Joint Multi-Sector Needs Assessment (J-MSNA)
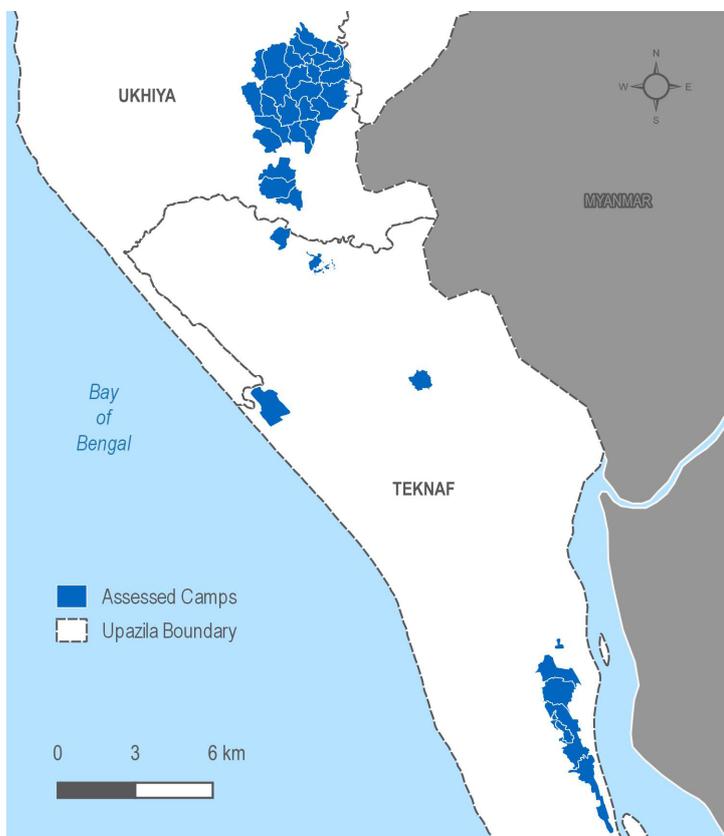
In-Depth | August - September 2019

ASSESSMENT OVERVIEW

In successive waves over four decades, Rohingya refugees have been fleeing to Bangladesh from Rakhine State, Myanmar. Since August 2017, an estimated 745,000 Rohingya refugees have arrived in Cox's Bazar, Bangladesh, increasing the total number of Rohingya refugees to more than 900,000.[1] Most of the newly-arrived refugees have settled in hilly, formerly-forested areas that are vulnerable to landslides and flash-flooding in monsoon season, and rely heavily on humanitarian assistance to cover their basic needs. As the crisis moves beyond the initial emergency phase, comprehensive information on the needs and vulnerabilities of affected populations is needed in order to inform the design and implementation of effective inter-sectoral programming.

To this aim, a Joint Multi-Sector Needs Assessment (J-MSNA) was conducted across Rohingya refugee populations to support humanitarian planning and enhance the ability of operational partners to meet the strategic aims of donors and coordinating bodies. This in-depth assessment is a follow-on to the June 2019 "Light" MSNA, which was used to inform the mid-term review of the humanitarian 2019 Joint Response Plan (JRP).[2] The J-MSNA was conducted to inform the Inter Sector Coordination Group (ISCG)'s 2019 Rohingya crisis MSNA Strategy, with the objectives of: (1) providing a comprehensive evidence base of household-level multi-sectoral needs for the 2020 JRP; and (2) providing the basis for joint multi-stakeholder analysis.

A total of 3,418 households were surveyed across 34 refugee sites, employing a simple random sampling methodology of shelter footprints within official site boundaries. Data collection occurred from 5 August through 15 September 2019. Each interview was conducted with an adult household representative responding on behalf of the household and its members. Findings in the factsheet are presented at the overall response level and are generalisable to all Rohingya refugee households living in camps with a 95% confidence level and 3% margin of error. Camp-level findings for indicators where substantial geographical variation was observed are available at the J-MSNA Dashboard. A more detailed methodology, as well as caveats and limitations, may be found in "Background and Methodology".[3]

This J-MSNA was funded by the United Nations High Commissioner for Refugees (UNHCR) and the Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO). The assessment was coordinated through ISCG's MSNA Technical Working Group (TWG) of the Information Management and Assessment Working Group (IMAWG), led by ISCG and comprised of: UNHCR, International Organization for Migration Needs and Population Monitoring (IOM NPM), ACAPS, World Food Programme Vulnerability Analysis and Mapping (WFP VAM), Translators without Borders (TWB), and REACH.
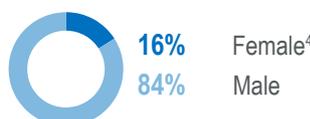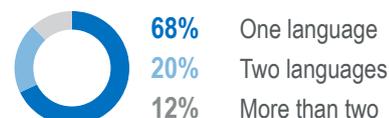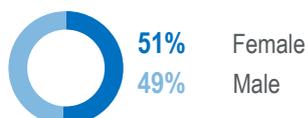

POPULATION PROFILE

Female (50%)	Age	Male (50%)
1%	60+	2%
14%	25-59	14%
9%	18-24	7%
7%	12-17	7%
10%	5-11	11%
9%	0-4	9%
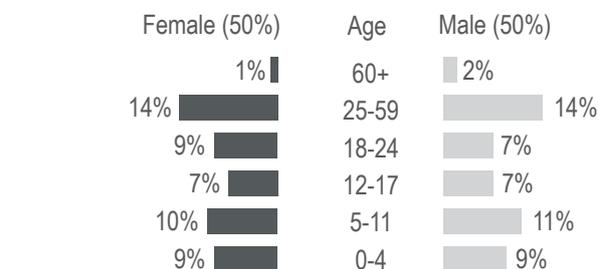
Gender of head of household

16% Female[4]
84% Male

Average household size

5.1 persons

Gender of respondent

51% Female
49% Male

% of households by number of languages spoken and understood

68% One language
20% Two languages
12% More than two

Map legend:
- UKHIYA
- MYANMAR
- Bay of Bengal
- TEKNAF
- ■ Assessed Camps
- □ Upazila Boundary
- 0 3 6 km

[1] Inter Sector Coordination Group (ISCG), *Situation Report Rohingya Refugee Crisis, Cox's Bazar, Bangladesh, May 2019* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[2] ISCG, *Light Mid-Term Multi-Sector Needs Assessment (MSNA) (June 2019)*, (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[3] The full terms of reference for the assessment may be found at: ISCG, *Assessment Concept Note, Rohingya Crisis Bangladesh, In-Depth MSNA, July 2019* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[4] The proportion of female-headed households in this assessment is lower than the rates reported in other assessments (usually constituting roughly one-quarter of all refugee households). This may be explained in part by the definition of "head of household" that was provided to respondents: "the individual who makes decisions on behalf of the entire household", irrespective of the name or number of people included on their registration card.

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% of households by period of arrival to Bangladesh

11% Before 2016
7% Jan 2016 - Jul 2017
82% Aug 2017 onwards

% of households by highest level of education in household[5]

27% No formal education
41% Some primary
32% Primary and above

% of households with at least one individual (aged 5 and above) reported as requiring assistance to complete daily activities[6]

10%

BACKGROUND & METHODOLOGY

- **J-MSNA framework:** the analytical framework for multi-sector analysis is based on the work undertaken by the Joint Inter-sector Analysis Group (JIAG)[7], tailored by ACAPS and other participants of the MSNA TWG to meet the specific needs of the Rohingya Humanitarian Crisis. The focus of the J-MSNA is to measure current humanitarian conditions, perceptions and preferences, and safety and security. The J-MSNA is not intended to capture information on natural or man-made hazards, legal or rights-based issues, logistics or humanitarian access. It is also not intended to inform long-term development programming.

- **Assessment design:** indicator identification and tool development were conducted in close consultation with all sectors, as well as various working groups and experts present in the response. These indicators and the overall tool were then finalised by the MSNA TWG.

- **Sampling strategy and household selection:** target sample sizes for each camp were based on the most recent population figures available from UNHCR. ISCG camp boundaries were overlaid onto REACH/UNOSAT shelter footprint data. A random distribution of GPS points was then generated, with each GPS point indicating a shelter to be approached for an interview. Additional buffer points were sampled to account for instances of non-eligibility or non-response. To ensure that the experiences and perspectives of both males and females were equally represented in the assessment, enumerator teams were composed equally (50:50) of men and women, with each enumerator interviewing an adult respondent of their own gender, who was most knowledgeable about affairs of the household (as defined by the household).

- **Data collection:** the J-MSNA was conducted from 5 August through 15 September 2019. Enumerators underwent a three-day training and a two-day pilot in order to familiarise themselves with the tool, field protocols, as well as the code of conduct and basic protection principles. Representatives of all sectors directly trained enumerators. During data collection, informed consent was sought, received and documented at the start of each interview.

- **Data cleaning and checking:** each day, data checking and cleaning was conducted according to a set of pre-established standard operating procedures, with checks including outlier checks, correct categorisation of "other" responses, and the removal and/or replacement of incomplete or inaccurate records. All changes to the dataset were documented in a cleaning log.

CAVEATS AND LIMITATIONS

- **Proxy:** data on individuals are collected by proxy from the respondent and not directly from household members themselves.

- **Respondent bias**: certain indicators may be under-reported or over-reported due to the subjectivity and perceptions of respondents (especially "social desirability bias" - the tendency of people to provide what they perceive to be the "right" answers to certain questions).

- **Perceptions:** questions on household perceptions may not directly reflect the realities of service provision or security conditions in refugee camps - only on individuals' perceptions of them.

- **Limitations of household surveys:** while household-level quantitative surveys seek to provide quantifiable information that can be generalised to the populations of interest, the methodology is not suited to provide in-depth explanations for complex issues. Thus, questions on "how" or "why" (e.g. reasons for feeling unsafe, or reasons for incurring debt, gender dynamics, etc.) are best suited to be explored through an accompanying qualitative component. The unit of measurement for this assessment was the household, and therefore does not focus on intra-household dynamics (including in relation to intra-household gender norms, roles and dynamics; disability; age, etc.). Users are reminded to supplement and triangulate findings from this survey with other data sources.

- **Subset indicators:** findings that refer to a subset (of the overall population) may have a lower confidence interval and a wider margin of error. For example, questions asked only to households with school-aged children, or to households with at least one individual reported as having an illness serious enough to require medical treatment, will yield results with lower precision. Any findings that refer to a subset are noted in this factsheet.

- **Timing of assessment:** when interpreting findings, users are informed that data collection was: (1) conducted during monsoon season; (2) included the festival of Eid-al-Adha; and (3) occurred at the same time as other events such as the commemoration of the anniversary of the events of 2017.

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[5] "No formal education" includes "none" and "madrassa only"; "Some primary" includes "Kindergarten" through "Elementary 4"; "Primary and above" includes "Elementary 5" through tertiary levels.

[6] Questions on household disability prevalence were not asked according to Washington Group Short Set of Questions on Disability. Respondents were asked to report on each individual in their household who required another person to help him / her complete daily activities such as eating, dressing, bathing or going to the toilet.
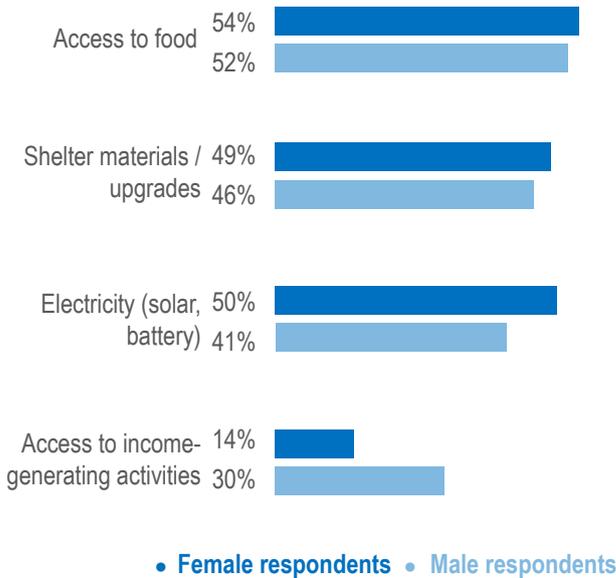
[7] JIAG is developing an analytical framework for inter-sectoral analysis, assisting with the identification of inter-linkages between various drivers, underlying and contributing factors, sectors and humanitarian conditions.

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COMMUNICATION WITH COMMUNITIES (CWC) AND PRIORITY NEEDS

PRIORITY NEEDS

% of households reporting the priority needs for which they require additional support, by respondent gender (top 4, unranked)[8,9]
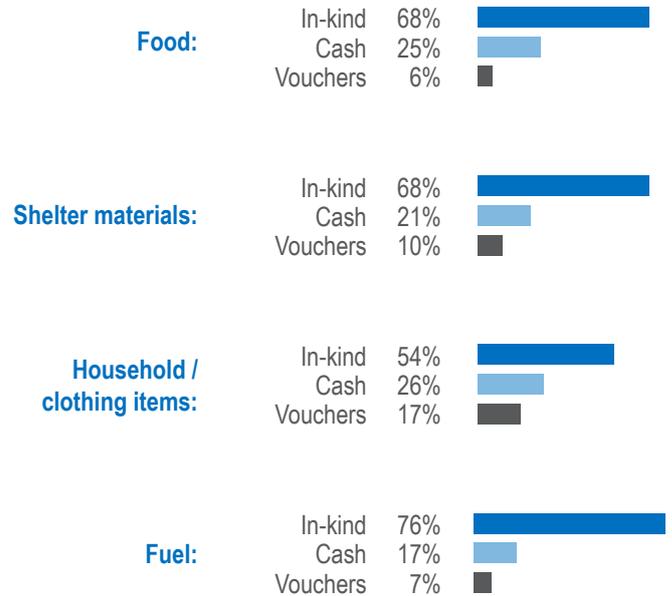
Access to food — 54% (Female), 52% (Male)

Shelter materials / upgrades — 49% (Female), 46% (Male)

Electricity (solar, battery) — 50% (Female), 41% (Male)

Access to income-generating activities — 14% (Female), 30% (Male)

● **Female respondents**   ● **Male respondents**

Top 4 household-ranked priority needs by their average weighted score[8,10]

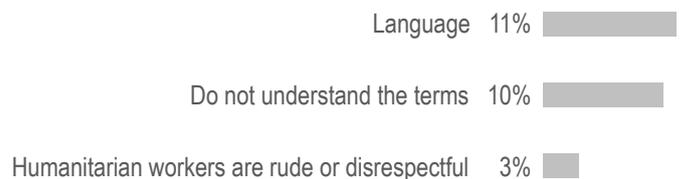| 1 | Access to food | 1.37 |
2	Shelter materials / upgrades	0.89
3	Electricity (solar, battery)	0.68
4	Access to income generating activities	0.32

A higher value in the table of ranked priority needs (bottom left) indicates that respondents prioritised this intervention above others. The maximum value possible was three. Although the top three priority needs (food, shelter materials and electricity) were reported by similar proportions of households, the ranking of these needs (bottom left) highlights the relative importance of these interventions. **"Access to food" features significantly higher than other stated needs.** There is minimum variation in stated needs when disaggregated based on respondent gender. "Access to clean drinking water" rounded out the top five, albeit ranking considerably lower than those reported in the bottom left corner.

PREFERRED AID MODALITIES

Of households reporting different priority needs, % reporting preferred modalities of assistance to meet each need[11]

Food:
In-kind 68%
Cash 25%
Vouchers 6%

Shelter materials:
In-kind 68%
Cash 21%
Vouchers 10%

Household / clothing items:
In-kind 54%
Cash 26%
Vouchers 17%

Fuel:
In-kind 76%
Cash 17%
Vouchers 7%

COMMUNITY PERCEPTIONS 👥

22% of households reported facing any barriers to interacting with humanitarian workers

Three most frequently reported barriers[12]

Language 11%
Do not understand the terms 10%
Humanitarian workers are rude or disrespectful 3%

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[8] Respondents were asked to report the top three priority needs for which their family required additional support, and then rank the 3 identified needs in order of importance.
[9] This figure presents the proportion of households that named each option as a top three priority need, regardless of rank.
[10] Rankings were analysed according to the Borda Count methodology, which determines the relative ranking of items by assigning each response a certain number of points corresponding to the position in which each respondent ranks it. Options ranked as the #1 need scored three points, #2 need scored two points, and #3 need scored one point. Aggregated ranking scores are then divided by all respondents, providing a score out of a maximum of three.
[11] Respondents were asked their preferred modality to receive these items if they reported any of them as a top three priority need. Respondents could only choose one modality of assistance. The denominator for each indicator is as follows: Food, n = 1,796; Shelter materials, n = 1,569; Household/cooking items, n = 688; Fuel, n = 212. Roughly 1-2% of households reported either a "combination" or "no preference" of modalities for each type of need.
[12] Respondents could choose up to three options.

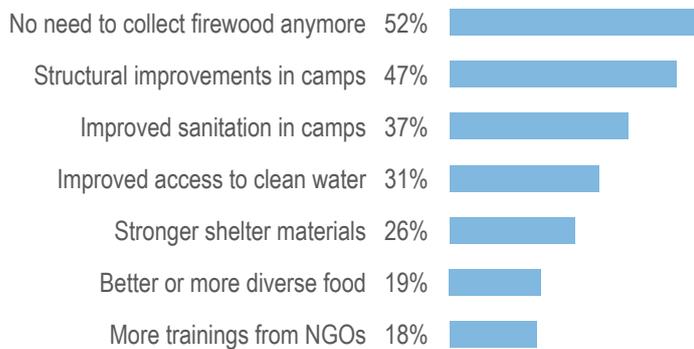% of households reporting how frequently they felt that their opinion was taken into account when providing feedback on aid and services received

38%	38%	12%	11%	1%
Always	Sometimes	Rarely	Never	Prefer not to answer
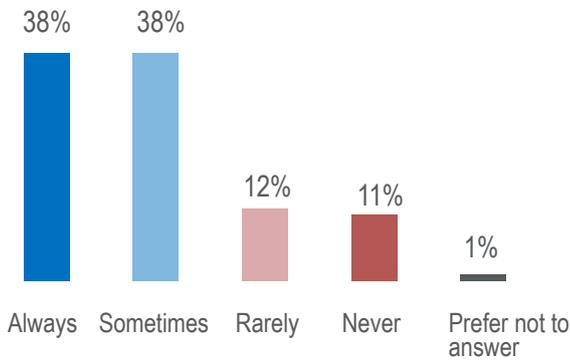
% of households reporting what is **not going well** with assistance and services received in the 6 months prior to data collection (top 7)[13]

Poor or insufficient shelter materials	36%
Insufficient access to income sources	29%
Insufficient/not diverse enough foods	25%
Insufficient camp infrastructure	22%
Health services insufficient/poor quality	20%
Insufficient access to clean water	20%
Insufficient cooking fuel (LPG, etc.)	16%
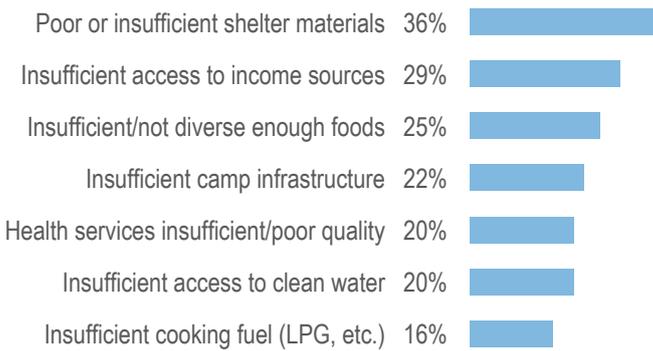
% of households reporting what is **going well** with assistance and services received in the 6 months prior to data collection (top 7)[13]

No need to collect firewood anymore	52%
Structural improvements in camps	47%
Improved sanitation in camps	37%
Improved access to clean water	31%
Stronger shelter materials	26%
Better or more diverse food	19%
More trainings from NGOs	18%

[13] For both questions, respondents could choose up to three options.

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🍲 FOOD SECURITY

FOOD CONSUMPTION

% of households by Food Consumption Score (FCS)[14]

5% Poor

41% Borderline

54% Acceptable

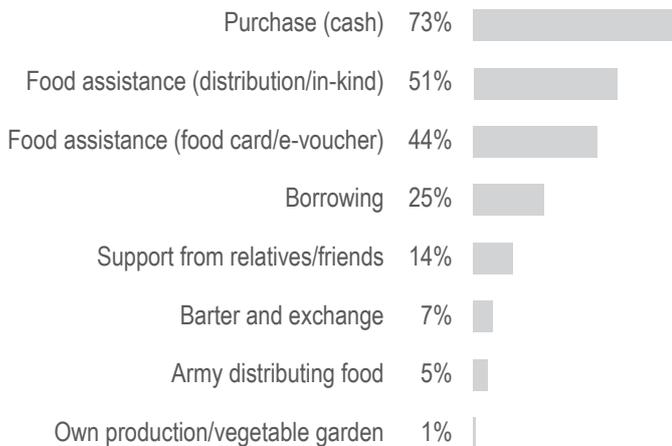% of households by estimated household dietary diversity[15]

35% 0 - 2 food groups

43% 3 food groups

22% 4+ food groups

FOOD SOURCES 🌾

% of households reporting the three main sources of food consumed in the 7 days prior to data collection[16]

Purchase (cash)	73%	
Food assistance (distribution/in-kind)	51%	
Food assistance (food card/e-voucher)	44%	
Borrowing	25%	
Support from relatives/friends	14%	
Barter and exchange	7%	
Army distributing food	5%	
Own production/vegetable garden	1%	

FOOD EXPENDITURES

% of households reporting spending any money (>0 BDT)[17] on **food** in the 30 days prior to data collection

95%

% of households reporting amount spent (BDT)[17] on food in the 30 days prior to data collection[18]

1 - 500	501 - 1000	1001 - 2000	2001 - 2000	5000+
9%	18%	28%	31%	9%
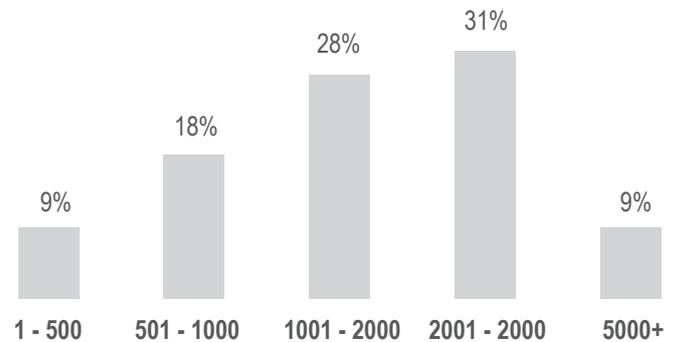
Overall FCSs suggest that **access to basic foods is extensive, and not indicative of widespread extreme gaps in food consumption patterns.** "Poor" FCSs - represented by diets of poor quality and quantity (mainly rice and fats, and certain greens)[19] - were not found to exceed nine per cent of households in any camp. **However, a significant proportion of households continue to endure "borderline" food consumption outcomes**. Estimates of household dietary diversity based on the reported quantity of food groups consumed during the seven days prior to data collection also suggest that **the majority of refugee families face difficulties accessing a varied diet.** Roughly three-quarters of households are estimated to consume three food groups or fewer in any given day. These outcomes should also be interpreted in conjunction with any additional coping strategies that refugees may employ beyond basic humanitarian assistance in order to meet basic needs, which may include sale of assistance items or incurring debt, as well as other more extreme mechanisms (see p.11 for further exploration). Most refugee households reported obtaining food through a combination of assistance from humanitarian actors and purchasing in cash. The above results reflect a continuation of conditions reported in the 2018 Refugee influx Emergency Vulnerability Assessment (REVA II).[19]

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[14] The Food Consumption Score is a composite score based on: (1) dietary diversity; (2) food frequency; and (3) relative nutritional importance of nine weighted food groups. The FCS is recorded from a seven-day recall period. In Bangladesh, thresholds for FCS classifications set by WFP are as follows: ≥ **42 Acceptable; 28 - 41 Borderline; ≤ 27 Poor.**
[15] The standard module to calculate a Household Dietary Diversity Score (24-hour recall period) was not included in the questionnaire. These findings represent the % of households who reported consuming numbers of food groups at least six or seven times in a week.
[16] Respondents could choose up to three options.
[17] BDT - Bangladeshi Taka
[18] 1% of respondents reported "do not know / prefer not to answer"; 4% reported spending 0 BDT on food expenses in the 30 days prior to data collection.
[19] WFP, *Refugee influx Emergency Vulnerability Assessment (REVA II) 2018, Cox's Bazar, Bangladesh* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).

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ACCESS TO MARKETS

% of households reporting length of time it takes to travel to the closest market by foot (in minutes)

7%   <5 minutes
36%   16 - 30 minutes
41%   5 - 15 minutes
16%   >30 minutes

% of households reporting spending any money (>0 BDT)[20] on **transportation** in the 30 days prior to data collection

77%

30% of households reported problems accessing markets in the 30 days prior to data collection[21]
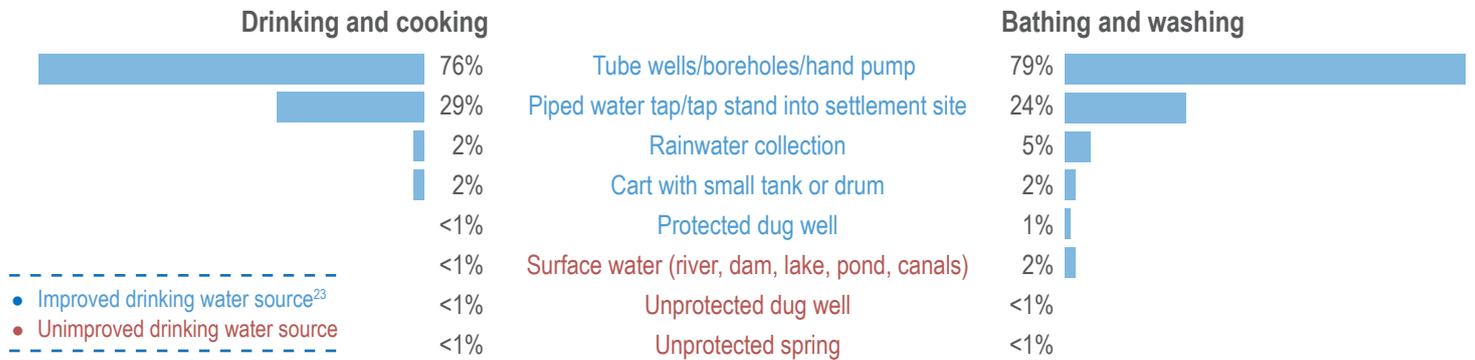
┌ ─ ─ ─ ─ Most frequently reported problems

Markets are too far	18%
Bad roads due to traffic/rough weather	8%
Transport is too expensive	8%
Safety/security concerns on the way to the market	5%
Safety/security concerns at the market	3%

[20] BDT - Bangladeshi Taka.
[21] Respondents could choose up to three options.

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WATER, SANITATION & HYGIENE (WASH)

WATER SOURCES

% of households reporting main source(s) of water used for the following purposes at the time of data collection[22]

Drinking and cooking		Bathing and washing
76%	Tube wells/boreholes/hand pump	79%
29%	Piped water tap/tap stand into settlement site	24%
2%	Rainwater collection	5%
2%	Cart with small tank or drum	2%
<1%	Protected dug well	1%
<1%	Surface water (river, dam, lake, pond, canals)	2%
<1%	Unprotected dug well	<1%
<1%	Unprotected spring	<1%

- - - ● Improved drinking water source[23]
- - - ● Unimproved drinking water source

% of households reporting **frequency of accessing surface water** for drinking or cooking purposes during the last dry season[24]
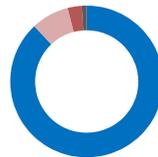
88% Never
8% A couple of times
3% Almost every day
1% Do not know

WATER COLLECTION

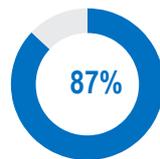% of households reporting collection times for water (fetch and return)

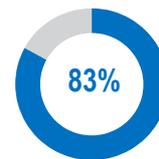**31%** <5 minutes
43% 5 - 15 minutes
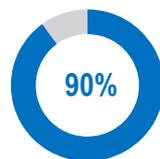**16%** 16 - 30 minutes
10% >30 minutes

WATER QUANTITIES

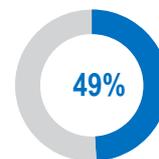% of households reporting having enough water to meet the following basic needs at the time of data collection[25]

87% Drinking
83% Personal hygiene
90% Cooking
49% Other domestic purposes

Ninety-nine per cent (99%) of refugee households reported accessing improved water sources as their main source of water for drinking and cooking purposes. This reflects similar findings from WASH Sector assessments conducted in May of 2019[26] and October 2018[27] (with data collection for the latter assessment also occurring during monsoon season). However, water originating from improved water sources and/or spouts may still be contaminated, with significant pollution of drinking water also occurring at the household level (related to hygiene and storage practices)[28]. Findings from this assessment indicate that not all households had enough water to meet basic needs during monsoon season. **Eleven per cent (11%) of households also reported the need to access surface water for drinking or cooking purposes either some days or almost every day during the last dry season**. Most households reporting the need to do so were concentrated in six camps in southern Teknaf (Camps 22, 24, 25, 26, 27 and Nayapara RC).

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[22] Respondents could choose more than one option.
[23] An "improved drinking-water source" is one "that by the nature of its construction adequately protects the source from outside contamination, in particular with faecal matter" (World Health Organization, *Key Terms - Water sanitation hygiene* (Geneva, n.d.). Available here (accessed 30 November 2019).
[24] Respondents were asked to recall frequencies from the previous dry season, as data collection occurred during the rainy season. The calendar period corresponding to "dry season" was not specifically defined but is commonly understood to include the months immediately preceding monsoon season (roughly April - May 2019).
[25] "Personal hygiene" includes activities such as washing and bathing; "other domestic purposes" includes activities such as cleaning house, floor, etc.
[26] WASH Sector Cox's Bazar and REACH Initiative, *Water, Sanitation and Hygiene (WASH) Household Dry Season Follow-up Assessment (May 2019)* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[27] WASH Sector Cox's Bazar and REACH Initiative, *Water, Sanitation and Hygiene (WASH) Assessment - Monsoon Follow-up (October 2018)* (Cox's Bazar, 2018). Available here (accessed 19 November 2019).
[28] World Health Organization, *Bi-weekly Situation Report #19, 26 September 2019* (Cox's Bazar, Bangladesh). Available here (accessed 19 November 2019).

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SANITATION & HYGIENE

% of households reporting types of sanitation facility (latrine or toilet) usually used

- Pit latrine with a slab and platform **60%**

- Pour or flush household latrine **33%**

- Pit latrine without a slab or platform **6%**

- Improved sanitation facility[29]
- Unimproved sanitation facility

% of households that reported **having soap** **67%**

% of households reporting on visible traces of environmental sanitation issues in the vicinity of their accommodation (30 metres) in the 30 days prior to data collection

- Waste **39%**

- Human faeces **26%**

- Stagnant water **16%**

% of households reported spending any money (>0 BDT)[30] on **hygiene items** in the 30 days prior to data collection **30%**

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[29] An "improved sanitation facility" is one which "hygienically separates human excreta from human contact". Classification of latrines in the present assessment is based on WHO/UNICEF guidelines. (World Health Organization, *Key Terms - Water sanitation hygiene* (Geneva, n.d.). Available here (accessed 30 November 2019).
[30] BDT - Bangladeshi Taka.

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HEALTH AND NUTRITION

WELLBEING[31,32]

80% of **households** reported the presence of **at least one person** with an illness serious enough to require medical treatment in the 30 days prior to data collection

35% of **individuals** were reported as having an illness serious enough to require medical treatment in the 30 days prior to data collection

Of individuals reported as having an illness, % by age range[33]

Of individuals reported as having an illness, % by gender[34]

Age	%
0 - 17	31%
18 - 59	36%
60+	70%

Gender	%
Male	32%
Female	38%

10% of **households** reported the presence of **at least one individual** (aged 5 and above) reported as requiring assistance to complete daily activities

3% of **individuals** (aged 5 and above) were reported to require assistance to complete daily activities[35]

28% of **individuals** aged 60 and above were reported to require assistance to complete daily activities[36]

% of **households** reporting **at least one member** ill with diarrhoea in the 2 weeks prior to data collection

31% reported the presence of at least one individual **under 5 years of age with diarrhea**[37]
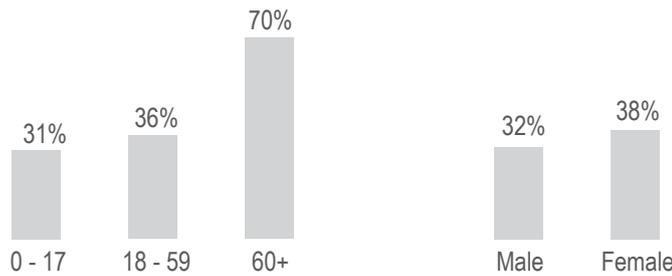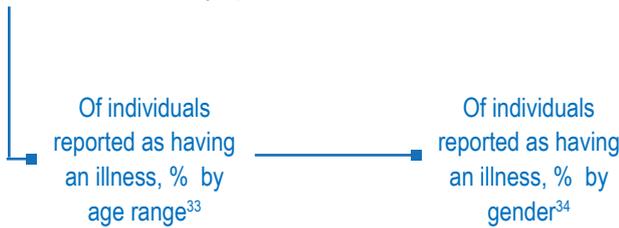
22% reported the presence of at least one individual **over 5 years of age with diarrhea**[38]

HEALTH-SEEKING BEHAVIOURS

Of individuals reported as having an illness serious enough to require medical treatment, % for whom **treatment was sought**[39] **97%**

Of individuals reported as having an illness serious enough to require medical treatment who **sought treatment**, % by **treatment location**[40]

| Location	%
NGO clinic	79%
Private clinic	29%
Pharmacy or drug shop in the market	22%
Government clinic	8%
Traditional / community healer	3%

[31] Data on individual illness and disability were collected by proxies (from respondents on behalf of all household members), and not directly from households members themselves.
[32] Questions on household disability prevalence were not asked according to Washington Group Short Set of Questions on Disability. Respondents were asked to report on each individual in their household who required another person to help him / her complete daily activities such as eating, dressing, bathing or going to the toilet.
[33] The denominator for this indicator is all individuals in the specified age groups (0 - 17, n = 5,870; 18- 59, n = 7,571; 60 and above, n = 648). The recall period is in the 30 days prior to data collection.
[34] The denominator for this indicator is all individuals of either gender (males, n = 8,559; females, n = 8,602). The recall period is in the 30 days prior to data collection.
[35] The denominator for this indicator is all individuals aged five and above (n = 14,089).
[36] The denominator for this indicator is all individuals aged 60 and above (n = 648).
[37] The denominator for this indicator is all households with children under five (n = 2,021);
[38] The denominator for this indicator is all households with individuals aged five and above (n = 3,418).
[39] The denominator for this indicator is individuals who were reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection (n = 5,967).
[40] Respondents could report more than one treatment location. The denominator for this indicator is individuals who were reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection, who sought treatment (n = 5,771).

ISCG INTER SECTOR COORDINATION GROUP

ACCESS TO HEALTH SERVICES

Of the **3%** of individuals reported as having an illness serious enough to require medical treatment who **did not seek treatment,** most-frequently reported reasons for not seeking treatment[42]

- Health services overcrowded (long wait times)

- Treatment not available

- Treatment is expensive

- Health service staff behaviour is bad

- Health services are too far away / lack of transport

Of households reporting at least one member (aged 5 and above) requiring assistance to complete daily activities, % reporting that they were able to **access support** for this individual.[43]

73%
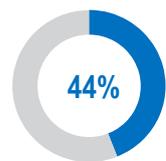
44% of households reported being visited by a community health worker during the two weeks prior to data collection

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The proportion of individuals reported to have sought treatment at an NGO clinic or Government clinic has remained consistent over MSNA data from January 2019 and July 2018. However, the proportion of individuals reported to have sought treatment at a private clinic or pharmacy / drug shop has increased by ten percentage points for both compared with January 2019. Reported treatment location did not vary significantly by camp. Male respondents (52%) were more likely to report having been visited by a community health worker in the two weeks prior to data collection than female respondents (38%).

Findings from the J-MSNA indicate that nearly three-quarters of households reported accessing support for individual(s) requiring assistance to complete daily activities. However, findings from Rounds III (May 2019)[44] and IV (October 2019)[45] of the WASH Household Surveys, in which the question regarding accessing support services was asked of each individual reported as having a disability (per Washington Group Short Set of Questions on Disability), roughly one-third of individuals reported to have a disability were reported to have accessed support, in both rounds.

MATERNAL, NEWBORN AND CHILD HEALTH

9% of households reported the presence of a pregnant woman

Of households reporting the presence of at least one pregnant woman, % indicating whether pregnant woman is currently enrolled in an **antenatal care (ANC) programme**[46]

70%

% of all households reporting primary decision-maker on location of delivery of child

53% Husband of the pregnant woman
14% Other relative of the pregnant woman
13% Pregnant woman herself
10% Joint decision between pregnant woman and someone else
9% Do not know / prefer not to answer
1% Community leader

Of children aged 0 to 11 months, % by reported location of delivery[47]

82% At home
18% At a clinic

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[42] The denominator for this indicator is individuals who were reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection who did not seek treatment (n = 196). Results are indicative. The five reasons reported above reflect those reported by roughly one-fourth of respondents who answered this question.
[43] The denominator for this indicator is all households reporting the presence of at least one individual requiring assistance to complete daily activities (n = 393).
[44] WASH Sector Cox's Bazar and REACH Initiative, *Water, Sanitation and Hygiene (WASH) Household Dry Season Follow-up Assessment (May 2019)* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[45] WASH Sector Cox's Bazar and REACH Initiative, *Water, Sanitation and Hygiene (WASH) Households Monsoon Season Follow-up Assessment (October 2019)* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[46] The denominator for this indicator is all households reporting the presence of at least one pregnant woman (n = 295).
[47] The denominator for this indicator is individuals 11 months of age or younger at the time of data collection (n = 520). Findings on location of delivery should be triangulated with health sector data, which may reflect increases in clinic births over recent months. "Clinic" may include government, NGO and/or private.

Of individuals aged 0 to 2 years at the time of data collection, % who were reported to have been **breastfed immediately / within an hour of birth**[48]

66%

Of households reporting the presence of at least one mother with a child aged 0 to 2 years, % reporting ever **receiving support on feeding young children**[49]
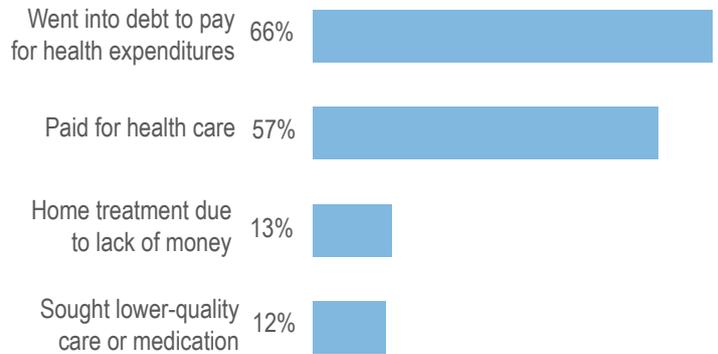
38%

Of individuals aged 6 to 59 months, % reported as being currently enrolled in any nutrition-feeding programme, by type of programme[50]

63% BSFP
7% TSFP
4% OTP
30% None
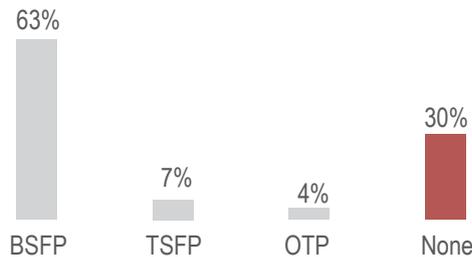
Findings from this J-MSNA indicate that a **majority of children born in the year leading up to data collection were born at home.** These findings do not specify whether births were attended by a skilled or unskilled birth attendant (e.g. midwife). The reported primary decision-maker on location of delivery of children did not vary based on respondent gender. Of those households reporting the presence of at least one mother with a child aged zero to two years that did report receiving support on feeding young children, 20% reported receiving support at home, and 18% at a facility. Of those households reporting at least one pregnant woman enrolled in an ANC programme (n = 218), the majority (87%) reported receiving an ANC card.
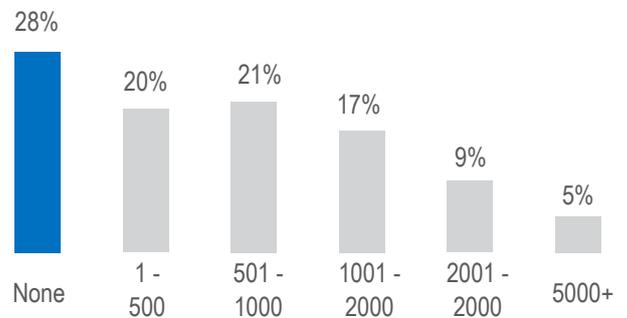
HEALTH COPING MECHANISMS

Of the **80%** of households reporting the presence of at least one member with an illness in the 30 days prior to data collection, % reporting **using coping mechanisms** for health-related issues (top 4)[51]

Went into debt to pay for health expenditures 66%
Paid for health care 57%
Home treatment due to lack of money 13%
Sought lower-quality care or medication 12%

HEALTH EXPENDITURES

% of households reporting amount spent (BDT)[52] on medical expenses, health care, and/or medicine in the 30 days prior to data collection

28% None
20% 1 - 500
21% 501 - 1000
17% 1001 - 2000
9% 2001 - 2000
5% 5000+

J-MSNA data show that although most individuals seek treatment for illnesses when it is necessary, **81%** of households that reported at least one individual with an illness in the 30 days prior to data collection **reported engaging in coping mechanisms** in order to manage health-related issues, including resorting to paying for care or even incurring debt in order to cover health expenses (19% of households reported not using coping mechanisms for health-related issues when a member of their household had an illness in the 30 days prior to data collection).

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[48] The denominator for this indicator is all individuals aged 0-2 years of age (n = 1,613). Respondents were asked how long after birth each child within this age range was put to the breast, and could only choose one option from "within one hour", "in the first day", "after the first day", or "do not know".
[49] The denominator for this indicator is households with at least one mother with a child aged 0-2 years (n = 1,382). Respondents were asked whether mothers received support on feeding young children at home, at a facility, or not at all.
[50] Respondents could choose more than one option. The denominator for this indicator is all individuals aged 6 to 59 months (n = 3,440). "BSFP" = "blanket supplementary feeding programme"; "TSFP" = "targeted supplementary feeding programme"; "OTP" = "outpatient therapeutic programme".
[51] Respondents could choose more than one option. The denominator for this indicator is all individuals who were reported to have had an illness serious enough to require medical treatment in the 30 days prior to data collection (n = 5,967).
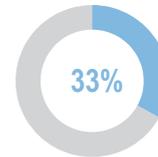[52] BDT - Bangladeshi Taka.

PROTECTION

PERCEPTIONS OF SAFETY

45%
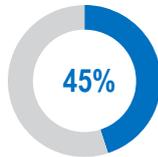
of **female respondents** reported at least one area in their neighbourhood where **female** members **do not feel safe**[53]

33%

of **male respondents** reported at least one area in their neighbourhood where **male** members **do not feel safe**[53]

Female members	Most frequently reported areas (top 6)		Male members
25% Latrines	1	Market	18%
14% Water points	2	Latrines	15%
12% Market	3	Shelter[54]	8%
9% Distribution points	4	Distribution points	6%
8% Health centres	5	Inside the home[54]	6%
7% Shelter[54]	6	On the way to or from key facilities	5%

Of households reporting at least one area in their neighbourhood where male / female members feel unsafe, % by **reason male and female members feel unsafe**, by gender[55]

Female members	Most frequently reported reasons (top 5)		Male members
50% Lack of enough light at night	1	Fear of abduction	61%
31% Petty crime, bullying, harassment	2	Lack of enough light at night	33%
29% Fear of abduction	3	Fear of criminal groups	30%
20% Violence	4	Violence	28%
12% Fear of criminal groups	5	Petty crime, bullying, harassment	24%

While bathing areas were frequently reported as an area where female members felt unsafe in the July 2018 MSNA (34%; within the top three), **a very low proportion of female respondents reported bathing areas in the present assessment.** This may be linked to more women choosing to bathe at home, as shown in the recent WASH household assessment (October 2019).[56]

[53] Respondents were asked to respond on behalf of household members of their respective gender only (male, n = 1,669; female, n = 1,749). Respondents could choose more than one option.
[54] "Shelter" implies issues related to the shelter structure itself; "inside the home" refers to other dynamics occurring within the home (e.g. social, domestic disputes, etc.).
[55] The denominator for this indicator is all households where male or female respondents indicated at least one area where male or female members do not feel safe (male, n = 547; female, n = 751).
[56] WASH Sector Cox's Bazar and REACH Initiative, *Water, Sanitation and Hygiene (WASH) Households Monsoon Season Follow-up Assessment (October 2019)* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).

REPORTING SAFETY CONCERNS

% of households reporting preferred point-of-contact if they needed to refer a friend who was sexually assaulted for care and support[57]

	Female	Male
Majhi	84%	81%
Legal aid service providers	8%	25%
Police and security	10%	20%
Health facilities	8%	22%
Community-based dispute resolution mechanisms	5%	17%
Psychosocial service providers	6%	6%
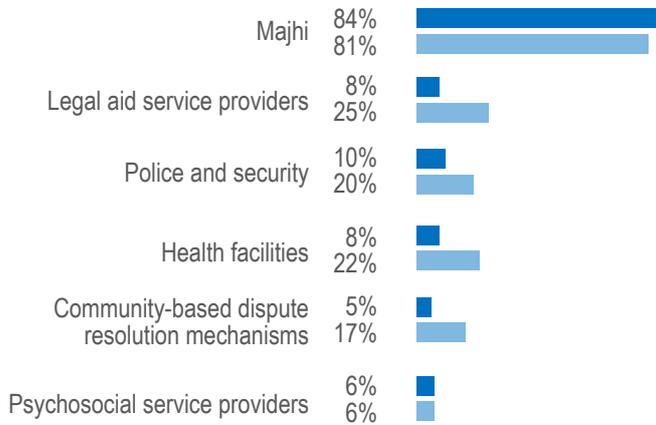
● **Female respondents** ● **Male respondents**

% of households reporting who they would report to first in the event of a **serious security issue**, by point-of-contact[58]

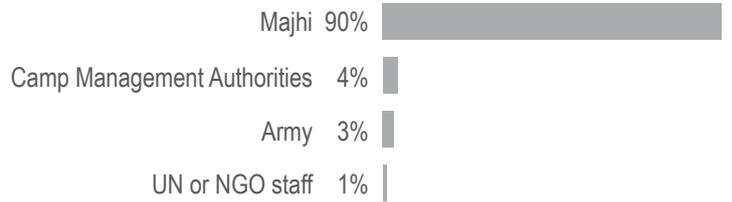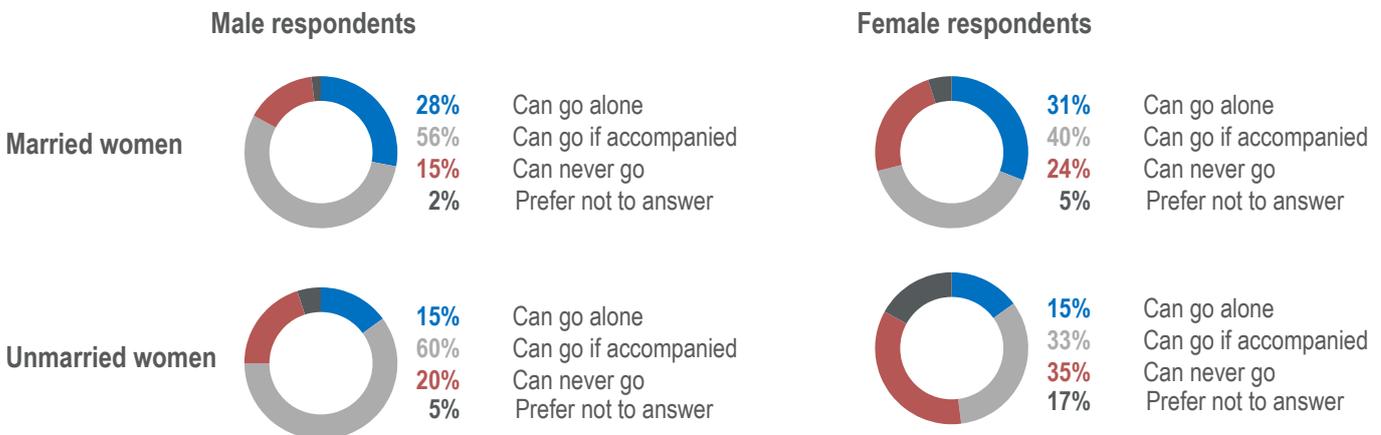|	
Majhi	90%
Camp Management Authorities	4%
Army	3%
UN or NGO staff	1%

The proportion of households citing Majhi[58] as first point-of-contact to report a security issue remained consistent with MSNA data from July 2018 and January 2019. Findings regarding point-of-contact for referral in the event of sexual assault show that while most male and female respondents would report to Majhi as first point-of-contact, **female respondents were less likely / able to name other resources or mechanisms of support.**
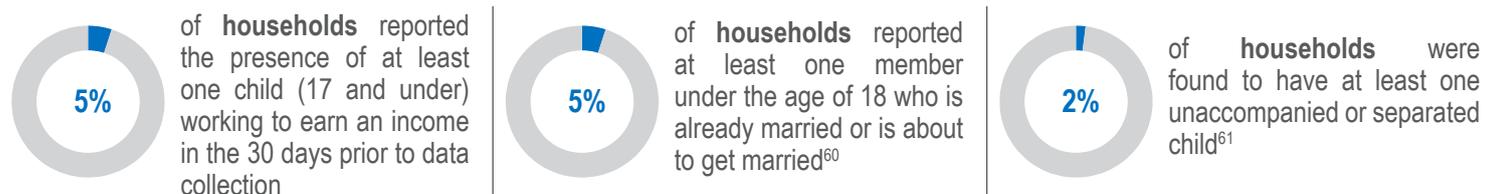
FREEDOM OF MOVEMENT FOR WOMEN

% of households reporting whether married and unmarried women (aged 18 and over) are allowed to go to the market - accompanied, unaccompanied, or not at all[59]

Male respondents

Married women
- **28%** Can go alone
- 56% Can go if accompanied
- **15%** Can never go
- **2%** Prefer not to answer

Unmarried women
- **15%** Can go alone
- 60% Can go if accompanied
- **20%** Can never go
- **5%** Prefer not to answer

Female respondents

Married women
- **31%** Can go alone
- 40% Can go if accompanied
- **24%** Can never go
- **5%** Prefer not to answer

Unmarried women
- **15%** Can go alone
- 33% Can go if accompanied
- **35%** Can never go
- **17%** Prefer not to answer

Unmarried women were less likely to be reported to be able to go to the market than married women. Female respondents were more likely than male respondents to report women as never being permitted to go to the market (either accompanied or unaccompanied). Male respondents were more likely than female respondents to report that women (married and unmarried) are allowed to go to the market, if accompanied by someone else.

CHILD PROTECTION

5% of **households** reported the presence of at least one child (17 and under) working to earn an income in the 30 days prior to data collection

5% of **households** reported at least one member under the age of 18 who is already married or is about to get married[60]

2% of **households** were found to have at least one unaccompanied or separated child[61]

[57] Respondents could choose more than one option. This question asked the respondent to answer based on a hypothetical scenario.
[58] Majhis are selected by the Government of Bangladesh to support camp management authorities and act as the focal point for an unofficial "block" of households. Majhis were appointed without a formalised process. The system was introduced in registered camps after the 1991-92 influx and revived after the onset of the recent crisis [ACAPS NPM Analysis Hub, *Rohingya Crisis: Governance and community participation, thematic report, June 2018* (Cox's Bazar, 2018). Available here (accessed 1 December 2019)].
[59] This question was only asked of households with at least one female individual over the age of 12 (n = 3,391).
[60] The denominator for this indicator is all households with at least one member between five years and 17 years of age (n = 3,067).
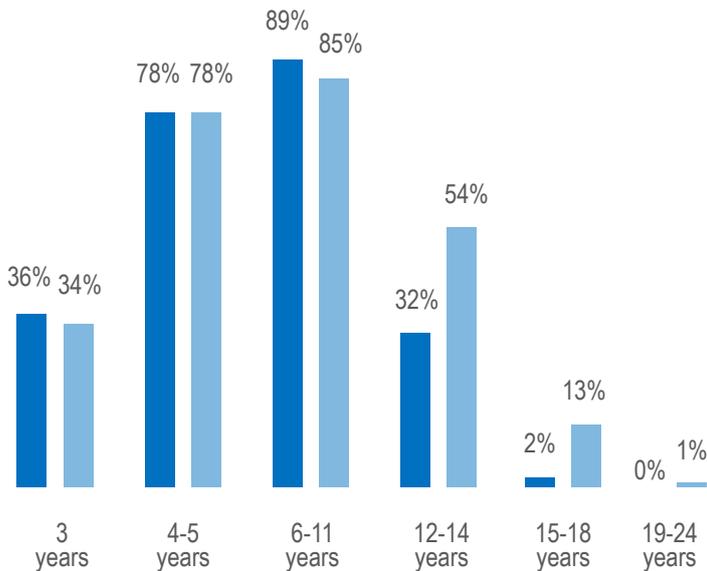[61] Households were classified as containing unaccompanied or separated children if they reported the presence of individuals under 18 who had joined the household since arriving to Bangladesh, excluding children who were born into the household.
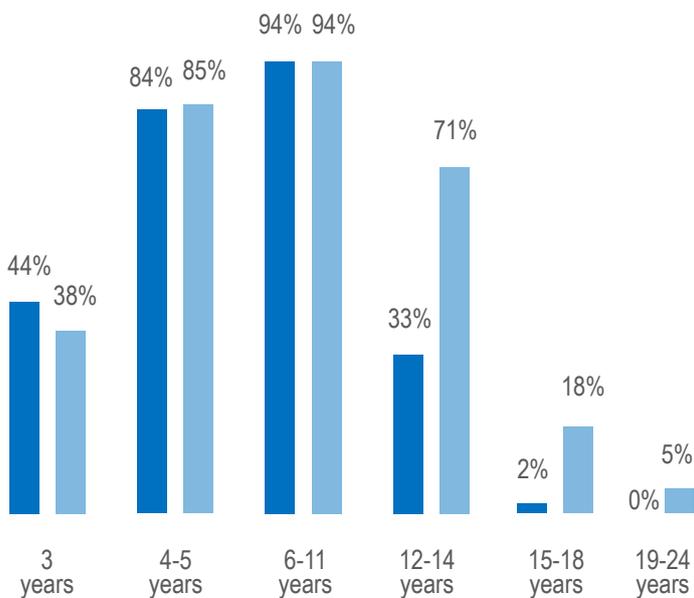
EDUCATION

EDUCATION ENROLMENT

% of children and youth reported to be attending a **temporary learning centre (TLC)** for at least 4 days per week during the 30 days prior to data collection, by age group and gender[62]

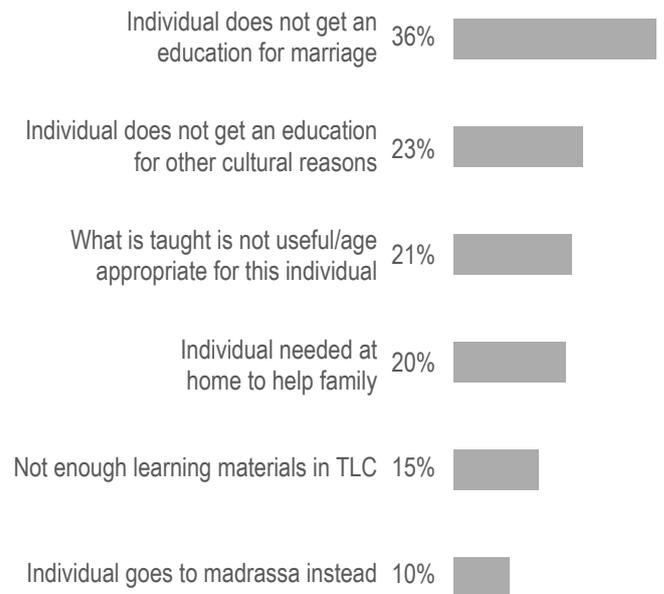| Age group	Females	Males
3 years	36%	34%
4-5 years	78%	78%
6-11 years	89%	85%
12-14 years	32%	54%
15-18 years	2%	13%
19-24 years	0%	1%

● **Females** ● **Males**

% of children and youth reported to be attending a **madrassa** during the 30 days prior to data collection, by age group and gender[62]

Age group	Females	Males
3 years	44%	38%
4-5 years	84%	85%
6-11 years	94%	94%
12-14 years	33%	71%
15-18 years	2%	18%
19-24 years	0%	5%

● **Females** ● **Males**

EDUCATION BARRIERS

Of households with at least one individual aged 3 - 24 reported as not regularly attending a TLC, % reporting **education barriers** (by type of barrier; top 6 shown)[63]

Barrier	%
Individual does not get an education for marriage	36%
Individual does not get an education for other cultural reasons	23%
What is taught is not useful/age appropriate for this individual	21%
Individual needed at home to help family	20%
Not enough learning materials in TLC	15%
Individual goes to madrassa instead	10%

% of households reporting spending any money (>0 BDT)[64] on **education materials** in the 30 days prior to data collection

25%

Education attendance rates dropped significantly for both adolescent boys and girls from age 12 onward, albeit decreasing more rapidly for girls than for boys. Adolescent boys aged 12 - 18 were more likely to be reported as regularly attending madrassa than a TLC, **while attendance rates for girls aged 12 - 18 were similarly low regardless of the type of learning space**. These findings reflect similar conclusions from the Education Needs Assessment conducted in March 2019 (ENA).[65] The aforementioned assessment noted through Focus Group Discussions (FGDs) that non-attendance of adolescent girls was closely linked to cultural practices and separation of boys and girls after puberty. These dynamics may be reflected in the above figure, which shows "cultural reasons" and "marriage" as the most frequently-reported reasons for non-attendance of children. This is followed by "what is taught is not useful or age appropriate", which may reflect frustrations voiced in ENA FGDs regarding perceptions that the current curriculum offered is not adequate for more advanced or older learners. The top education barriers reported above also mirror those reported in the ENA.[65] **Compared with the July 2018 MSNA, attendance rates at TLCs have increased.** For example, 64% of boys and 63% of girls aged 6 - 14 were reported as regularly attending a TLC during the 2018 MSNA, compared with 76% of boys and 71% of girls aged 6 - 14 during the present assessment.

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[62] The denominator for each age range is all males or females in the specified age group. Three years of age (males, n = 365; females, n = 385); 4 - 5 (males, n = 673; females, n = 630); 6 - 11 (males, n = 1,534; females, n = 1,398); 12 - 14 (males, n = 654 females, n = 644); 15 - 18 (males, n = 792; females, n = 944); 19 - 24 (males, n = 932; females, n = 1,094).
[63] Respondents could choose up to three options. The denominator for this indicator is all households reporting at least one individual aged 3 - 24 as not regularly attending a TLC (n = 2,792).
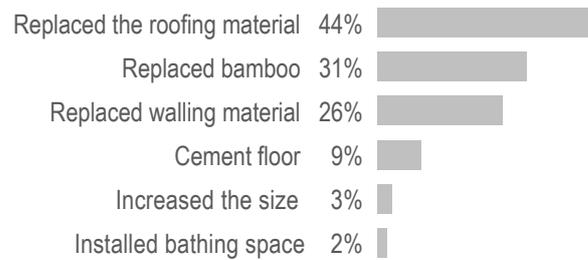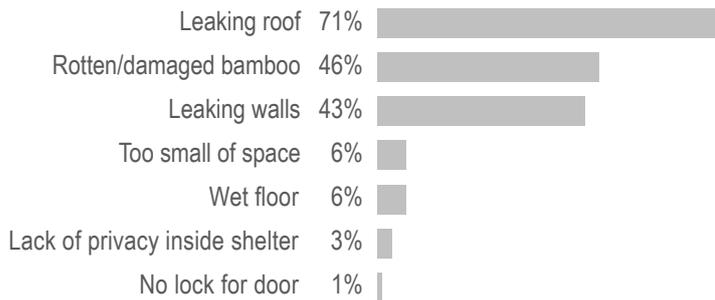[64] BDT - Bangladeshi Taka.
[65] REACH Initiative, *Education Needs Assessment: Rohingya Refugee Response, March 2019* (Cox's Bazar, Bangladesh). Available here (accessed 19 November 2019).

⌂ SHELTER & NON-FOOD ITEMS (NFI)

SHELTER STRUCTURE & MAINTENANCE

81% of households reported **facing any issues with their shelter** in the 6 months prior to data collection[66]

Issues reported by households

Leaking roof	71%	
Rotten/damaged bamboo	46%	
Leaking walls	43%	
Too small of space	6%	
Wet floor	6%	
Lack of privacy inside shelter	3%	
No lock for door	1%	

54% of households reported having **made any improvements to their shelter** in the 6 months prior to data collection[67]

Most frequently-reported improvements

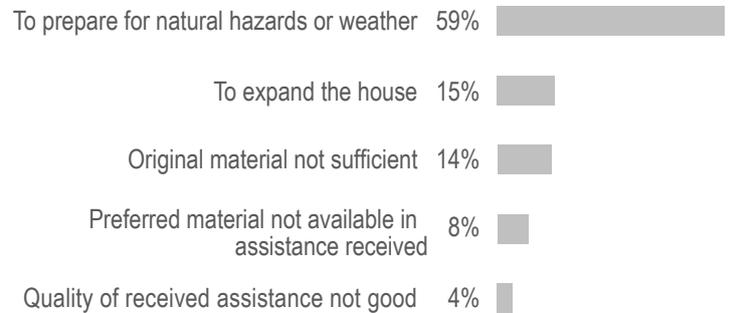|		
Replaced the roofing material	44%	
Replaced bamboo	31%	
Replaced walling material	26%	
Cement floor	9%	
Increased the size	3%	
Installed bathing space	2%	

32%

of households reported not making any improvements to their shelter in the 6 months prior to data collection, **despite reporting the need to do so**

Of households reporting **not** making improvements to their shelter in the 6 months prior to data collection, % reporting **lack of enough money** as a reason for not making improvements[68] **65%**
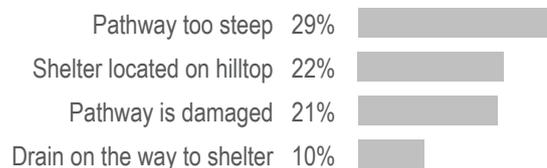
34% of households reported **purchasing materials (or exchanging other goods)** in order to make improvements to their shelter in the 6 months prior to data collection[69]

Reported reasons for purchasing materials

To prepare for natural hazards or weather	59%	
To expand the house	15%	
Original material not sufficient	14%	
Preferred material not available in assistance received	8%	
Quality of received assistance not good	4%	

SHELTER ACCESS

51% of households reported that members face any physical challenges accessing their shelter at the time of data collection

Reasons for inaccessibility reported by households[70]

Pathway too steep	29%	
Shelter located on hilltop	22%	
Pathway is damaged	21%	
Drain on the way to shelter	10%	

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[66] Respondents could choose more than one option. Users are reminded that data collection was conducted during the rainy season in August and September, which may have had an impact on the overall proportion of households citing experiencing issues with their shelter, as well as on the type of issues reported.
[67] Respondents could choose more than one option.
[68] The denominator for this indicator is all households that reported not making improvements to their shelter in the 6 months prior to data collection (n = 1,555).
[69] Respondents could choose more than one option. This question was only asked of households that reported making improvements to their shelter in the 6 months prior to data collection (n = 1,863), but the indicator is represented as a proportion of all households. The number of households indicating having purchased shelter materials (or exchanged other goods) in order to make shelter improvements (n = 1,136) is less than the number that reported making any improvements to their shelter, indicating that not all households that reported making improvements to their shelter in the 6 months prior to data collection purchased materials in order to do so (for example, because all items required for improvements were met through aid distributions or self-collection of items). Of those households that did report purchasing any materials, the most commonly-purchased materials were tarpaulin, borak bamboo, rope and cement.
[70] Respondents could choose more than one option.

SHELTER RENT PAYMENTS

% of households reporting that they have paid money or goods to anyone to live in their current shelter in the 6 months prior to data collection

10%

As a proxy for security of land tenure, households were asked whether they had paid rent in the form of goods or direct cash in the six months prior to data collection. **While most households reported not paying rent, those reporting the need to do so were concentrated in certain Teknaf camps** (excluding Nayapara RC). The proportion of households overall, as well as the localities with higher proportions of households reporting paying money or goods to live in their shelter, closely align with findings from the July 2018 MSNA.

COOKING FUEL[71]

88% of households reported **exclusively using LPG** (cooking gas cylinder) as a fuel source in the 4 weeks prior to data collection

11% of households reported using **purchased firewood** as a fuel source in the 4 weeks prior to data collection

2% of households reported using **self-collected firewood** as a fuel source in the 4 weeks prior to data collection

The proportion of households that reported exclusively using liquid propane gas (LPG) for cooking has increased over a short period of time, from 75% of households in the June 2019 Light MSNA[72] to 88% in August-September during the present assessment. Only 12% of households reported using any type of firewood (either purchased or self-collected) in the four weeks prior to data collection during the current J-MSNA. Of the households indicating using self-collected firewood as a fuel source (n = 79), most reported that adult males were the primary gatherers. "No need to collect firewood anymore" was the most frequently-reported aspect of what was going well with assistance and services received by refugee households in the six months prior to data collection.
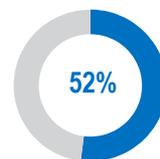
OTHER NON-FOOD ITEMS

% of households reporting the number of (functioning) portable lamps that they possess
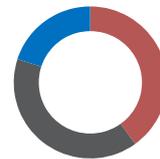
40% None
40% One lamp
20% Two or more
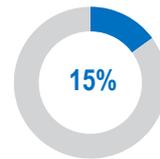
15% of households were found to have at least one floor mat per household member[73]

52% of households were found to have at least one blanket per household member[73]

EXPENDITURES RELATED TO SHELTER & NFI

% of households that reported spending any money (>0 BDT)[74] on the following items in the 30 days prior to data collection

- Shelter materials (e.g. plastic rope, wire, tarpaulin, cement, bamboo) **27%**

- Cooking fuel **16%**

- Clothing and shoes[75] **46%**

- Kitchen items and utensils **26%**

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[71] Respondents could choose more than one option.
[72] ISCG, *Joint Multi-Sector Needs Assessment (J-MSNA) Bangladesh, Refugee Sites, June 2019* (Cox's Bazar, 2019). Available here (accessed 19 November 2019).
[73] These indicators were both calculated by comparing the reported number of floor mats / blankets to the reported household size.
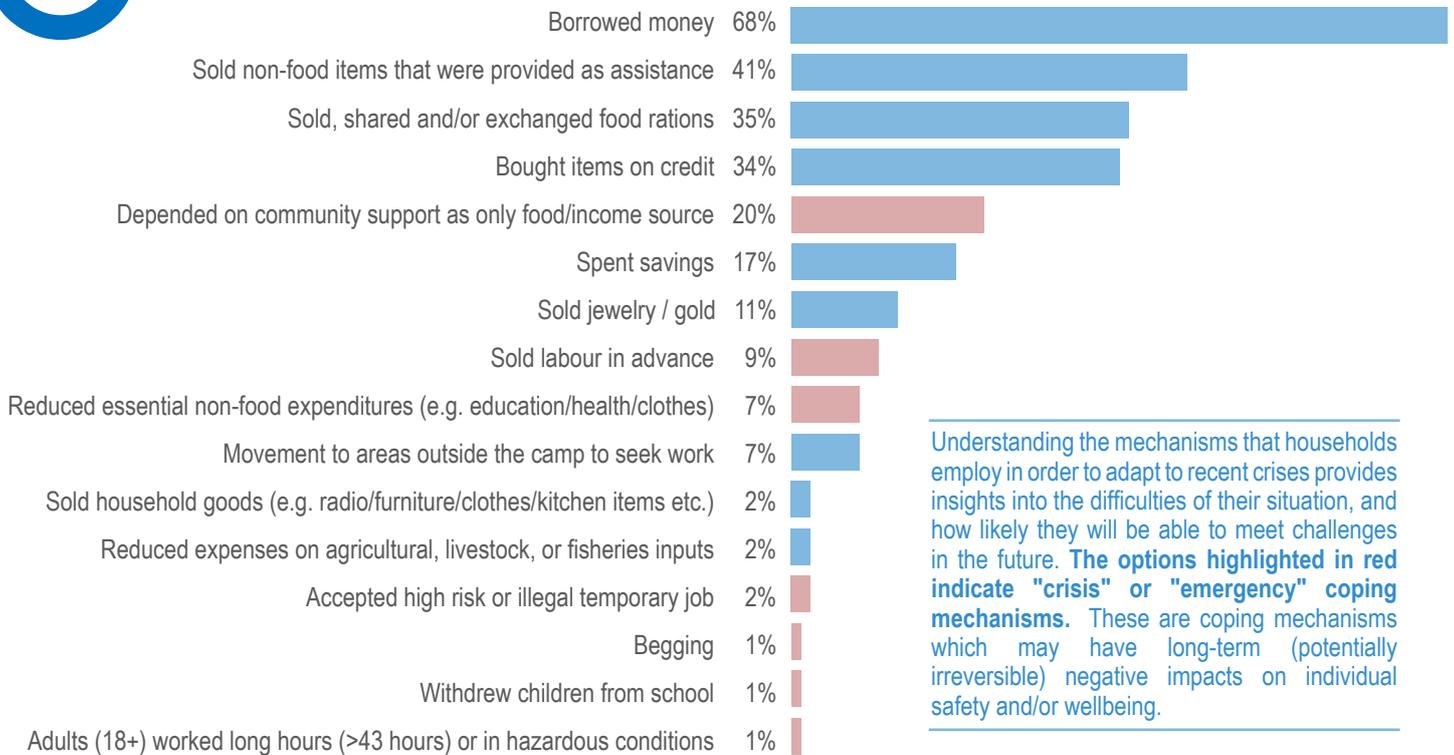[74] BDT - Bangladeshi Taka.
[75] The data collection period included the festival of Eid al-Adha, which may explain the expenditures on clothes/shoes.
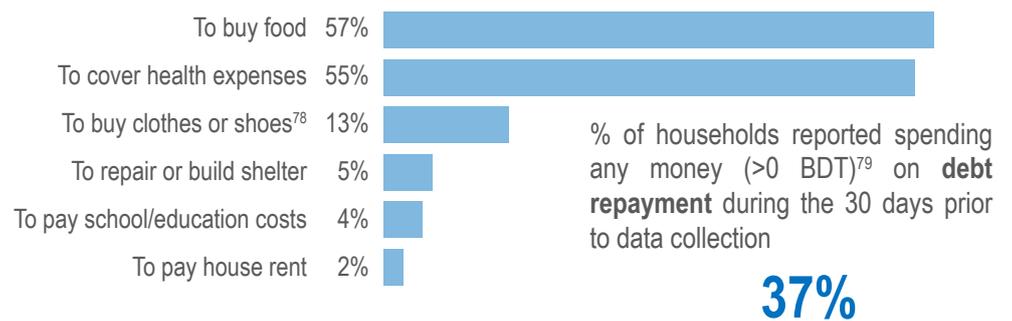
↔ COPING CAPACITIES
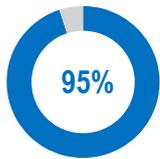
95% of households reported **engaging in coping mechanisms** due to a lack of money to meet basic needs during the 30 days prior to data collection[76]

Coping mechanism	%
Borrowed money	68%
Sold non-food items that were provided as assistance	41%
Sold, shared and/or exchanged food rations	35%
Bought items on credit	34%
Depended on community support as only food/income source	20%
Spent savings	17%
Sold jewelry / gold	11%
Sold labour in advance	9%
Reduced essential non-food expenditures (e.g. education/health/clothes)	7%
Movement to areas outside the camp to seek work	7%
Sold household goods (e.g. radio/furniture/clothes/kitchen items etc.)	2%
Reduced expenses on agricultural, livestock, or fisheries inputs	2%
Accepted high risk or illegal temporary job	2%
Begging	1%
Withdrew children from school	1%
Adults (18+) worked long hours (>43 hours) or in hazardous conditions	1%

Understanding the mechanisms that households employ in order to adapt to recent crises provides insights into the difficulties of their situation, and how likely they will be able to meet challenges in the future. **The options highlighted in red indicate "crisis" or "emergency" coping mechanisms.** These are coping mechanisms which may have long-term (potentially irreversible) negative impacts on individual safety and/or wellbeing.

% of households reporting **reasons for borrowing money or purchasing items on credit** (i.e. incurring debt) (top 6)[77]

Reason	%
To buy food	57%
To cover health expenses	55%
To buy clothes or shoes[78]	13%
To repair or build shelter	5%
To pay school/education costs	4%
To pay house rent	2%

% of households reported spending any money (>0 BDT)[79] on **debt repayment** during the 30 days prior to data collection

37%

While J-MSNA findings point to generally high coverage of basic needs and services, **refugees reported the need to seek out additional means beyond humanitarian assistance in order to cover their basic needs. Only 5% of households reported not engaging in any coping mechanisms** due to a lack of income to meet basic needs in the 30 days prior to data collection. Levels of household-level coping extended beyond aid dependency and selling of assistance items. **Nearly seven out of ten refugee households reported borrowing money, most frequently to meet basic survival needs related to food consumption and health. The proportion of households reporting incurring new debts (borrowing money or purchasing items on credit) also appears to be increasing** across different rounds of the MSNA, from 35% in the July 2018 MSNA, to 45% in the January 2019 MSNA, to 69% during the current round. Information gaps persist regarding who the holders of this debt are, from whom money is being borrowed, and the associated risks that may permeate this informal system. There are also indications that the rate at which debt is being incurred outpaces the rate at which households are repaying debts or paying off credit, with only 37% of households reporting repaying debts in the 30 days prior to data collection. This raises additional questions about how long refugee households will continue to be able to live off of credit while avoiding negative outcomes.

[76] Respondents were asked whether anyone in the household engaged in each of the reported behaviours due to a lack of money to meet basic needs in the 30 days prior to data collection.
[77] This question was only asked to households who had indicated borrowing money and/or purchasing items on credit when asked about coping strategies due to a lack of money to meet basic needs in the 30 days prior to data collection (n = 2,239) . However, findings are presented as a proportion of all households. Respondents could choose more than one option.
[78] The data collection period included the festival of Eid al-Adha, which may provide explanation for debt incurred to buy clothes/shoes.
[79] BDT - Bangladeshi Taka.

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LINKS TO OTHER J-MSNA PUBLICATIONS

- [2019 Refugee J-MSNA Clean Dataset](#)
- [2019 Refugee J-MSNA Data Analysis Tables](#)
- [J-MSNA Dashboard](#)
- [2019 J-MSNA Key Findings Presentation](#)

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