Australian Government
Department of Foreign Affairs and Trade

ISCG INTER SECTOR COORDINATION GROUP | Rohingya Refugee Response Bangladesh

handicap international | humanity &inclusion

Report

Sector-Specific Barriers and Enablers Assessment

December 2024

A child with a disability entering his shelter using a bamboo handrail. © HI

Handicap International Federation - Humanity & Inclusion

Acknowledgment

The Barriers and Enablers assessment report is published by Humanity & Inclusion (HI), with financial support from DFAT (Department of Foreign Affairs and Trade). We extend our heartfelt gratitude to all organizations and individuals who contributed to the successful completion of the Barriers and Enablers Assessment in the Rohingya refugee camps of Cox's Bazar. This assessment would not have been possible without the unwavering support and collaboration of people with disabilities, ISCG, ADTWG, Sectors, United Nations agencies, international and national non-governmental organizations (I/NGOs).

We are especially thankful to people with disabilities and their caregivers, who shared their invaluable insights, experiences, and perspectives, enabling a comprehensive understanding of the challenges and opportunities in ensuring an inclusive humanitarian response.

Twenty-three key informants and twenty focus group discussions, desk reviews and observational visits at ten service points contributed to this report by sharing their knowledge and experience. Finally, we acknowledge the tireless efforts of field teams, local stakeholders, and volunteers who facilitated this process with professionalism and dedication.

HI would like to express its deepest gratitude to all contributors, acknowledging not only the quality of their input but also their constructive team spirit and their commitment to promoting disability-inclusion.

Contents

List of Acronyms

ADTWG	Age and Disability Technical Working Group
CDD	Centre for Disability in Development
CRPD	Convention on the Rights of Persons with Disabilities
DI	Disability Inclusion
DFAT	Australian Department of Foreign Affairs and Trade
FSS	Food Security Sector
GBV	Gender-based violence
IASC	Inter-Agency Standing Committee
IEC	Information, Education, and Communication
LSDS	Livelihood and skills development Sector
OPD	Organization of Persons with Disabilities
SCCCM	Shelter – Camp Coordination and Camp Management
UNHCR	United Nations High Commissioner for Refugees
WGFS	Women & Girl Friendly Space
WGQ	Washington Group Questionnaire

Executive Summary

Overview of the Context

In response to the refugee influx in Cox's Bazar, national and international organizations, alongside the Government of Bangladesh, have been delivering humanitarian assistance since 2017. According to the REACH survey conducted in the Rohingya refugee camps in Cox's Bazar, the overall prevalence of persons with disabilities (aged 2 and above) was 12%. The survey also found that 76% of persons with disabilities faced difficulties moving around the camp. These challenges are often heightened during humanitarian crises, where conflicts and disasters increase the risk of disability and exacerbate existing barriers due to factors such as hilly terrain, lack of adapted facilities, and limited inclusive interventions.

Globally and nationally, HI is the leading agency in disability inclusion providing services to remove barriers and to ensure meaningful participation of persons with disabilities. In the humanitarian response of the Rohingya people, HI is currently implementing the project titled "Improving disability inclusion in the Rohingya and Host Communities Humanitarian Response" funded by the Australian Department of Foreign Affairs and Trade (DFAT). Numerous barriers prevent men, women, girls, and children with disabilities from fully and equitably accessing and participating in basic services. The project conducted the Barriers and Enablers Assessment to identify the barriers (focusing on the four major inclusion barriers: Environmental/ Physical, attitudinal, communication and institutional) that persons with disabilities face when accessing humanitarian assistance across five sectors in the Rohingya camp: Health, Protection, LSDS, SCCCM, and FSS.

Due to the functional impacts of their specific impairments, persons with disabilities may face various barriers in their physical and social environments. Barriers are those aspects of society that, either intentionally or unintentionally, exclude people with disabilities from full participation and inclusion in society.

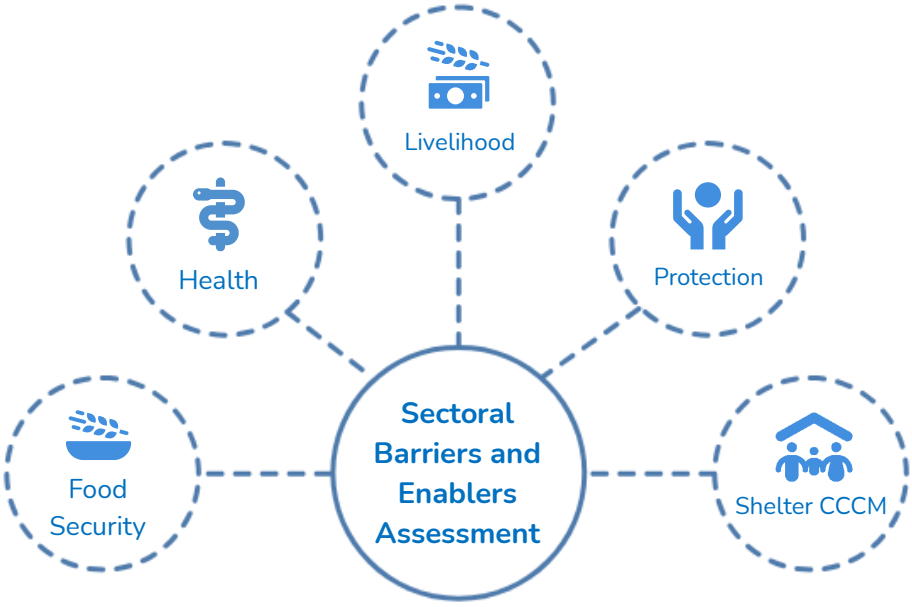

Photo: An older person with disabilities cautiously using an axillary crutch to go down the stairs in a Rohingya camp. © HI

Barriers experienced by persons with disabilities

1. Lack of awareness and understanding of disability inclusion among families, communities, educators, humanitarian staff, and government officials, contributing to stigma and marginalization.
2. Physical barrier for persons with disabilities accessing humanitarian services (Health, protection, LSDS, SCCCM, FSS) due to uneven terrain and lack of basic accessibility features like ramps and toilets.
3. Persons with disabilities face also significant barriers to accessing services at the point of delivery, due to long waiting times, lack of specialized services, and inadequate support from caregivers and community members.
4. Women and children with disabilities face additional barriers, including limited decision-making power, stigma, and exclusion by external organizations.
5. Lack of understanding of disability among staff, leading to discriminatory attitudes and behaviors, as well as limited support, such as the absence of assistance for persons with disabilities to reach services, exacerbating these challenges.
6. Information is not provided in an accessible format, leaving persons with disabilities unaware of available services or how to access them.
7. Humanitarian organizations prioritize disability inclusion less, lacking policies and accountability mechanisms.
8. Gaps in data and identification processes result in persons with disabilities not being identified and exclusion from services.
9. Economic challenges and limited income opportunities increase vulnerability. Persons with disabilities are often excluded from program design and planning.
10. Lack of adequate training for humanitarian staff on disability inclusion leads to unintentional exclusion during program implementation

Sector Specific Barriers and Enablers

Food Security Sector (FSS)	
Barrier	✓ The main challenge, reported by 48.4%, is the long distance to distribution points and non-adapted distribution mechanisms. Additionally, 26.06% noted difficult terrain (uneven, hilly, or muddy) contributing further to the distance, and 17.55% cited a lack of accessible infrastructure such as the absence of handrails, improper ramp gradients, lack of accessibility in toilets, absence of clear and inclusive signage or symbols, limited accessible communication techniques etc. These findings suggest that while ramps are present in many locations, comprehensive accessibility is still lacking in certain aspects that are essential for persons with diverse disabilities. ✓ Lack of Support and Service Limitations: 20.21% reported no assistance with carrying heavy food items or transportation support. 12.77% faced long wait times, 10.11% were physically unable to carry food packages.
Enabler	✓ Participants experienced respectful behavior at distribution points, with WFP and partners improving access through ramps, priority service, fresh food support, and porter services. ✓ HI trained staff on disability inclusion, enhancing sensitivity, while IOM with support of AD TWG conducted accessibility audits and provided design recommendations.

Photo: An inaccessible entry point in front of a food distribution center in the Rohingya camp. © HI

Sector Specific Barriers and Enablers (Cont.)

Health Sector	
Barrier	✓ Inaccessible infrastructure –Health services are located in distant locations (34%) which is further exacerbated by the uneven and hilly terrain providing inaccessible routes to reach services (47.87%). ✓ Inaccessible facilities - 35.64% reported that health posts lack essential accessibility features like ramps, handrails, and accessible washrooms, in addition 63.3% reported long wait times without adaptations to supports persons with disabilities. ✓ Limited institutional support and inclusion – 27.13% of respondents stated that health posts do not meet their specific needs, such as assistive device provision and have less capacity, funding, and disability data, leading to inadequate health services. ✓ Lack of awareness and attitudinal barriers – Discriminatory behavior from staff was reported by 15.96%, and concerns about staff capacity to support persons with disabilities were noted. Moreover, 11.17% of individuals lack someone to accompany them to health facilities, further restricting access.
Enabler	✓ Some health facilities near shelters offer priority lines and basic accessibility features, though universal design is lacking. ✓ HI and CDD trained staff on inclusive data collection and community support, and advocacy improved referrals to specialized services.

Livelihood and Skills Development Sector (LSDS)	
Barrier	✓ 59.57%, is the lack of accessible information about LSDS services. Additionally, qualitative feedback revealed that staff often avoid communicating with persons with disabilities, further contributing to exclusion. ✓ 27.13% experienced negative attitudes from community members, fostering social exclusion and discouraging participation in LSDS activities. 7.98% also noted that programs often lack suitable activities tailored to their needs. ✓ Physical access is hindered by lack of transportation (10.64%), distant service locations (9.54%), inaccessible infrastructure (9.04%).
Enabler	✓ In Teknaf, HI facilitated inclusive training in gardening, tailoring, carpentry, and crafts. ✓ Participants reporting respectful behavior from staff and inclusive experiences.

Sector Specific Barriers and Enablers (Cont.)

	Protection Sector
Barrier	✓ Persons with disabilities, especially women, are often unaware of available social protection services due to inaccessible information and mechanisms. The most reported issue was limited outreach, with 37.23% indicating inadequate door-to-door or community-based services. Additionally, 13.80% said they were excluded from sessions or programs due to lack of invitation or awareness, and 9.20% were unaware of their eligibility to participate. Challenges to reach and enter Women and Girls Safe Spaces (WGSS), with 31.94% reporting inaccessible infrastructure (e.g., lack of ramps or wide doorways) and 31.38% citing difficult pathways.
Enabler	✓ Participants joined events and life skills sessions, with agencies referring persons with disabilities to HI for support. ✓ Protection actors and PERU volunteers received training in disability inclusion and DIDRR, while community actors distributed assistive devices and improved accessibility with HI's support.

	Shelter – Camp Coordination and Camp Management (SCCCM) Sector
Barrier	✓ Inaccessible shelter and camp infrastructure – The top concern, reported by 44.68%, was inadequate space within shelters, limiting movement and storage of assistive devices. 27.66% also noted that narrow doorways restrict access for those using mobility aids. ✓ Lack of Accessible Facilities and Infrastructure: 39.36% cited the absence of accessible toilets and bathing areas nearby, while 36.17% reported missing features like ramps and handrails. 21.28% highlighted uneven and slippery pathways, and 28.72% pointed to poor lighting in communal areas, affecting nighttime safety. ✓ 11.17% of respondents shared that staff were unwilling to provide necessary assistance, indicating a lack of awareness of accessibility requirements, limited understanding, and a limited opportunity for training on disability inclusion among humanitarian actors, which leads to exclusion of people with disabilities.
Enabler	✓ Participants noted respectful behavior from staff and the formation of Disability Inclusion & Support Committees amplified voices of persons with disabilities ✓ Some agencies installed ramps and handrails following advocacy and consultations, and while some site staff were trained by HI, coverage remains inconsistent

Key Recommendations

Sector (Humanitarian Actors, Sector Leads)

- **Policy & Planning:** Integrate disability-specific actions in sectoral strategies and assessments including disability-inclusive indicators and dedicated budgets.
- **Infrastructure:** Design facilities like WASH units, health posts, learning centers, and distribution points using universal design principles. Conduct regular accessibility audits and address gaps in physical infrastructure.
- **Data & Assessment:** Use Washington Group Questions (WGQs) in all household and service assessments to identify persons with disabilities. Conduct participatory assessments that involve persons with different types of disabilities directly.
- **Communication:** Disseminate information in formats like large print, pictorial messages, sign language, and audio recordings. Install visual signage (high contrast, pictorial) at key service points.
- **Accountability & Coordination:** Engage persons with disabilities and their representative groups in planning, monitoring, and evaluation processes. Ensure all feedback mechanisms are accessible (e.g., hotlines with sign language, easy-to-read formats).
- **Capacity Building:** Train frontline staff, volunteers, and sector leads on rights-based disability inclusion. Include practical modules on communication with people with cognitive, sensory, or speech impairments.

Disability-Focused Organizations

- **Advocacy & Representation:** Advocate for and represent disability inclusion concerns in coordination platforms, joint assessments, and monitoring visits.
- **Technical Support:** Review and co-development of assessment tools, awareness and communication/IEC materials, infrastructure design, and referral systems to ensure inclusivity and accessibility.
- **Capacity Building:** Facilitate capacity-building sessions for humanitarian actors on disability inclusion, community engagement, and inclusive humanitarian action to strengthen understanding and practice on the concept of disability and inclusion.
- **Awareness & Engagement:** Organize or co-lead inclusive community dialogues with persons with disabilities, Mahjis, and Imams to reduce community stigma and promote disability rights.

Community (Including Persons with Disabilities, Caregivers, Community Influencers)

- **Participation & Voice:** Join in focus group discussions, need assessments, and community coordination meetings to share experiences and needs. Mobilize persons with disabilities to use and promote feedback & complaint systems and raise voice about inclusion gaps.
- **Leadership & Influence:** Collaborate with Mahjis, Imams to reduce stigma and promote disability inclusion.
- **Referral & Feedback:** Support referrals of persons with disabilities for need based services and provide feedback on access to services.

1. Introduction

The Rohingya camps in Cox's Bazar are overcrowded and located in hilly, landslide-prone areas, putting refugees at significant risk and sometimes hindering their access to essential services. Despite the humanitarian community stretching its resources to meet refugees' needs, the situation is worsening, with escalating social and security issues. The Government of Bangladesh considers the refugee presence temporary, anticipating returns when conditions in Myanmar allow, but the ongoing conflict in Rakhine State may delay this process. According to the February 2025 Joint Government of Bangladesh–UNHCR Population Factsheet, nearly one million Rohingya refugees (51% female and 49% male) reside in Cox's Bazar, Bangladesh, which hosts the world's largest refugee camp.[1] Of this population, 48% are adults, while 52% are children.

Upon arrival, they faced dire conditions, including overcrowded shelters, limited access to clean water, food, healthcare, and education. While the situation has stabilized in some respects due to coordinated humanitarian responses, challenges persist, particularly for persons with disabilities. Individuals with disabilities often face compounded barriers, including inaccessible infrastructure, a lack of inclusive communication, and stigma, which significantly hinder their ability to access essential services across sectors such as health, protection, education, WASH, and livelihoods.[2]

Considering the prevalence of disability, the 2021 REACH Study reported that overall, 12% of the Rohingya population, across both genders, are persons with disabilities. Additionally, the prevalence of disability increases with age, ranging from 2% among children aged 2–4 to 51% among older persons aged 60 and above.[3] A similar disability prevalence rate was revealed in the findings of Inter-Sector Needs Assessment report published in February 2025, which highlights that 12% of Rohingya individuals have at least one disability. Difficulty in walking and climbing steps is the highest reported disability at 7.2%, followed by difficulty in seeing even after wearing glasses at 4.6%, difficulty with self-care at 4.4%, difficulty remembering or concentrating at 3.9%, difficulty hearing even after wearing a hearing aid at 2.8%, and difficulty understanding or being understood at 2.14%.[4]

The World Health Organization (WHO) estimates that around 16% of the world's population has a disability, with 70% of these individuals living in the Asia and Pacific region. Among women, 19% have a disability, compared to 12% for men.

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[1] Joint Government of Bangladesh & UNHCR. (2025, March 19). *Joint Government of Bangladesh - UNHCR Population Factsheet as of February 2025*. UNHCR. https://data.unhcr.org/en/documents/details/115200

[2] Humanity & Inclusion. (2019). *Inclusive services for persons with disabilities in Jadimura Camp, Cox's Bazar*. Humanity & Inclusion. https://www.hi.org/sn_uploads/document/BP_inclusion_bengladesh-V3.pdf

[3] UNHCR Bangladesh Operational Dashboard 2023: available at: https://data2.unhcr.org/en/situations/myanmar_refugees

[4] Inter-Sector Coordination Group (ISCG). (2025, February). *Inter-Sector Needs Assessment (ISNA) – Rohingya Camps, Cox's Bazar*. https://data.unhcr.org/en/documents/details/115200

This discrepancy is even greater in lower-income countries, where 22.1% of women have disability, partly due to longer life expectancy and inequality in service access.[5]

Despite ongoing humanitarian efforts, persons with disabilities in Cox's Bazar continue to face disproportionate challenges in accessing and participating in essential services. This assessment aims to identify the key barriers and enabling factors that influence disability inclusion within the humanitarian response. In this context, Humanity & Inclusion (HI) a global leader in promoting disability rights and inclusion—has been actively working to address these challenges and foster meaningful participation. The findings of this study aim to support these efforts by providing evidence-based recommendations to enhance inclusive practices and uphold the rights and dignity of persons with disabilities throughout the response.

1.1 Current Situation of Persons with Disabilities: Perception and Barriers

According to the age and disability inclusion need assessment 2021 by REACH, the prevalence of persons with disabilities (aged 2 and above) in the Rohingya camps is 12%, with no gender differences, though prevalence increases with age and ranges from 6% to 19% across camps. Persons with disabilities, particularly those with self-care, mobility, or upper-body movement challenges, face significant barriers, including difficulty moving within shelters, accessing bathing and latrine facilities, and traveling to services due to long distances and lack of assistance. Participation in meetings and opportunities to provide feedback on services remain low, especially among those with self-care difficulties. These findings highlight critical gaps in accessibility and inclusion.[6]

Persons with disabilities and their families face heightened risks of poverty, unemployment, poor health, and limited access to income generating activity and the major difficulty is to lack of appropriate information regarding service availability in the camp as well as livelihood opportunity. These challenges are more severe for women and girls with disabilities, who endure intersecting discrimination, including cultural expectations. They are disproportionately affected by systemic, structural, and associative biases, such as employers perceiving them as less productive caregivers. Women with disabilities also face greater violations of their sexual and reproductive health rights and have triple the illiteracy rate and double the unemployment rate compared to men with disabilities.[7]

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[5] Asian Development Bank. (2024, May). *Gender equality and disability inclusion: Guidelines to address the specific needs of women and girls with disabilities*. https://www.adb.org/sites/default/files/publication/970411/gender-equality-disability-inclusion-guidelines.pdf

[6] REACH. (2021, May). *Age and disability inclusion needs assessment: Rohingya refugee camps, Cox's Bazar, Bangladesh*. https://www.impact-repository.org/document/reach/17afa088/REACH_BGD_Report_Age-and-Disability-Inclusion-Needs-Assessment_May-2021.pdf

[7] Asian Development Bank. (2024, May). *Gender equality and disability inclusion: Guidelines to address the specific needs of women and girls with disabilities*. https://www.adb.org/sites/default/files/publication/970411/gender-equality-disability-inclusion-guidelines.pdf

The humanitarian sector has frequently overlooked the needs of persons with disabilities, leading to their isolation and exclusion from vital assistance. This marginalization often results in increased suffering, loss of independence, and even life-threatening consequences. As such, integrating disability inclusion into humanitarian programming is vital to ensure that persons with disabilities receive the necessary support to survive and thrive, particularly in emergency situations.

The recent Inter-Sector Needs Assessment (ISNA) conducted by the ISCG reveals that 79.21% of persons with disabilities face challenges in accessing humanitarian assistance, primarily due to physical and communication barriers. The assessment highlights critical gaps, including insufficient disability inclusion across all sectors, limited accessibility within the camps, inadequate access to information, and the absence of mechanisms for persons with disabilities to voice their concerns or take on leadership roles. Addressing these gaps is essential to ensure equitable access and promote meaningful participation of persons with disabilities in humanitarian efforts.[8]

Accessibility audit/ Observation findings

- Persons with disabilities often face challenges accessing food distribution points due to the distances required to travel to access, uneven terrain, lack of ramps, inadequate signage and lack of technical capacity of staff and volunteers to meet specific needs. These obstacles hinder their ability to receive aid independently.
- Health facilities are commonly inaccessible to Person with disabilities, with lacking handrails, width doors, ramps, accessible toilets, and clear signage. Additionally, healthcare providers often lack training in communicating effectively with Person with disabilities, leading to inadequate care.
- Training centers often lack necessary accommodation, such as accessible entrances, assistive devices and materials in alternative formats, limiting Persons with disabilities participation in skill development programs.
- Protection centers are often not equipped to accommodate People with disabilities, with physical barriers and a lack of trained staff hindering their access to protection services.
- Major distribution points often lack accessible infrastructure, including ramps, wide doorways, and appropriate signage, making it difficult for disabilities to access essential services.

[8] ISCG, Inter-Sector Needs Assessment (ISNA), February 2025.

Initially, the rights and specific needs of persons with disabilities were often overlooked. Distribution points, safe spaces for women and children, and sanitation facilities in the camps are challenging for individuals with physical impairments to access or use. Many infrastructures have steps, narrow entrances, lack of universal signage and latrine blocks that are too cramped to accommodate personal assistance. Additionally, stigma and discrimination within the Rohingya community prevent persons with disabilities from leaving their makeshift shelters, effectively rendering them invisible. This isolation increases their vulnerability, exposing them to heightened protection risks, exploitation, and abuse.[9]

Most stakeholders interviewed for this study were aware of the multiple forms of discrimination and barriers that persons with disabilities experience daily and were actively working towards reducing the above-mentioned barriers. Several organizations entered partnerships with international and national disability-focused organizations to strengthen their own capacities on including persons with disabilities in their programming.

Organizations are also increasingly reaching out to the Age and Disability Technical Working Group (ADTWG) to seek technical support on the inclusion of persons with disabilities in their response. Many humanitarian actors in Cox's Bazar have recently started changing their practices, though further sustained efforts are needed to mainstream disability into their programmes, organizational structures and the wider humanitarian response, in order to ensure the inclusion of persons with disabilities in humanitarian action.

What You Need to Know

Persons with disabilities include those who have **long-term sensory, physical, psychosocial, intellectual or other impairments that, along with various barriers, prevent them from fully and effectively participating in society on an equal basis with others.**

According to the World Health Organization, an estimated 1.3 billion people – about **16 percent** of the global population – currently experience significant disability.

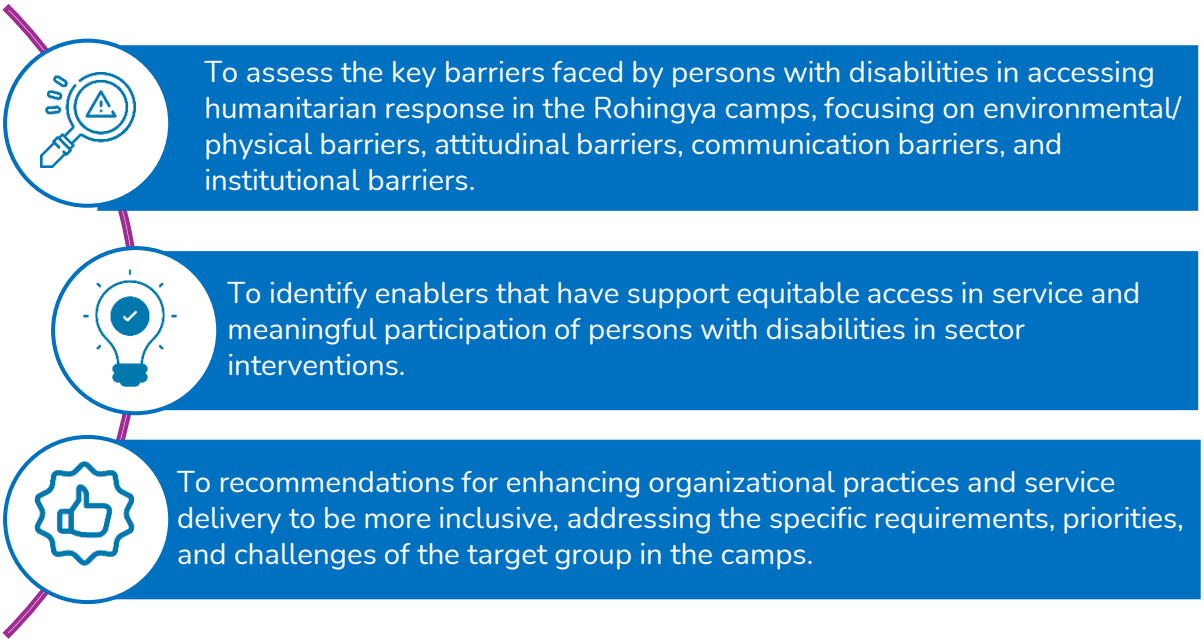
1.3 billion people have a disability globally.

Estimates show that **18 percent** of the female population have a disability compared to **14.2 percent** of the male population.

More than **80%** of persons with disabilities live in developing and the world's poorest countries.

[9] Funke, C. (2020, October 6). *Strategic partnerships and disability-inclusive humanitarian action: The Rohingya refugee response in Bangladesh*. Humanitarian Practice Network. https://odihpn.org/publication/strategic-partnerships-and-disability-inclusive-humanitarian-action-the-rohingya-refugee-response-in-bangladesh/

2. Objective of the Assessment



3. Methodology

The assessment was designed in close coordination with ADTWG and thematic experts active in the response. According to the need for a response, the assessment has been carried out. The barriers and enablers assessments have utilized qualitative approaches, including:

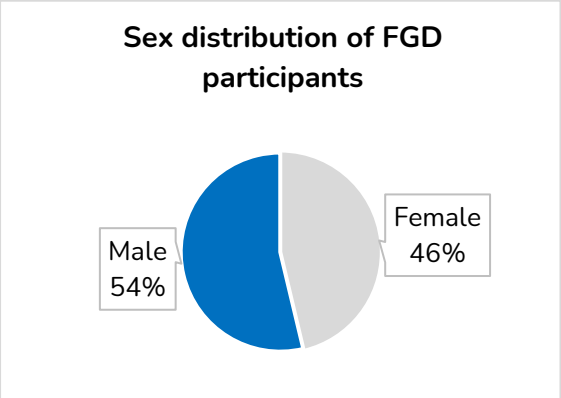
Focus Group Discussions (FGD) n= 20 FGD	Key Informant Interviews (KII) n= 23 KII	Desk Reviews	Access Audits (Observational) n= 10 Location

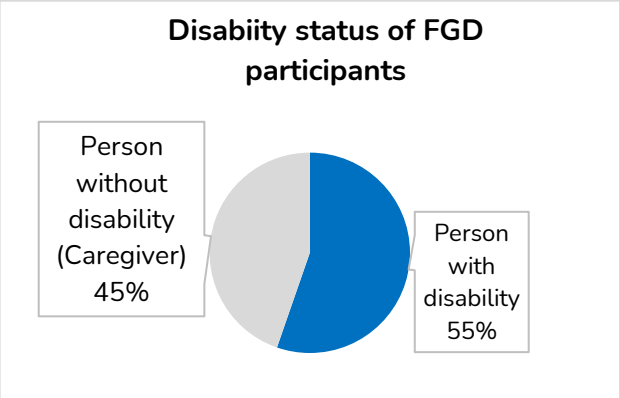
Convenient sampling has guided the selection of participants for FGDs and KIIs. The findings will be shared and presented in a participatory workshop to establish a common understanding of the results, secure sector endorsement, and provide recommendations. As part of the methodology, HI was undertaking the following tasks:

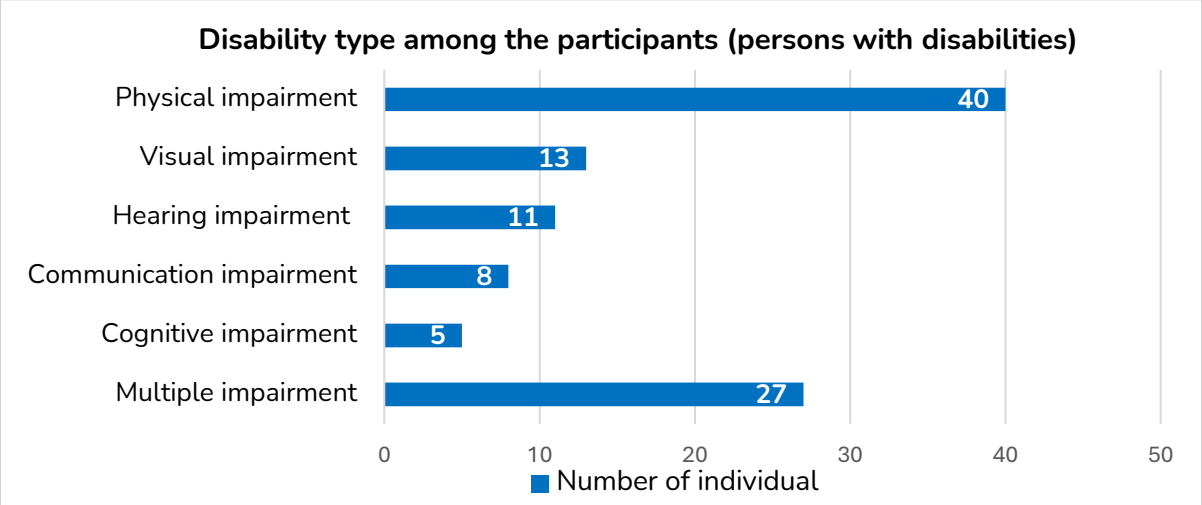
i. Focus Group Discussion

To ensure a comprehensive understanding of the needs and challenges faced by person with disabilities across camps in Ukhiya and Teknaf, a total of 20 Focus Group Discussions (FGDs) (8-12 persons per FGD) were conducted (Total: 188, Female 87, Male 101).

Two FGDs were conducted per camp across 10 selected camps covering Health, Protection, Livelihood, Food Security, and SCCCM services. The camps have been strategically chosen based on their high ratio of persons with disabilities, as determined by available data and demographic insights from the "Age and Disability Inclusion Needs Assessment Factsheet - Rohingya Refugee Response".



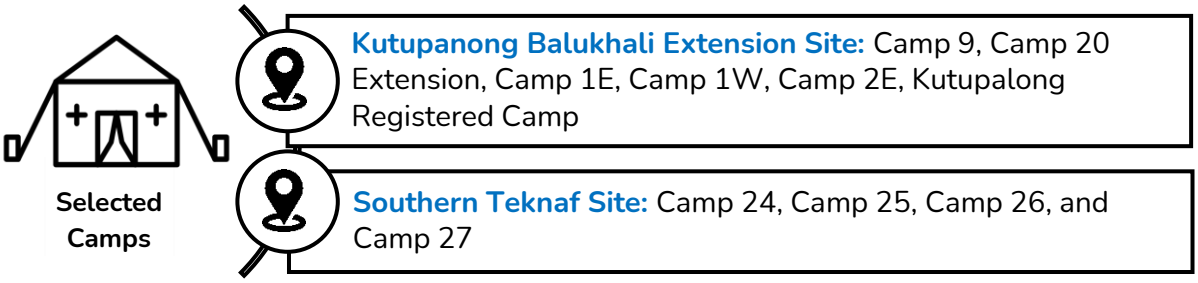




FGD has been conducted with:

a) Women with disabilities and caregivers
b) Men with disabilities and caregivers

This targeted selection represents a deliberate effort to focus on locations where persons with disabilities are most concentrated. By conducting FGDs in these 10 camps, we aim to gain insights that not only reflect the unique challenges of these high-priority camps but also provide an indicative understanding of the overall situation across all 33 camps in Ukhiya and Teknaf.



ii. Key Informant Interviews (KII)

A total of 23 Key Informant Interviews (KII) have been conducted to gather information on barriers and enablers to inclusion and accessibility with specific service provision. A semi-structured questionnaire has guided the interviews. The participants have included:

- Humanitarian actors and camp focal persons (sector-specific representatives from various agencies)- conducted 15 KII including UN agencies, International/National Organizations staff, local organizations
- Community-based group, DIPG/DISC/DSC/PSG leaders/ members- Conducted 8 KII with person with disabilities who lead the persons with disabilities groups existing in the camp.

iii. Desk Reviews

The team have reviewed various documents produced by different sectors, including Sectoral assessment reports, Case studies, Research, Bulletins. This review aims to gain insights into the barriers and enablers individuals with disabilities face in accessing services. Additionally, teams have also reviewed sectoral guidelines to understand the guidance provided by the Disability Inclusion initiative for improving beneficiary access to facilities and addressing barriers.

iv. Access/Observation Audit

The team has conducted observations at 10 service locations (two per sector: FSS, Health Sector, LSDS, Protection Sector, SCCCM sector) to collect qualitative data on the accessibility features currently available and identify areas for further improvement.

Study Population

The assessment included respondents from diverse backgrounds, such as:

a. Camp community people, of various sex and age groups
b. People with different types of disabilities
c. Focal persons from different sectors and organizations.

4. Limitations

- ✓ Stigma within the community can discourage person with disabilities and their caregivers from sharing their experiences or participation in the assessment, leading to incomplete insights.
- ✓ Lack of education and awareness regarding their rights and entitlements that also restricted sharing of their opinion.
- ✓ The dynamic nature of the humanitarian crisis in the camps leads to rapidly shifting needs, making it difficult to ensure the findings remain relevant over time.
- ✓ It is difficult to address and accommodate men with and without disabilities in one place for discussion because most men are busy with their income-generating activities. Most of them stay outside during the day.
- ✓ As per the activity plan, all initiatives should be coordinated with the ADTWG and relevant sectors. However, due to their unavailability and other priorities, the process was delayed.
- ✓ During observation visits to explore the presence of accessibility features, some agencies refused to agree to this activity, further delaying the process.
- ✓ Persons with disabilities and community members primarily focused on discussing basic needs. There was limited education and awareness regarding rights, entitlements, and barriers to accessing services, which also diverted attention from addressing sector-specific barriers.
- ✓ The findings are based on the personal perceptions of persons with disabilities and their caregivers in the community and may include minor deviations due to the subjective nature of responses and potential respondent bias during data collection.

5. Key Findings

5.1 Cross-Cutting Barriers

5.1.1 Cross-Cutting Barriers to Accessing Services for Persons with Disabilities

A. General Lack of Knowledge and Understanding of Disability Inclusion: Common Perception

There is a widespread lack of awareness and understanding of disability inclusion and the rights of persons with disabilities among families, communities, teachers, humanitarian staff, and government officials. This contributes to stigma, isolation, and the exclusion of persons with disabilities.

The FGD findings indicate a widespread lack of understanding of disabilities within the Rohingya community:

- 30% of participants admitted to having limited knowledge about disabilities and their causes due to a lack of information.
- Women participants especially struggled to define disability, reflecting the minimal awareness and resources available to women in the camps.
- Some caregivers relied on cultural beliefs, spiritual explanations, or incomplete knowledge, which suggests that many individuals, including those caring for persons with disabilities, lack access to accurate information or training.

This lack of knowledge and understanding creates significant barriers to the inclusion of person with disabilities. Misunderstandings about disabilities lead to an inability to identify and address the needs of person with disabilities within families, communities, and service.

B. Resulting Stigma and Isolation

The lack of awareness fosters stigma, as seen in the community's perception of disability:

- Disabilities were often attributed to divine will (Allah's will, mentioned by 80% of participants), curses, or supernatural causes. Such beliefs reinforce a view of disability as unchangeable or as a punishment, contributing to negative attitudes.
- Persons with disabilities were frequently labeled using terms such as atur (crippled) or bub (deaf), phaul (mental illness), majur (paralyzed), dhila (Intellectual impairment) which further stigmatize and isolate them.

This stigma often results in the social isolation of persons with disabilities, as they are seen as dependent and less capable of contributing to their families or communities.

C. Exclusion from Services and Participation

- 30% of participants mentioned poor living conditions in the camps due to inaccessible infrastructures, uneven pathways, a lack of specific support services such as provision of assistive devices and negative attitudes among staff which can exacerbate exclusion. This highlights systemic neglect in addressing the specific needs of persons with disabilities.

- Only 20% of participants mentioned delayed response from the service providers or a lack of resources as barriers, indicating that many may not even recognize the importance of timely and accessible services for person with disabilities.

"I am often told that my disability is something from God, something I must accept, but no one teaches my family or me how to live with it. I can't walk like others, I need help to do basic things, but there is no one to help me understand how to get the support I need. In the camps, people look at me like I am different, and I feel isolated. There are no programs that teach others how to include me or what my rights are. It's hard to be a part of the community when they don't know how to help or include someone like me."

FGD Participant from Ukhiya

D. Barriers to Accessing Services for Persons with Disabilities

Persons with disabilities in the Rohingya camps encounter significant barriers to accessing services, driven by inadequate infrastructure, societal discrimination, and a lack of specialized support. These challenges prevent them from participating equally in camp activities, leading to marginalization.

- Services in the Rohingya camps are not fully accessible or equitable for all individuals, particularly persons with disabilities. Poor infrastructure, such as distance to services, uneven and hilly terrain and poor service facility design such as a lack of ramps, handrails, and accessible washrooms, creates significant physical barriers.
- The shortage of specialized services and provision of therapy or rehabilitation and assistive devices further limits independence and access.
- A lack of staff training in disability inclusion resulting in discriminatory attitudes, especially toward children with disabilities, compound infrastructure accessibility challenges.
- Women and girls face cultural restrictions that hinder mobility, while older individuals and those with disabilities struggle with transportation barriers.
- Protection centers and distribution points are not accessible, and services are not provided through outreach resulting in limited access for persons with disability.
- Adolescents with disabilities are often missed by children specific services and adult services resulting in confinement to their homes and missing out on essential services.
- Inconsistent data collection results in unknown needs and exacerbates exclusion, leaving their needs unaddressed.

Reasons for Inaccessibility and Inequity of Services

- Inaccessible infrastructure
- Inadequate assistive devices
- Lack of specialized services
- Cultural barriers for women and girls
- Inconsistent data collection
- Lack of accessible transportation
- Inaccessible protection and skill development center
- Age-related challenges

E. Representation of people with disabilities in community-based groups (DIPG, DISC, DSC, SHG)

Among the affected populations in the refugee camps of Cox's Bazar, person with disabilities remain among the most marginalized and underserved groups. Despite the efforts of some agencies to form disability inclusion promotion groups, support committees, and self-help groups, significant challenges persist in ensuring their functionality and sustainability.

These groups, composed of individuals with diverse disabilities, including both men and women, were established to strengthen the capacity of persons with disabilities, facilitate referrals to appropriate services, and raise awareness about their rights and needs.

Key Activities	Key Barriers
• Capacity strengthening initiatives for person with disabilities • Referral of persons with disabilities to essential Services • Conducting awareness-raising sessions • Advocacy for inclusion in humanitarian activities • Community engagement to address Stigma	• Lack of capacity-building support • Lack of assistive devices, transportation • Not invited by other agencies except founder agencies. • Negative attitudes among service providers lead to limited support and collaboration • Inaccessible infrastructure, pathways, community spaces and centers • Limited representation and not involved them in decision making process

5.1.2 Cross-Cutting Barriers to Providing Disability Inclusive Services

Key Attitudinal Barriers

- Persons with disabilities experience bullying, teasing and offensive comments
- Negative attitude, stigma, isolation by community people.
- Community members often pity persons with disabilities, seeing them as dependent and incapable of self-sufficiency.
- Limited knowledge and understanding on disability inclusion by staffs & volunteers.
- Assumptions among staff that individuals with disabilities cannot contribute to the responses.
- Lack of understanding that persons with disabilities have "**specific needs**".
- Women and girls with disabilities face heightened stigma, with cultural norms.
- People usually used negative language like lang, atur, major, paul, dhila etc.

During KIIs with humanitarian actors from different agencies, it was critically identified and agreed that persons with disabilities face multiple levels of barriers due to a lack of awareness and limited understanding of the concept of disability inclusion.[10] It is often observed that actors assume it is solely the responsibility of disability-focused organizations to provide support to persons with disabilities. During FGD, participants expressed that external organization don't include them in different activity as well meeting, some agencies are trying to include them only for showcase, person with disabilities are awaited long time while receiving services.

Additionally, negative attitudes from actors hinder the participation of persons with disabilities in accessing services. KIIs and FGDs also revealed that some national and international agencies, with the support of disability-focused organizations and consortium efforts, are trying to mitigate these barriers. However, behavioral issues, lack of attention, and the limited technical capacity of staff and volunteers have slowed the progress of disability inclusion in society.

Furthermore, people are often preoccupied with their own priorities and tend to overlook the specific needs of persons with disabilities. They sometimes use disrespectful language, even if unintentionally, contributing to exclusion.[11]

"I was not included in any training or livelihood programs because they assume I cannot work. They never ask us what we need. Some people says that persons with disabilities should stay at home because they cannot contribute."

FGD Participant from Ukhiya

Key Environmental/ Physical Barriers

- Lack of assistive devices
- Inaccessible infrastructure/service center such as uneven pathways, high stairs, narrow entrance, not available of handrails, ramps etc.
- Long distances between residences and service points
- Lack of accessible toilet facilities
- Lack of transportation
- Non-availability of reasonable accommodation

[10] KII participants from Protection Actor, Ukhiya, 2025
[11] KII participants from Health Actor, Ukhiya, 2025

In Rohingya camps, the major barriers identified through consultation of person with disabilities including different actors were environmental/physical barriers. Before designing the project or infrastructure, the needs of person with disabilities are overlooked and not identified because of the lack of concentration and unwillingness to involve them in project phase. In KII with participants stated that there was no mechanism in place to response their need without having knowledge and adequate budget. It is also identified that agencies are not included in the project planning phase while need assessment has done because of lack of data and limited knowledge.

"Some service facilities are not in a good location. Some of them are very close to hilly area. But again, I understand, the acquisition of land is a bit of a problem, so to get appropriate place where services are safe and easy to access could be a challenge."

FGD Participant from Ukhiya

Overall, there is a general lack of assistive devices, including wheelchairs, crutches, prostheses, white canes, glasses and hearing aids. It is quite difficult for them to reach the center for accessing services because of uneven pathways, hilly terrain, absence of handrails and the open drainage system in the camp.[12] Moreover, there is no transportation system inside the camps, even some are found in the camp as alternative way, but it is expensive and many persons with disabilities are unable to afford it.[13]

Key Communication Barriers

- Lack of information in multiple communication formats
- Lack of signage and symbol
- Lack of sign language interpreters
- Absence of sign language practices
- Lack of accessible communication materials, IEC

Communication barriers affect the lives of persons with disabilities in Rohingya camps due to low literacy, lack of accessible material and lack of knowledge of sign language and sign interpreters. In KII, participants identified that volunteers conducted various types of community awareness sessions but a lack of knowledge on how to communicate with people with different types of disabilities results in restriction of information for persons with disabilities to access services. Furthermore, the non-availability of sign language

[12] KII participant from Health Actors, Ukhiya, 2025
[13] KII participants from SCCCM Actors, Ukhiya, 2025

interpreters or knowledge on inclusive communication techniques resulted in exclusion from livelihood interventions as well as others services. Furthermore, the FGD participants emphasized the lack of directional and service signage at the service location, noting that such signage would significantly help in navigation and ease of understanding.

Key Institutional Barriers

- Lack of disability-inclusive policies and programs, funding, and strategy to promote inclusion
- Lack of knowledge and skills of humanitarian actors to mainstream DI
- Inaccessible humanitarian assistance and services
- Exclusion of persons with disabilities from decision-making and community leadership
- Gaps in disability data collection and identification, resulting in unknown needs

During consultations with focus group discussion (FGD) and key informant interview (KII) participants, concerns were raised about the significant institutional barriers faced by persons with disabilities in accessing humanitarian services in the Rohingya camps. During KII participants highlighted the absence of disability-inclusive policies, strategies, and dedicated funding, which limits the promotion of meaningful inclusion in humanitarian response. [14] Many also pointed to the lack of knowledge and skills among humanitarian actors to effectively maintain disability inclusion, resulting in exclusionary practices.[15]

Additionally, participants emphasized that humanitarian assistance and services remain largely inaccessible, particularly in health, WASH, education, and food distribution. They further expressed frustration over the exclusion of persons with disabilities from decision-making and leadership roles, reducing their ability to advocate for their needs. Lastly, gaps in disability data collection and identification processes were identified as a major challenge, often leading to the underrepresentation of persons with disabilities in aid programs, unknown needs and a lack of targeted support services.[16]

[14] KII participants from Health sector
[15] KII participants from Protection Sector
[16] KII participants from Protection Sector

5.2 Sector Specific Barriers to Accessing/ Providing Disability Inclusive Services

5.2.1 Food Security Sector

A previous study by Humanity & Inclusion (HI) highlighted that persons with disabilities often face challenges in accessing food distribution points, primarily due to mobility limitations and the lack of adequately accessible pathways .[17] Although there is an improvement in service access in the recent days but still some barriers has remained that are affecting equal access. The most frequently reported issue was distance, with 48.4% of respondents indicating that distribution points are located too far from shelters, making it difficult to access necessities. 26.06% of respondents shared that the roads to the facilities are uneven, hilly, or muddy, which hinders access services. Additionally, 25.53% reported experiencing stigma, discrimination, or harassment from other community members, creating a socially hostile environment.

The FGD findings highlights that Persons with disabilities, especially women and the elderly, are often discouraged from attending food distributions due to assumptions about their mobility or capacity. Priority queues for persons with disabilities sometimes trigger negative reactions from others, who see it as unfair advantage. Women and girls with disabilities face added barriers, including family restrictions due to fear of community gossip. Some humanitarian staff lack disability awareness, leading to unintentional disrespects such as shouting at people with visual impairments or ignoring those with psychosocial disabilities.

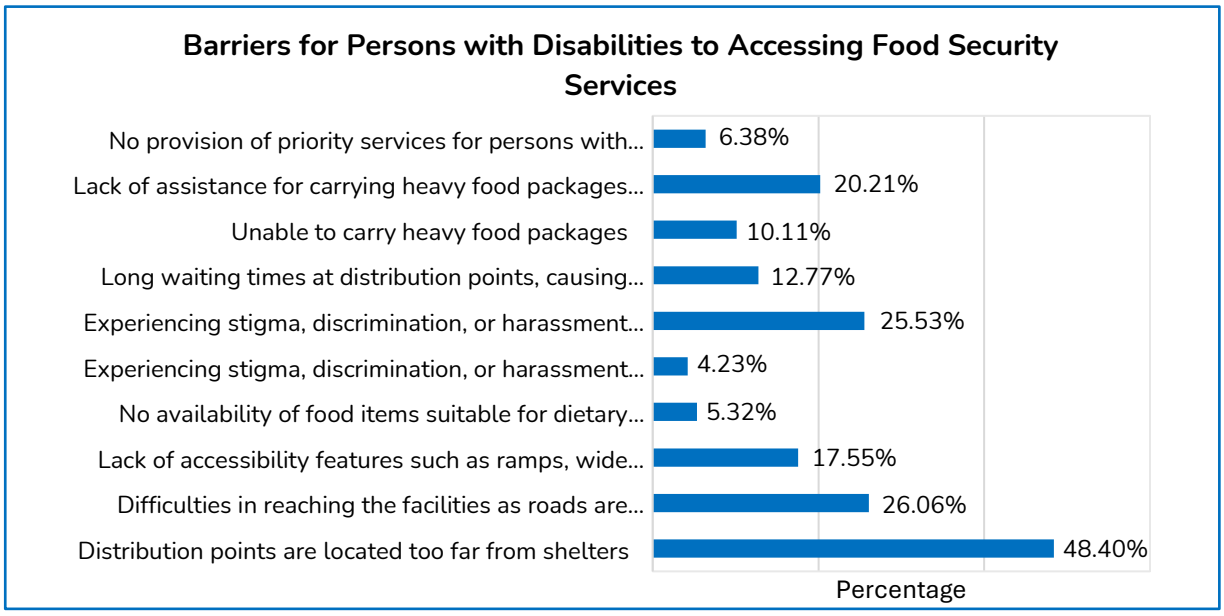


Chart 1: % of Different Barriers for Persons with disabilities to Accessing Food Security Services

[17] Humanity & Inclusion. (2019). *Inclusive services for persons with disabilities in Jadimura Camp, Cox's Bazar*. Humanity & Inclusion. https://www.hi.org/sn_uploads/document/BP_inclusion_bengladesh-V3.pdf

20.21% of individuals mentioned a lack of assistance for carrying heavy food packages or transportation support, while 17.55% highlighted the absence of accessibility features such as ramps, wide entryways, handrails, or shaded waiting areas. 12.77% faced long waiting times at distribution points, which can lead to fatigue or exacerbate health conditions. 10.11% said they are unable to carry heavy food packages, and 6.38% noted the lack of priority services for persons with disabilities at these sites. A smaller percentage, 5.32%, indicated that there were no suitable food items for their dietary restrictions, such as for diabetes, allergies, or malnutrition. Lastly, 4.23% reported experiencing stigma, discrimination, or harassment from staff, underscoring the need for disability awareness and sensitivity training among distribution personnel. A study by Care International found that persons with disabilities were sometimes excluded from community networks and self-help groups, reducing their ability to advocate for their needs in food distribution systems (Care, 2021).

Physical Barriers	Institutional Barriers	Attitudinal Barriers
1. Distribution points are located too far from shelters. 2. Difficulties in reaching the facilities as roads are uneven, hilly, or muddy. 3. Less accessibility features such as ramps, wide entryways, handrails, or shaded waiting areas. 4. Difficulty to reach due to lack of assistive devices 5. Difficulty in carrying heavy food packages and transportation. 6. Lack of accessible information materials.	1. Lack of accurate data on persons with disabilities and their locations. 2. Sector and agencies are less prioritized person with disabilities to engage them in program activity. 3. Sectors have less specific strategy and policy on disability inclusion. 4. Staffs are not oriented on disability inclusion component. 5. Agencies are not conducting targeted assessments of the food security requirements of persons with disabilities.	1. First responders lack awareness and knowledge about persons with disabilities. 2. Community members viewed that person with disabilities is less capable or less deserving of assistance compared to others. 3. Person with disabilities should be taken care of by family members, leading to exclusion from direct access to food distributions. 4. Social exclusion makes it difficult for persons with disabilities to participate in community decision-making.

Enablers to Inclusion

During the FGD, participants stated that some staff at the food distribution points assisted them in accessing food and used respectful language. Beneficiaries acknowledged that the Food Security Sector, including WFP, has taken notable steps to address access barriers. These efforts include the installation of ramps at distribution points, prioritization of persons with disabilities during distributions, provision of fresh food support for vulnerable individuals, and the availability of porter services to assist persons with disabilities; however, it remained challenging to fully support the transport of heavy food items at once. With the support of HI, actors from various agencies received capacity-building training on providing need-based support to persons with disabilities and effective communication with individuals with different types of disabilities. IOM, with support from ADTWG, conducted accessibility audits at several food distribution centers and provided actionable recommendations to ensure that center designs incorporate universal accessibility features.

Recommendations

- Ensure physical accessibility of food distribution points: Modify pathways, provide ramps, handrails, ensure accessible toilets as well as pathways should be non-slippery. Moreover, reasonable accommodation should be provided for persons with disabilities with need in the form of porter support to transfer food.
- Although there are challenges regarding the location of distribution points—such as being too far from shelters or situated in uneven, hilly, or muddy areas—these physical barriers hinder access to essential services. Such issues may fall under the scope of SMSD responsibilities, particularly concerning infrastructure, relocation planning, or pathway improvements. These barriers highlight the need for cross-sectoral coordination to ensure that no person with a disability is excluded from accessing essential services. Addressing these challenges requires joint action between the Food Security and SMSD sectors, and potentially others, to ensure that services are not only available but also accessible to all. This kind of situation is a key advocacy point for disability inclusion by AD TWG.
- Use multiple accessible communication channels: Distribute food distribution schedules through audio messages, pictorial guides.
- Set up community-based feedback and complaint mechanisms: Ensure mechanisms are accessible for people with visual, hearing, or cognitive disabilities (e.g., complaint desks with sign language interpreters).
- Train frontline staff and volunteers: Provide training to food distribution actors on disability awareness and respectful interaction with person with disabilities.
- When conducting food security assessments, consult people with disabilities in affected communities.
- Mainstream disability inclusion in sector strategies: Develop policy, tools, resources.

5.2.2 Health Sector

Access to health services remains a significant challenge for persons with disabilities in the camp. The most reported issue was long waiting times at the health post, mentioned by 63.3% of respondents. This aligns with the public health need assessment (PHNA)[18] in Rohingya Refugee Camps 2024-2025, where 41.94% (281 respondents) identified long waiting times as a major barrier to accessing health services.

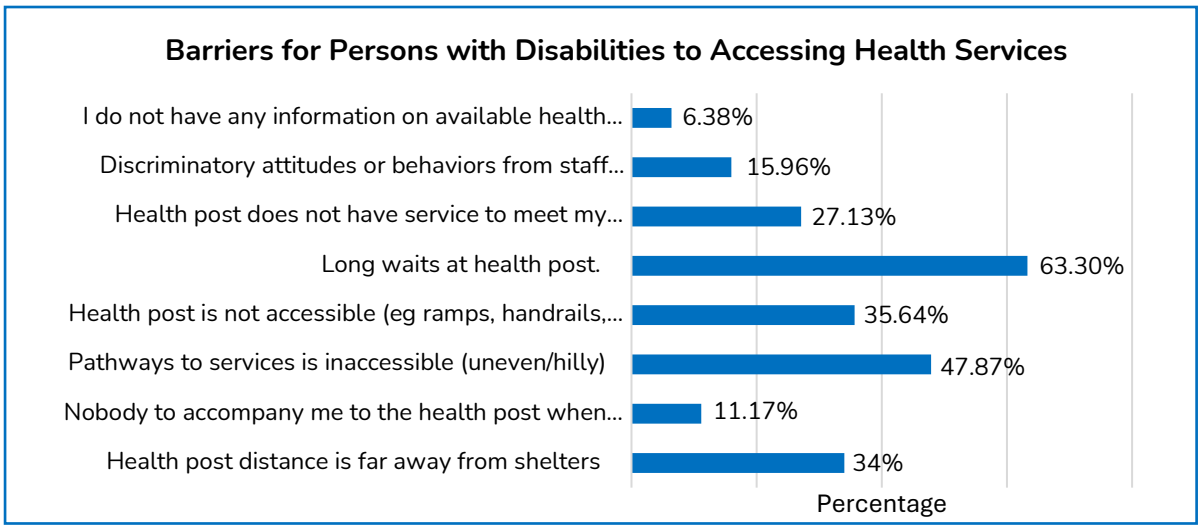


Chart 2: % of Different Barriers for Persons with disabilities to Accessing Health Services

Inaccessible pathways were also frequently cited, with 47.87% stating that routes to services are uneven or hilly, making travel difficult and unsafe. Health post infrastructure poses further challenges, as 35.64% reported that the facilities lack essential accessibility features such as ramps, handrails, and accessible washrooms.

Additionally, 34% of persons with disabilities reported that the distance to the health post is too far (more than 30 minutes) from their shelters. While this is notably higher than the 10% reported in PHNA 2025, it reflects the added mobility and environmental barriers faced by persons with disabilities—factors that may not be as pronounced in the mixed population assessed by PHNA.

In terms of service adequacy, 27.13% of person with disabilities reported that the health posts lack services that address their specific needs—such as physiotherapy, assistive device provision. This gap highlights the limited availability of inclusive health and rehabilitation services within the current system. Additionally, attitudinal and capacity-related barriers were evident, with 15.96% of respondents reporting experiences of discriminatory behavior by health staff. Many also expressed concerns that health workers are not adequately trained or sensitized to respond to the unique needs of persons with disabilities. Lastly, 11.17% of individuals expressed that they have no one to accompany them when they require medical attention, adding an additional layer of difficulty in seeking care. These findings highlight the urgent need to improve infrastructure, incorporate

[18] *Public Health Needs Assessment (PHNA) in Rohingya Refugee Camps 2024–2025*. (2025). https://app.powerbi.com/view?r=eyJrIjoiMGIyOTE0YmYtYzM3ZC00YTE0LWJmYzktYzQ2MzFkNzQ3MzI0IiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9

different modes of service delivery (e.g. static point-based service, outreach service), introduce priority queues for persons with disabilities and raise staff capacity, while also addressing social attitudes to ensure inclusive and equitable healthcare for all.

Physical Barriers	Institutional Barriers	Attitudinal Barriers
1. In camps and Health centers, accessibility issues for people with disabilities present several challenges: Uneven, slippery, and hilly pathway. 2. Narrow entrance, absence of handrails. 3. The non-availability of accessible toilet facilities, barriers include low-seating toilets, narrow door, lack of grab bars, and less lighting. 4. Health post distance is far away from shelters. 5. Nonavailability of assistive devices and inadequate transportation. 6. Inaccessible waiting area for persons with disabilities (difficult to stand for long periods).	1. Limited knowledge and capacity of humanitarian organizations to mainstream disability. 2. Less meaningful consultations and participation from persons with disabilities. 3. Existing health systems and infrastructures do not address the specific health needs of persons with disabilities. 4. Lack of disability data in health management information systems. 5. Lack of budget to provide specific intervention (assistive devices, rehabilitation services). 6. Individuals with disabilities are not sufficiently empowered due to a lack of awareness of their rights.	1. Negative attitudes and discrimination against persons with disabilities by health workers. 2. Less understanding that persons with disabilities have specific requirements. 3. Discriminatory attitudes or behaviors from staff and volunteers due to impairments. 4. Less awareness about the rights and services available for person with disabilities.

Enablers to Inclusion

From the FGD, participants stated that some health facilities are closer to shelters and have a separate priority line for them. Agency staff and volunteers received capacity-building training from HI and CDD on disability inclusion, data collection, and community etiquette, which supports their easy access but still they are waiting for long time. It was also noted that some agencies have started collecting data and providing need-based support but no specialized services are available such as rehabilitation services, provision of assistive devices, prosthesis and orthosis services, eye & hearing services. Some health facilities have slightly introduced accessibility features, such as ramps and handrails but not considered universal design principal. During the advocacy initiative by HI, the disability-focused service mapping was shared with all agencies. As a result, health facilities refer to persons with disabilities to specialized agencies for rehabilitation interventions and assistive devices.

Recommendations

- Ensure physical accessibility by introducing all accessibility features into existing health posts by including ramps with handrails, accessible toilet facilities, wide entrance and providing reasonable accommodation based on the needs of persons with disabilities.
- Conduct regular capacity building training on disability inclusion, rights, inclusive health practices, and how to interact with persons with disabilities with dignity as well as recruit person with disabilities to involve them in health services.
- Ensure availability of mobility aids, hearing aids and set up a referral system linking health facilities with specialized rehabilitation service providers.
- Collect and disaggregate disability data using tools like WGQ. Design health registers for use in health facilities, and in outreach and home-based care, that collect data on sex, age, and disability.
- Conduct participatory health need assessments with persons with disabilities to identify ongoing challenges and set up inclusive complaint and feedback mechanisms, including anonymous reporting options.
- Ensure representation of person with disabilities in health sector coordination meetings, different committees, surveys and establish partnership with disability-focused organization for technical guidance and program implementation.

5.2.3 Livelihood and Life Skill Development Sector

Generally, a higher proportion of persons with disabilities than those without disabilities reportedly face barriers in accessing services. As of 2024 ISNA results showed 79% of Rohingya households reported at least one source of income, but 21% lacked any income source (excluding food rations). However, accessing income or livelihood opportunities remains a challenge for the majority of the Rohingya households, including women, due to limited access to livelihoods, long wait times for opportunities, and movement restrictions.[19]

Additionally, households engaged in the informal sector that include persons with disabilities receive lower average daily per capita incentives compared to households in the informal sector without persons with disabilities.[20] Discussions during FGDs and KIIs further reflected that fewer persons with disabilities are involved in income-generating activities. Moreover, men tend to have more opportunities than women in this regard.

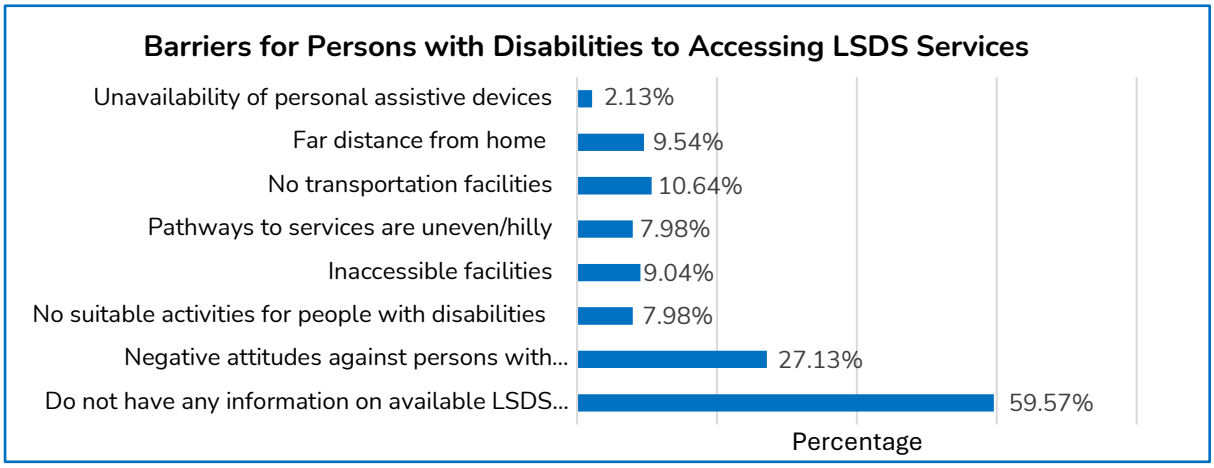


Chart 3: % of Different Barriers for Persons with disabilities to Accessing LSDS Services

The most significant barrier, reported by 59.57% of respondents, is the lack of information about available LSDS services, which prevents many from participating in opportunities that could enhance their well-being and independence. 27.13% shared that they experience negative attitudes from community members and peers, which contributes to social exclusion and discourages engagement.

In addition, avoidance of communication by staff toward persons with impairments further alienates them from accessing services, though this was noted qualitatively without a specific percentage. 10.64% of respondents highlighted the lack of transportation facilities, making physical access to services a consistent challenge. 9.54% cited the far distance of services from their homes, while 9.04% pointed out that facilities themselves are not accessible, lacking essential features like ramps or handrails. 7.98% of participants stated

[19] Inter-Sector Coordination Group (ISCG). (2025, February). *Inter-Sector Needs Assessment (ISNA) – Rohingya Camps, Cox's Bazar*. https://data.unhcr.org/en/documents/details/115200
[20] Inter-Sector Coordination Group (ISCG). (2024, February). *Joint multi-sector needs assessment (J-MSNA) 2023 factsheets: Cox's Bazar camps*. https://rohingyaresponse.org/wp-content/uploads/2024/04/BGD_CXB_J-MSNA-2023_Factsheets_Camps_Feb-2024.pdf

that there are no suitable activities designed for people with disabilities, and another 7.98% reported that pathways to services are uneven or hilly, both of which hinder participation.

Physical Barriers	Institutional Barriers	Attitudinal Barriers
1. Inaccessible and unsafe markets, places of work and related facilities (e.g. toilets). 2. Limited accessible information on markets, social protection, how to use facilities, opportunities such as skills training, job openings. 3. Training and work opportunities are often located far from households. 4. Many livelihood and skills training centers are not physically accessible due to the lack of ramps, handrails, and accessible latrines. 5. Some of the activities are not designed in consideration of different types of impairments.	1. Most livelihood programs are designed without considering the diverse needs of persons with disabilities leading to their exclusion. 2. Many organizations do not have specific funding or strategies to ensure the participation of persons with disabilities. 3. Many vocational training programs do not offer inclusive methods, such as sign language interpretation or accessible materials. 4. Humanitarian organizations prioritize persons without disabilities for cash-for-work and income-generating activities. 5. Humanitarian organizations less awareness and training on disability inclusion.	1. Negative attitudes and discrimination against persons with disabilities in the workplace. 2. Less awareness and knowledge about the capacities of persons with disabilities and their possible contributions in the workplace. 3. Women with disabilities face double discrimination, with fewer opportunities compared to men. 4. Person with disabilities perceived that there are no suitable activities for me to participate.

Enablers to Inclusion

During the FGD, most participants stated that they do not have proper information related to life skills training, and they did not match the entry criteria. Only a few people received training from other organizations, while the majority did not participate. FGD findings from Teknaf camps indicated that, with the support of HI, participants received training in homestead gardening, tailoring, wood-bamboo carpentry, and handicrafts. HI ensured accessibility measures, and beneficiaries actively participated in the training sessions, feeling respected and valued. However, most organizations overlooked inclusion criteria due to a lack of knowledge, skills, and available data. It is expected that humanitarian agencies and actors implement inclusive life skills interventions, ensuring the participation of persons with disabilities and collaborating closely with disability-focused organizations for technical support.

Recommendations

- Collect and analyze data of persons with disabilities for livelihood, disaggregated by disability, gender and age -Using WGQ.
- Ensure accessibility and reasonable accommodation-specific support (, modification of training and facilities to meet specific needs), conduct accessibility audit in the training center.
- Sensitize the community, staff and partners on the rights of persons with disabilities and inform them about the rights and capacities of persons with disabilities.
- Allocate resources, budget and capacity building training on disability inclusion.
- Recruit a specialized staff on Person with Disabilities to better support in disability inclusion to Livelihoods projects where possible.
- Adapt livelihood and skills development assessment and monitoring tools.
- Input support should be given on a priority basis, if required involve caregiver.
- Support person with disabilities and their group to participate in decision-making process and recruit person with disabilities.
- Provide information about livelihoods opportunities in different formats and develop specific strategies and policy, guidance.
- Ensure that livelihood targeting criteria adequately address the needs of person with disabilities.

5.2.4 Protection Sector

People with disabilities often face heightened risks due to exclusion, limited access to essential services, societal stigma, and barriers to livelihood opportunities, which contribute to increased levels of poverty. Estimates show that 18 per cent of the female population have a disability compared to 14.2 per cent of the men.[21] Women and girls with disabilities face additional barriers in most areas of life, particularly when it comes to equal access to education, economic opportunities, social interaction and justice.[22]

Women and girls with disabilities continue to face multiple barriers in accessing services at Women and Girls Safe Spaces (WGSS) and related outreach initiatives. The most reported issue was inadequate door-to-door and outreach service delivery, cited by 37.23% of respondents, which limits their access to essential information and support. 31.94% of respondents reported that the centers lack accessible features such as ramps, handrails, or wide doorways, making physical access difficult.

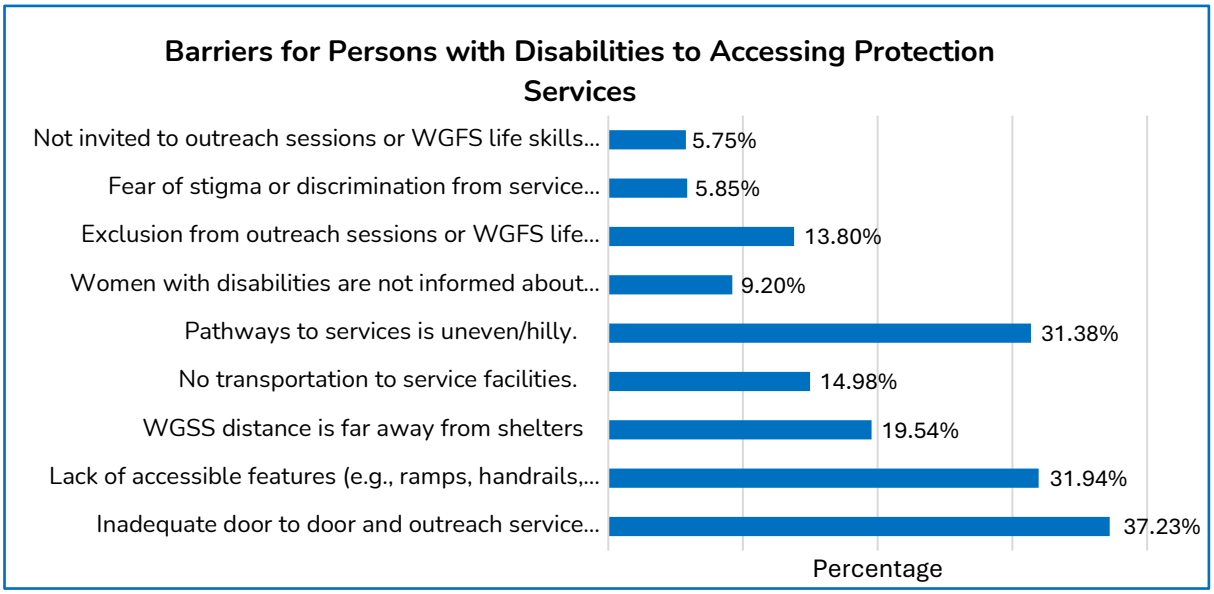


Chart 4: % of Different Barriers for Persons with disabilities to Accessing Protection Services

Similarly, 31.38% mentioned that pathways to service locations are uneven or hilly, further obstructing mobility for those with physical impairments. 19.54% of women with disabilities stated that WGSS centers are located too far from their shelters, posing a geographical barrier. Additionally, 14.98% highlighted the lack of transportation to reach

[21] World Health Organization. (2022, December). *Global report on health equity for persons with disabilities*. https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/global-report-on-health-equity-for-persons-with-disabilities

[22] United Nations Department of Economic and Social Affairs. (2018). *UN flagship report on disability and development: Realization of the Sustainable Development Goals by, for and with persons with disabilities*. United Nations. https://social.desa.un.org/publications/un-flagship-report-on-disability-and-development-2018

service facilities, a critical gap for those who rely on mobility aids or assistance. 13.80% of respondents noted exclusion from outreach sessions or WGFS life skills programs, often due to not being invited or lacking awareness. This lack of inclusive communication further marginalizes them. Relatedly, 9.20% shared that they were not informed about their eligibility to attend such services.

A smaller group, 5.85%, expressed fear of stigma or discrimination from service providers, which can deter them from seeking support. Finally, 5.75% reported not being invited to outreach sessions or WGFS life skills sessions, underlining a communication and outreach gap.

Physical Barriers	Institutional Barriers	Attitudinal Barriers
1. Inadequate door to door and outreach service delivery. 2. Accessibility issues at protection centers such as narrow entrance, low lighting, inaccessible washroom. 3. Less accessible features (e.g., ramps, handrails, wide doorways) at center. 4. No transportation & pathways to services is uneven/hilly. 5. Lack of accessible toilet facilities. 6. Do not have the proper information on the availability of protection services or any skill development initiative. 7. Information is not provided in multiple communication format such as pictorial, audio or signage etc.	1. Limited technical and financial capacity to promote inclusion. 2. Less targeting by sector and humanitarian organization as well as less prioritization. 3. Less organizational policies to address disability inclusion needs. 4. Lack of accurate data of person with disabilities and capacity building initiatives.	1. Less awareness about legal capacity of persons with disabilities to participate in decision-making. 2. Assumptions by protection staff that persons with disabilities lack capacity to participate in life skills training. 3. Women with disabilities are not informed about their eligibility to attend services. 4. Exclusion from outreach sessions or WGFS life skills programs due to lack of invitation or awareness. 5. Community members often mistreat and use derogatory language such as Nafang (deaf), Anda (blind), Lang (lame).

Enablers to Inclusion

During the FGD, participants shared that some agencies have invited persons with disabilities to various celebration programs, and WGSS facilities are located near their homes/blocks. Additionally, it was noted that some agencies are making efforts to involve persons with disabilities in life skills training, helping them live more independently in the camp. Referrals to disability-focused organizations, primarily HI, have been made by protection actors. From the KII, protection actors stated that during capacity-building initiatives led by HI and the protection sector, they received a series of training sessions on disability inclusion. Community-based protection actors have provided some assistive devices and allocated budgets to enhance accessibility at service centers with support from HI. PERU volunteers have also received training on disability inclusion (DI) and disability-inclusive disaster risk reduction (DIDRR), improving their skills in humanitarian response. However, there is still room for improvement, and agencies should take further initiatives to effectively address the needs of persons with disabilities.

Recommendations

- Ensure minimum accessibility standards and provide reasonable accommodation to improve access to protection service centers by collaborating with HI for accessibility assessments and incorporating accessibility features accordingly while seeking feedback from individuals with disabilities for necessary adaptations.
- Strengthening identification & referral mechanisms: Train caseworkers and community protection volunteers, & person with disabilities groups on disability identification using WGQ for strengthening identification and referral.
- Ensure functional referral pathways for persons with disabilities to access specialized services (e.g., assistive devices, rehabilitation, psychosocial support) and conduct outreach activities to reach high priority cases to include them in services.
- Provide individualized case support for persons with disabilities, ensuring family and caregivers are also supported to prevent neglect and abuse.
- Provide assistive mobility devices (e.g., wheelchairs, walking aids) at safe spaces and information hubs to support.
- Ensure accessible latrines, ramps, handrails, and seating arrangements in protection centers.
- Include basic concepts and misconceptions about disability in awareness sessions to improve community people's understanding. Ensure people with disabilities know about available protection services and support. Also, inform them about disability-specific services in their camps.

5.2.5 Shelter Camp Coordination and Camp Management Sector

A reported 52% of persons with disabilities aged 2 and above face difficulties moving inside shelters without support from others, while 76% of persons with disabilities aged 15 and above struggle to move around the camps. These mobility challenges are particularly severe for individuals with difficulties in self-care or mobility, as they face significant barriers both inside shelters and throughout the camps[23].

People with disabilities face numerous challenges within the shelter environment, significantly affecting their mobility, safety, independence, and dignity. The most pressing issue reported by 44.68% of respondents was the inadequate space within shelters, making it difficult to move around or accommodate assistive devices. 39.36% indicated the lack of accessible toilets or bathing facilities nearby, severely limiting basic hygiene practices. Similarly, 36.17% highlighted the absence of ramps, handrails, or other accessibility features in and around shelters, increasing the risk of injury and dependence on others.

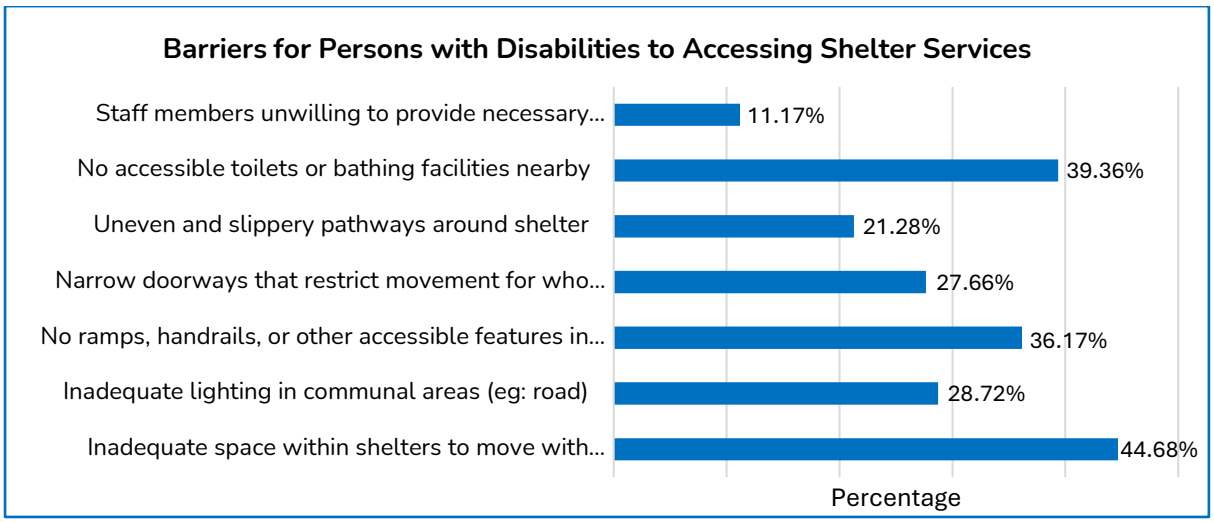


Chart 4: % of Different Barriers for Persons with Disabilities to Accessing Shelter Services

Poor infrastructure continues to pose barriers: 28.72% noted inadequate lighting in communal areas, such as roads, which compromise safety during movement, especially at night. 27.66% shared that narrow doorways restrict the movement of those using mobility aids, and 21.28% reported uneven and slippery pathways around their shelters, creating additional hazards. Lastly, 11.17% of respondents pointed to the unwillingness of staff members to provide necessary support, reflecting a gap in inclusive service delivery and awareness.

[23] REACH. (2021, May). *Age and disability inclusion needs assessment: Rohingya refugee camps, Cox's Bazar, Bangladesh*. https://www.impact-repository.org/document/reach/17afa088/REACH_BGD_Report_Age-and-Disability-Inclusion-Needs-Assessment_May-2021.pdf

Physical Barriers	Institutional Barriers	Attitudinal Barriers
1. Inadequate space within shelters to move with accommodate assistive devices. 2. Inadequate lighting in communal areas (eg: road, toilets). 3. No ramps, handrails, or other accessible features in and around the shelter. 4. Narrow doorways that restrict movement for those who use mobility aid. 5. Uneven and slippery pathways around the shelter. 6. Unavailability of accessible information regarding shelters, NFI, camp management activity. 7. Lack of transportation facilities to access services.	1. Less technical capacity to promote the inclusion. 2. No budget provision for access and accommodation for persons with disabilities at camps. 3. Lack of accurate data on persons with disabilities. 4. Less targeting by sector and humanitarian organization as well as less prioritization. 5. Individuals with disabilities are not sufficiently empowered due to a lack of awareness of their rights. 6. Less representation of person with disabilities in the community group.	1. Limited knowledge and awareness within humanitarian actors and organizations about how to meet accessibility and other requirements of persons with disabilities. 2. Stigma against persons with disabilities during displacement. 3. Staff assume that persons with disabilities do not have the capacity to contribute to leadership and decision-making at the community level. 4. Agencies often exclude them in need assessment and planning phase and their needs are overlooked.

Enablers to Inclusion

During the FGD sessions across different camps, led by IOM, participants stated that staff and volunteers generally demonstrated a respectful attitude and established a Disability Inclusion Support Committee to amplify their voices. Additionally, beneficiaries have participated in various events facilitated by site management. However, they also mentioned that only those who personally know them and work closely with them tend to be supportive, whereas other SCCCM actors are less engaged. During KIIs with site management actors, it was noted that priorities are determined based on needs. Some site management staff reported receiving capacity-building training from HI, though not all personnel were trained. Instead, they were referred to disability-focused organizations for further support. Additionally, one respondent mentioned that some agencies installed ramps and handrails because of advocacy initiatives and consultations with persons with disabilities. However, this is not yet a regular practice within the SCCCM sector.

Recommendations

- Strengthen disability-inclusive site planning & infrastructure: ensure accessible pathways, modify existing shelters/centers, wide entrance in the house, accessible toilets etc.
- Identify and address barriers experienced by persons with disabilities that arise within programming carried out by humanitarian and development agencies.
- Collect, analyze and report disability disaggregated data to inform programming and develop evidence.
- Ensure humanitarian actors and SCCCM sector have a rights-based understanding of disability, disability inclusive approaches and initiate capacity building training for staffs, volunteers on DI.
- Conduct regular consultations with persons with disabilities to inform decision-making, using focus groups and participatory mapping exercises.
- Budget for accessibility measures and reasonable accommodations in programming (providing transport, sign interpreters and where possible the provision of assistive devices) consultations, project activities to ensure persons with disabilities can actively participate.
- Provide multiple accessible reporting channels for complaints and feedback (in-person, sign language interpreters, mobile).
- Ensure that emergency warnings and drills use multiple formats (audio, visual, tactile) and prioritize accessibility.
- Identify and remove barriers to participation in cash-for-work schemes by providing flexible work options, accessible workspaces, and assistive devices.

6. Conclusion

The assessment of Barriers and Enablers affecting the access and inclusion of persons with disabilities in the Rohingya humanitarian response reveals persistent challenges across multiple sectors. The Barriers and Enablers assessment highlights the critical gaps in accessibility and inclusion for persons with disabilities in the Rohingya refugee response. Environmental/physical, attitudinal, communication and institutional barriers persist, restricting equitable access to essential services and meaningful participation of people with disabilities. While some progress has been made through targeted advocacy and the involvement of different disability focused agencies, these efforts remain inconsistent and require a more coordinated and sustained approach.

Persons with disabilities should be familiar with their rights and be empowered to speak up for themselves. In the camps, persons with disabilities sometimes form informal disability committees for the advocacy of their rights. Organizations should encourage the formation of more informal groups and strengthen their capacity to meaningfully participate and contribute to matters of concern inside the camps. Addressing these challenges through evidence-based strategies is essential to ensuring that disability inclusion is not an afterthought but a fundamental component of humanitarian action, fostering an equitable and dignified response for all persons with disabilities alongside others in the Rohingya camps.

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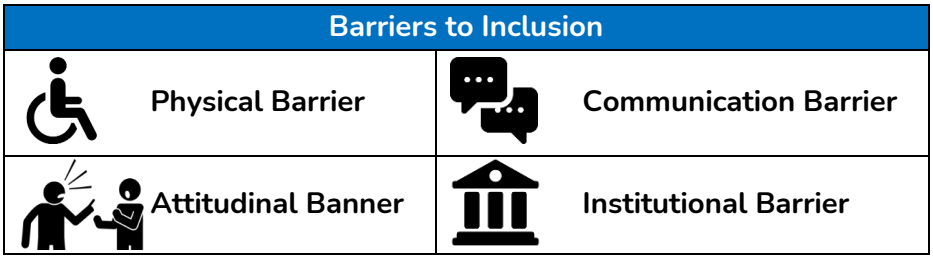
Annex-1 (Key Concepts and Definition)

Accessibility is one of the eight principles that enable the rights affirmed in the CRPD to be interpreted. It affirms the right of persons with disabilities to enjoy "access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. Accessibility is a precondition of inclusion: in its absence, persons with disabilities cannot be included.[24]

Assistive technology, devices and mobility aids are external products (devices, equipment, instruments, software), specially produced or generally available, that maintain or improve an individual's functioning and independence, participation, or overall well-being. They can also help prevent secondary impairments and health conditions. Examples of assistive devices and technologies include wheelchairs, prostheses, hearing aids, visual aids, and specialized computer software and hardware that improve mobility, hearing, vision, or capacity to communicate.[25]

Barriers are factors in a person's environment that hamper participation and create disability. For persons with disabilities, they limit access to and inclusion in society. Barriers may be attitudinal, environmental or institutional.



- Attitudinal barriers are negative attitudes that may be rooted in cultural or religious beliefs, hatred, unequal distribution of power, discrimination, prejudice, ignorance, stigma and bias, among other reasons.
- Environmental barriers include physical obstacles in the natural or built environment that "prevent access and affect opportunities for participation" and inaccessible communication systems. The latter do not allow persons with disabilities to access information or knowledge.[26]
- Institutional barriers include laws, policies, strategies or institutionalized practices that discriminate against persons with disabilities or prevent them from participating in society.

[24] United Nations. (2006). *Convention on the Rights of Persons with Disabilities: Article 9—Accessibility*. https://www.internationaldisabilityalliance.org/sites/default/files/article_9_crpd_.pdf
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- Communication barriers: Inaccessible communication systems prevent access to information, knowledge and opportunities to participate.

Disability Inclusion is achieved when persons with disabilities meaningfully participate in all their diversity, when their rights are promoted, and when disability-related concerns are addressed in compliance with the CRPD.[27]

Mainstreaming is the process of incorporating CRPD in protection principles, promoting the safety and dignity of persons with disabilities, and ensuring they have meaningful access to humanitarian support and can participate fully in humanitarian interventions. Mainstreaming does not focus on what is done, but on how it is done. Disability should be mainstreamed in all sectors and all phases of the humanitarian programme cycle.

Enablers are measures that remove barriers, or reduce their effects, and improve the resilience or protection of persons with disabilities. Diagram: Barriers and enablers to the inclusion of persons with disabilities in humanitarian action (referenced from IASC Guideline on Inclusion of Persons with Disabilities in Humanitarian Action).

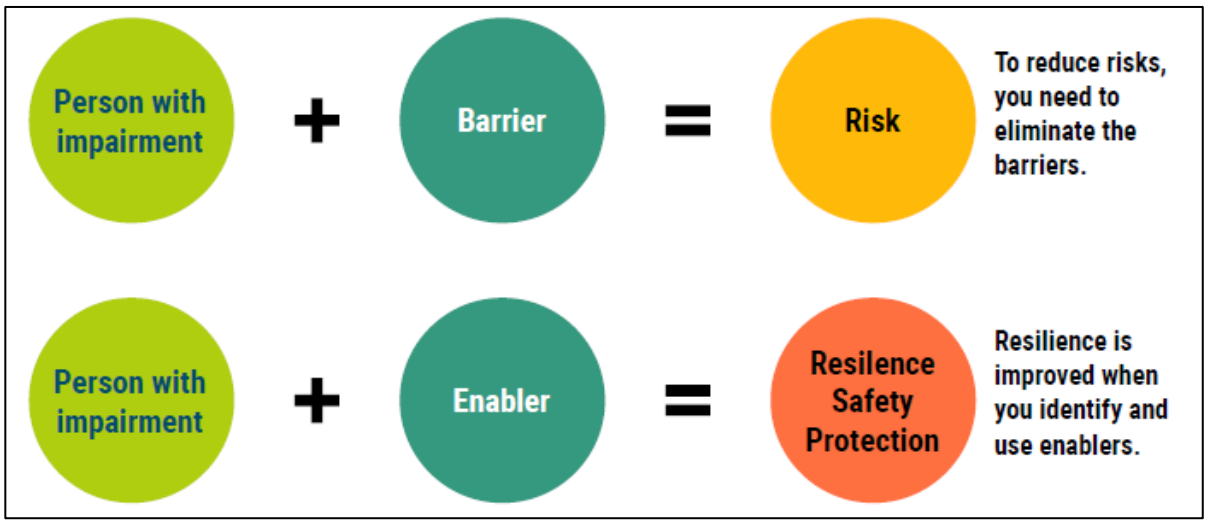

Figure: Barriers and enabler to inclusion of persons with disabilities in humanitarian settings

[27] United Nations. (2019). *United Nations Disability Inclusion Strategy*. https://www.un.org/en/content/disabilitystrategy/assets/documentation/UN_Disability_Inclusion_Strategy_english.pdf

Handicap International -Humanity & Inclusion

Co-recipient of the 1997 Nobel Peace Prize, Humanity & Inclusion (previously known as Handicap International) is a 40-year-old independent and impartial organization, that runs programs in health and rehabilitation and social and economic integration with local partners. HI has been working in Bangladesh since 1997 to promote the inclusion of people with disabilities.

Website: www.hi.org