelters being reported as damaged, compared to the same period in 2019 – despite similar rainfall levels (ACAPS et al. 20/08/2020). Households that previously struggled to upgrade their shelters as a result of financial hardship will be less likely to be able to afford repairs post-pandemic because of medical expenses, loss of income, or both (ACAPS 04/10/2020). The pandemic worsened overall vulnerability within the camps, preventing income-earning household members from working. This compounded existing financial difficulties, especially among households with people with disabilities, members with chronic illnesses, and older people who may require additional medical attention (ISCG 07/2020).

Understanding how gender affects disability is key when designing accessible interventions. The number of women and girls with disabilities in the camps risks being underreported because of barriers to adequate representation, potential neglect by caregivers, social barriers that impact female mobility among the Rohingya, and social and physical barriers that are commonly faced by people with disabilities and/or older people (key informant interview 07/2020). Rohingya female-headed households are already generally more vulnerable because of the combination of sociocultural norms, the governance structure within the camps, safety and security issues, gender-based violence, lack of

gender-responsive facilities, and existing assistance and service delivery methods that make accessing assistance and services challenging for women (ACAPS 12/2019; UN Women, CARE, Oxfam 05/2020). Female-headed households with disabled members or households headed by women with disabilities experience compounding vulnerabilities that worsen existing vulnerabilities with regards to food security, economic status, and protection (ACAPS 04/10/2020; WFP 04/2020).

Female-headed households with at least one disabled member or older person requiring assistance with daily tasks participated less in income-generating activities, which is significantly correlated with higher levels of vulnerability (WFP 04/2020; ACAPS 04/10/2020). These households also relied more on negative coping mechanisms to meet their basic needs. For example, prior to COVID-19, female-headed households with at least one disabled member were more likely to borrow food (61%) than male-headed households with a disabled member (38%) (WFP 20/04/2020). As income-generating activities were halted or scaled down to mitigate the spread of COVID-19, any access to income that female-headed households or women with disabilities had prior to the pandemic was diminished or ended, further limiting their ability to access essential services as they were unable to pay transportation costs or pay porters for support in carrying distribution items (although this service is intended to be free). These households were more likely to shift from coping mechanisms such as borrowing food and money and selling distribution items to extreme coping mechanisms, such as selling labour in advance, child labour, or early marriage (ACAPS 04/10/2020).

As mentioned earlier, people with disabilities and older people often face difficulties accessing WASH facilities. Even under normal circumstances, Rohingya women – both with and without disabilities – struggled with safe access to latrines and bathing facilities because of overcrowding and safety concerns. To avoid harassment and waiting in line with unknown men, many women and girls would access WASH facilities at strategic times when men and boys were unlikely to be there, such as working hours during the day (UN Women, CARE, Oxfam 05/2020). In 2020, Rohingya women reported challenges in accessing shared latrines during the day, because men were at home all day as opposed to being at work – as a result of COVID-19 movement restrictions. Women also struggled to wash and dry menstrual cloths because of stigma around menstruation and reported difficulties accessing adequate menstrual hygiene items (ACAPS, IOM 04/2020). For women with disabilities, this access constraint was likely further worsened by the fact that people with disabilities and older people are often kept away from WASH services by family members or caretakers, because of the amount of time they spend using the facilities (WASH Sector, ISCG, ADWG 05/2020).

COVID-19 movement restrictions, the drastic reduction in the presence of humanitarian actors in the camps, and the suspension of most protection services not considered essential led to a spike in protection concerns. Higher instances of tension and violence against women within the household were reported, associated with confined living conditions and stress stemming from a sudden loss of income (UN Women, CARE, Oxfam 05/2020). People with disabilities and older people also likely experienced an increase in protection concerns, especially women with disabilities and older women, given the existing discrimination and stigma they face (ACAPS 04/10/2020). The socio-economic impacts of COVID-19 also disproportionately affected at-risk women and girls and further hindered safe access to gender-based violence services. The specific impact on women with disabilities is yet to be explored (UNHCR 06/2020; Frontline Negotiations 15/07/2020).

Experiences of living with disabilities vary with age. While it is widely suggested that disability rates rise as age increases – and age and disability are therefore frequently grouped together in data collection and analysis (REACH 11/2019) – **age itself is not a disability and older people may not consider themselves to be a person with a disability,** despite experiencing physical limitations and having specific needs (ADH, CDD, ASB 2017). Older people with disabilities are more likely to experience difficulties accessing humanitarian assistance than other people with disabilities or the general population, because of their compounding vulnerabilities and the stigma of both older age and disabilities (WASH Sector, ISCG, ADWG 05/2020).

Older people are also at greater risk of requiring hospitalisation or dying if they contract COVID-19. As a precautionary measure, many older people were further isolated, and movement restrictions negatively impacted access to services that was already limited. A survey across five camps in May 2020 found that 81% of 121 older people (aged 60+) had reduced the quantity of food they consumed because of COVID-19, attributed to factors such as loss of household income and an inability to collect assistance independently. 27% of older people also reported being unable to maintain distance from others, rendering them more vulnerable to contracting the virus, and 31% said they were unable to wash their hands properly (HelpAge International 07/2020). Anecdotal evidence suggests forgetfulness linked to dementia, along with inadequate WASH facilities and not fully understanding COVID-19 messaging, were factors contributing to the inability to comply with COVID-19 measures (WASH Sector, ISCG, ADWG 05/2020). These challenges are likely worse for older people with disabilities who require more household support to access assistance and who are more vulnerable to social isolation (ACAPS 04/10/2020).

CHILDREN WITH DISABILITIES

Children and youth with disabilities in the camps generally receive less attention from teachers and have lower education outcomes than their peers (USAID 10/2018). Prior to COVID-19, the attendance rate for children with disabilities at learning centres was lower than that of their peers; only 19% of children aged 3 to 5 and 53% of children aged 6 to 14 with a disability attended learning centres, compared to 65% and 73% of their peers without a disability (REACH 11/2019). A 2019 education needs assessment found substantial physical access constraints for children with disabilities, as well as worrying levels of verbal and physical abuse from peers and teachers at learning centres (REACH 03/2019; UNFPA 07/2018). The main barriers impeding access to education include a lack of: essential physical adaptations, such as accessible WASH facilities, ramps, and classrooms; appropriate lighting for children with visual impairments; blackboards adjusted at appropriate heights; and accessible play areas where children with disabilities can play with others (REACH 03/2019). Other barriers, such as difficulties getting to class, are caused by the difficult topography in the camps, obstacles along the way, and distance. Learning materials and teaching methods are also rarely adapted for children with disabilities with communication impairments and learning difficulties, and very few staff reported receiving training to support children with disabilities.

Even prior to the pandemic, the lack of inclusive learning environments discouraged children with disabilities from accessing education (REACH 03/2019; DFID 01/2019; key informant interview 07/2020). In line with the Government of Bangladesh's decision to close schools nationwide in response to COVID-19, learning facilities in the camps were closed in mid-March 2020. For the Rohingya, opportunities to resume learning online are difficult and distance learning alternatives are limited to exercise books and home tutoring (HRW 22/10/2020). Many students may not receive appropriate support for home tutoring as the adults in their household may not have received adequate education themselves. Students with disabilities are further marginalised because the available distance learning options are not always adequately adapted to meet their needs or because their households are unable to support remote learning. This is especially true for girls with disabilities, who are among the most marginalised – among both people with disabilities and the general population – because of social and gender norms and bias around both disability and gender (UNESCO 04/06/2020).

Time out of school has long-term ramifications on education; data indicates that the longer children remain out of school the less likely they are to return (UNICEF 06/2020; key informant interview 07/2020). Because of the economic impacts of COVID-19, parents are more likely to withdraw their children from education and children with disabilities are more likely to be withdrawn than their peers – as a result of the perceived lack of value in educating children with disabilities and the logistical burdens and costs related to sending them to class. As children with disabilities are less likely than other children to understand or be able to enforce social distancing and hygiene practices, parents may also be afraid to send their children back to learning facilities, further contributing to their risk of never completing their education or worsening their vulnerability to numerous protection risks.