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Humanitarian Response for Improving Quality of Life of Persons with Disabilities: A study on Rohingya Camps of Cox's Bazar, Bangladesh

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ABSTRACT

As a result of ethnic cleansing, more than one million Rohingya refugees from the Arakan state of Myanmar found their way to Bangladesh. They have been sheltering in sprawling camps in Cox's Bazar since August 2017, having fled from horrific violence and oppression. Although this crisis affects all segments of the populace, it is redundant to say that men, women, boys, and girls will not be equally vulnerable. Not being in a homogeneous group, the needs and difficulties of refugees with disabilities remain unaddressed in most circumstances. The key objective of this study is to explore the prevailing nature of the humanitarian response to identify how well do the interventions take inclusive needs into account. Both qualitative and quantitative methods are used to assess the contemporaneous issues of humanitarian assistance. International and national policy accords on refugees with disabilities are reviewed for taking an in-depth idea of ensuring inclusive humanitarian interventions more accurately. Among 34 makeshift settlements of Rohingya refugees, two camps at Kutupalong Mega Camp of Ukhia Upazila in Cox's Bazar district of Bangladesh are selected for the

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research. Availability of persons with disabilities is mainly considered while selecting refugee camps. This paper attempts to add an inclusive lens to analyze existing humanitarian response toward persons with disabilities. All over the globe, extremely vulnerable individuals are seen as 'receivers' rather than 'providers.' In normal times, they lack basic rights to uphold quality of life in comparison to others. Hence, an inclusive need-based approach should emerge to improve their condition by reimaging them as contributors. This study is also keen to identify the nature of humanitarian interventions and to generate implications for more inclusive interventions for enlightening current condition of persons with disabilities in the camp area.

1. Introduction

Humanitarian complexities of refugees are one current widespread concern of the world. People fleeing from their homes due to persecution or war are not a new phenomenon. Beginning from 25th August 2017 more than 720,000 Rohingyas, including women, child and aged people arrived in Bangladesh fleeing massacre, arson and rape during ethnic cleansing by Myanmar military in Rakhine. Against this backdrop, local, national and international humanitarian actors are aiding the forcibly displaced Myanmar people, who had suffered egregious human rights abuses in their native country. Right after the independence in 1971, Bangladesh is experiencing constant refugee flight of Muslim minorities from Myanmar because of ethnic persecution (Ullah, 2011). The Rohingya were the majority ethnic group settled in Maungdaw and Buthidaung, the only towns in Myanmar with a majority Muslim populace. The 1982 Citizenship Act omitted the Rohingya from the list of formally recognized ethnic minorities and rejected to provide many basic rights including nationality, independence of movement, access to healthcare and formal education, marital registration and the ability to vote (Mathieson, 2009).

The crisis excessively affected women, adolescents and the most vulnerable and marginalized Rohingya groups in terms of accommodation, shelter, food, medical assistance, education, employment and other services for survival in camp areas. The state of their lives

was certainly hard to elucidate in words. Persons with disabilities are especially the victims of this ethnic cleansing of the Myanmar government. They generally suffer from lower quality of life (QOL) during normal times; their vulnerabilities and challenges have increased excessively during the current crisis (Nasreen & Tate, 2007). Due to prevailing inequalities, people with disabilities face disproportionate effects often in terms of ensuring proper QOL. Absences of appropriate and need-based interventions are making the situation bad for marginalized persons with disabilities. Basically, the study aims to investigate the nature of humanitarian responses taken for improving QOL of persons with disabilities inside camps. Besides basic needs, this group of people require some need-based interventions as well to live with dignity and independency. On the other hand, accessibility to services can assure the ultimate goal of proving assistance to refugees for humanitarian actors.

Participation of all segments of a forcibly displaced population is required for ensuring QOL in camp areas. If refugees with disabilities have the right to make decisions about their requirements, desires and opportunities, they can have a life with quality. Hence, acceptance of persons with disabilities by removing social barriers can stimulate inclusion. The purpose of the research is to assess diverse humanitarian interventions in terms of accessibility of persons with disabilities for improving their QOL. More emphasis on adopting need-based inclusive humanitarian assistance can change their current inequity of receiving adequate prerequisites for survival certainly.

1.1 Rationale of the Research

By being in the minority group, inevitability, persons with disabilities are often overlooked by humanitarian actors. The majority of the persons with disabilities have complications in performing basic physical activities. Consequently, they are reliant on others, such as caregivers, volunteers, and neighbors for obtaining continuous assistance. In a time of crisis, lack of appropriate preparedness places them in a life-threatening condition. Hence, the susceptibility of persons with disabilities may be reduced significantly and their capability to survive can be increased by providing them access to overall services. Specialized services like

physical rehabilitation, supportive devices, sign language interpreters, and so on, are needed for ensuring inclusion. Inclusive humanitarian interventions on accessibility and participation can generally improve QOL of persons living with disabilities. Relocating their shelters to safe places, making distribution points adjacent, and the practice of disability mapping can ensure active participation and remove dependency. Moreover, special needs of persons with disabilities should also be considers as a cross-cutting concern of humanitarian actors. Constant enthusiasm can flourish the culture of inclusion among diverse humanitarian agencies which can place the disability issue as a vital component. Reimaging inclusive interventions is required for most of the government and humanitarian actors working for Rohingya refugees. Exclusive interventions lead to insecure conditions resulting in acquisition of new sort of disabilities (Scott, 2013). Although, attention towards persons with disabilities is receiving more attention by national, regional as well as international accords, there is still a lack of enough consideration.

Therefore, it is necessary to assess the existing humanitarian interventions through an inclusive lens to identify the capacities as well as the inadequacies for supporting persons with disabilities for improving their QOL. Prospects for mainstreaming inclusive humanitarian interventions may also produce knowledge for social workers, policy makers, counselors, researchers, academicians, field workers and humanitarian associates who can replicate the findings and recommendations of the study in their field of interest.

2. Review of literature

2.1 Humanitarian Rights for Persons with disabilities

Persons having long-term physical, intellectual, mental or any other sensory impairments either congenitally or as an outcome of disease or accident which hinders full and efficient social participation are generally known as ‘persons with a disability.’ Including persons with a disability in disaster risk reduction (DRR) plan, design and application is a comparatively new phenomenon globally. The universal disaster risk reduction framework, the Sendai Framework for Disaster Risk Reduction (SFDRR) 2015 – 2030 reinforced by the rights framework of the UN

Convention on the Rights of Persons with Disabilities (CRPD), provides incentives for further progress in this field (Stough & Kang, 2015). Prior to SFDRR, two others international DRR policies – Yokohama Strategy and Hyogo framework for Action (HFA) did not consider the disability issue as a global concern. In 2012, regionally it came to notice by the Yogyakarta Declaration. In the Article 11 of CRPD, necessary measures for providing protection and safety to persons with disabilities in humanitarian emergencies are strictly mentioned for State Parties. Other articles of CPRD, specifically Article 9 and 29, indicates inclusion in DRR and policy frameworks accordingly (Priestley & Hemingway, 2007). Hitherto, common practices reveal that at the time of the onset of a disaster, emergency or a conflict, people with disabilities are more likely to be left behind or inhibited during evacuation. Policies are there, but practically there are limited actions to implement them. In terms of Bangladesh government policies, social inclusion is a cross-cutting issue of national action plans (NPDM 2016-2020). Initiatives and plans for underlying inclusion issues are generated on the basis of Sustainable Developmental Goals (SDGs) to leave no one behind. The first worldwide conference on disability and disaster risk management held in Dhaka on 2015 was adopted as Dhaka Declaration; this vividly addressed persons living with multiple disabilities around the globe. It indicates inclusive DRR through whole-of-society approach where interventions should incorporate all segments of marginalized groups. The national law of Bangladesh, Rights and Protection Laws for Persons With Disabilities (2013), identifies 12 types of disabilities to be addressed in time of any humanitarian emergencies. Moreover, the second international conference on disability also occurred in Dhaka, known as 'Dhaka Declaration ++' addressing lessons learnt and good practices from the first conference. All the considerations and suggestions are taken into attention by Bangladesh government to adopt a culture of inclusive development.

In this regard, a 'twin track approach' can generate suitable access to both mainstream and specialized services through effective networking and coordination between the mainstream actors and disability service providers.

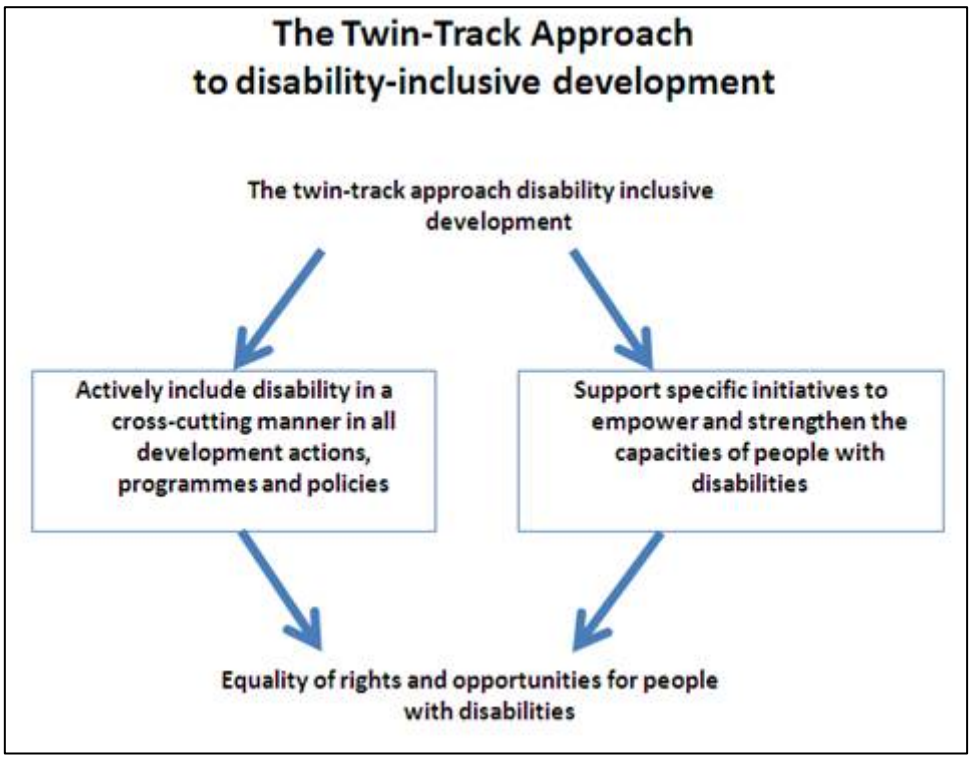

Figure 1: Twin-Track Approach to disability- inclusive development

This approach is undertaken in most humanitarian sectors for maintaining inclusion and a right-based approach (Brown, 1988). In the study, the researchers adopted this approach to incorporate inclusive humanitarian response as a cross-cutting issue and empower persons with disabilities in the camps so that they can uphold their QOL.

2.2 Humanitarian Crisis for Refugees with Disabilities

Epidemics, war, conflicts, natural disasters or other major emergencies cause humanitarian crisis and at times they also result into refugee crisis. Refugees with disabilities are the greatest affected group of people who have the highest risks at times of conflict or crisis. According to IOM, of all the refugees around the world, about 10 million are persons with disabilities (International Organization for Migration [IOM], 2016). Due to diverse level of disabilities ranging from mild to severe, they are more vulnerable and can easily develop post-traumatic stress disorder. They are also physically vulnerable to injury, death, illness as well as abuse. The CRPD rejects what is known as the 'social welfare' approach to disability, which views persons with disabilities as "'objects' of charity, medical treatment and social protection;" rather, it

conceptualizes persons with disabilities as rights-bearers, who are "empowered to claim their rights" (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2008, p. 7). Due to communication or physical barriers, negative attitudes or other obstacles, persons with disabilities face many hurdles in accessing assistance and protection. They may also face a heightened level of disability during displacement because of changes in their environment or lack of appropriate care and services. Moreover, they are often seen as passive recipients of aid rather than active participants. Unfortunately, despite a willingness by mainstream organizations to encompass disability issues in their response mechanisms, they claim their lack of expertise prevents then turning this enthusiasm into practice. Inaccessible information, disruption of health services, immense physical barriers, and the breakdown of social networks can worsen people with a disability's quality of life in the camps. Refugees with disabilities are vulnerable to safety violations ranging from physical, sexual and emotional exploitation due to a lack of access to integrated schemes and documentation. Children with disabilities are three to four times more likely to be physically or emotionally molested. Exclusion and abuses can be caused by any number of factors including communication barriers, no access to complaint mechanisms, inability to run or call for help, or simply not being aware of the danger. Women and adolescent girls with disabilities are more prone to unsafe conditions leading to harassment and gender-based violence. People with disabilities face heightened vulnerability in conflict situations which may also cause severe psychological and physical trauma to the affected population. When it comes to refugees with disabilities, much work remains to be completed. It is to be anticipated that the goodwill and vigor generated by the CRPD will touch the lives of these most vulnerable and underprivileged of refugees (Cheung, 2011). Persons with disabilities living in circumstances of conflict and humanitarian adversity must assuredly rank amid the world's most vulnerable individuals because their experience of forced migration is compounded by numerous and diverse challenges arising from their impairment (Reilly, 2010).

3. Methodology

3.1 Study Design

This study uses a mixed method approach. A combination of qualitative and quantitative data collection is used in the different stages of the research to assess the present context of humanitarian response mechanism for improving the quality of life of persons with disabilities. Triangulation is used for verification in this study a legitimate inquiry approach that delivers appropriate knowledge and information about the concerned subject matter (Creswell et al., 2003). At first, secondary data was collected through literatures and articles written on the refugee and refugees with disabilities. Due to the influx of Rohingya population in Bangladesh there are lots of reports such as situation analysis reports, quarterly reports, bi monthly reports and so on from several organizations like UNDP, the International Federation of Red Crosses (IFRC), and Inter Sector Coordination Group (ISCG). In the next phase of the data collection, both qualitative and quantitative data was collected. In order to collect the qualitative data, the methods were: key informant interviews (KII), in depth interviews (IDI) and Case Studies. Key informant interviews included officials of government and non-governmental humanitarian actors who are implementing varied humanitarian interventions on ground. Rohingya community leaders were also taken into consideration for assessing in-depth needs and challenges of forced displaced Myanmar nationals (FDMNs). The key informants were selected based upon their knowledge on the relevant field in order to analyze the issue thoroughly. For the study, twenty KIIs were taken face to face, using semi-structured questionnaire. There were five in-depth interviews, taken from persons with disabilities to gain detailed assessment of their prior and concurrent condition of life. Ten case studies have been conducted from the beneficiaries of inclusive humanitarian interventions to make comparison between inclusive and exclusive services. Site observation was been done for further referral to inclusive interventions.

An extensive amount of quantitative data collection was conducted in the Rohingya camps to get the necessary information required to fulfill the objective of the study. The questionnaire used for quantitative data collection contains several types of question as for example dichotomous, multiple response and Likert-type scale questions. The questionnaire

was divided in several sectors containing more than 70 questions, such as: demographic information, health information, food and nutrition information, shelter and housing information, education information, perception of existing social security, and recommendations.

3.2 Study Area & Sample Size

The study was conducted at world's largest refugee camp, Kutupalong Mega Camp of Ukhia Upazila in Cox's Bazar district in Bangladesh. Kutupalong Mega Camp has been divided into 34 camps with extensions into makeshift settlements. Each camp is divided into blocks for keeping track of the displaced population with their essentials. Among the 34 camps, camp 04 and camp 18 are selected for this study. The reason behind selection of these two camps are that they have more disability friendly space, a home-based medical facility systems for persons with disabilities, inclusive infrastructural facilities, and critically the number of persons with disabilities is high in these camps.

As for the sampling strategy, purposive sampling was done. Purposive sampling is a non- probability sampling done by the researcher based on the target of the study so that the objective of the study can be fulfilled accordingly. The total number of people surveyed in the quantitative survey is 188. Basically respondents are selected from both camps which is shown in the table below.

Table 1: Sample size for Quantitative Analysis

Criteria	**Camp 4**	**Camp 18**	**Total**
Persons with Disability/(s)	50	55	105
General refugees	-	45	45
QoL Assessment (Inclusive & Exclusive interventions receiver)	20	18	38

Total sample size for Quantitative Analysis, n = 188

Respondents are categorized into 3 groups to reach the findings of the study in a systematic manner:

1) Persons with Disabilities are the key respondents for the study (n=105),
2) General refugees – their perception for inclusive humanitarian response is essential to promote the culture of acceptance
3) Inclusive and exclusive interventions receiver – to differentiate QOL score amidst respondents.

3.3. Demography of the sample

Elementary information on household features such as sex, age, educational status, total number of family members, earning members, occupation criteria are basically provided for giving an overview of the socio-demography of persons with disabilities in refugee camps. Out of 105 respondents, 55.2 % are females and 44.8% are males. Most of the respondents (55.4%) are in the age group of 18-59 years. The young persons with disabilities are suffering from various needs and vulnerabilities in the camp. Education is an important indicator for the standard of quality of life. But this study reveals that half of the respondents (48%) have no formal educational background, 38.1 % have some formal education, and 14.3% of them can sign only. This study reveals that joint and extended families are dominant (63.8%) in the camp areas with more than seven members on average. Nuclear families are rarely found inside the camp. Also, 71.4 % of persons with disabilities work as day laborers in the camp. The number of small businesses and grocery shop owners is also significant in the area. Persons with disabilities can work as Imams at mosques. Nevertheless, most of them are underprivileged and cannot find suitable work opportunities due to physical deficiency and mental incapability (Beyrer, & Kamarulzaman, 2017).

3.4 Supervision and Quality Control Mechanism:

In the respondents, some cross-cutting issues considered were sex, disability, economic capacity, and source of earning. Recently, increasing violations through the data collection

process has increased survey non response. Non response occurs as absence or refusal, and it depends upon the demographic, socio-economic, cultural characteristics of the selected respondents. Several initiatives were taken in this research to reducing the non-response rate. The respondent was only interviewed when they were convinced and agreed to cooperate with the study questions. A brief of the purpose of the study was also given to them for their better understanding. Strict quality control measures have been taken while doing the data collection. Two specialized groups were used. In the beginning, they were trained on the questionnaire and then given the introduction about the condition of the refugee camps so that they do not fall into any kind of trouble. A group of specialized people were also contacted who gave recommendations on the proper process of data collection from the camps. The two teams are: 1) qualitative data collection, 2) quantitative survey. The team consisted of students who had prior experience of data collection and had the relevant capacity.

3.5 Ethical issues, privacy and confidentiality

The study ensured all the possible measures to maintain the ethical standards of working in a refugee area and specially, to work with persons with disabilities. All the respondents were asked about their consent and there were written consent options. The time, place and name of the respondents are not going to be disclosed and will be kept confidential. They were also informed about their right to refuse and the data collectors were also ordered not to give anyone any pressure. Only people who were satisfied with the explanation and showed eagerness to talk were interviewed. Finally, respect for every respondent i.e., dignity, anonymity, privacy, equality and diversity included in the evaluation design and process was confirmed by the research team (Farrelly, 2004).

4 Findings of the study

4.1 Situation Analysis of persons with disability/(s)

Understanding the prevailing situation regarding persons with disabilities in camps is indispensable to elucidate the overall situation. The number of persons with disabilities in a family, their type and level of disability and basically the reasons behind their disability are the major concerns of this portion. The study reveals that 87 % of households have one person with disability whereas the range of 2-4 people is very nominal (13.3%). Among the respondents, the proportion of physical disability is significant in number (92.4%). Multiple types of disabilities include more than one inability. In the study, most multiple types of disabilities (34.3%) comprises of physical, intellectual, hearing, speech and visual disabilities. Furthermore, 20% respondents have visual disability, 17.1% have hearing disability and more than 12% have speech disability. Other types of disabilities are not significant in number. Again, the level of disability depends on diverse factors such as the type of disability, educational qualifications, livelihood capabilities, and accessibility to services as well as capacities to become resilient.

Table 2 reveals that significant portions of respondents (56.19%) have moderate level of disability while almost 27 % of the respondents think their level of disability is severe in terms of their accessibility in camp area. Some of them (17.14%) deliberate that they are in mild level of disability as they are being healed with the help of health interventions associated with them.

Table 2: Disability related information about the respondent

Disability Related Information	Frequency	%
Number of persons with disability in the house		
1	91	86.7
2-4	14	13.3
Total	105	100

Types of disability/(s)	**Frequency**	**%**
Autism or autism spectrum disorders	0	0
Physical disability	97	92.4
Mental illness leading to disability	3	2.9
Visual disability	21	20
Speech disability	13	12.4
Intellectual disability	12	11.4
Hearing Disability	18	17.1
Deaf blindness	2	1.9
Cerebral palsy	8	7.6
Down Syndrome	0	0
Multiple disability	36	34.3
Other disability	1	1
Total (N=105)	211*	
Level of disability		
Mild	18	17.14
Moderate	59	56.19
Severe	28	26.67
Total	105	100

*Multiple Response (Field survey, 2019)

There are numerous reasons behind the disability. Some of them are common in nature such as by birth, genetically inherited, physical, general weakness, aged, polio, and cerebral palsy (Haagsma et al., 2015). Bangladesh is currently free from polio but some Rohingya refugees with disabilities have this physical disability. The refugee crisis has increased the number of people with a disability through, for example, spinal cord injuries, low back pain, stroke, traumatic injury, lower limb deformity and so on. Different types of persons with a disabilities necessitates diverse assistance required in terms of assistive devices or personnel support. Almost half (49.5%) of the respondents require partial assistance while 23.8% need supervision. Moreover, 20% of them are fully dependent, whereas 6.7% of persons with

disabilities are self-determining in their lives that they do not want any kind of support for their mobility in the camp area.

Early after reaching to the camp, Hosanara an 18-year-old woman in camp 4 in Kutupalong realized that her leg condition was worse. As per her statement, they have settled in the refugee camp in Bangladesh, but life is not easy: Here is no peace as we don't have our own land, our own people, and our country. And while I have to use crutch to move, I cannot do a work without difficulties." said Hosnara [Source: KII]. Social vulnerability often makes persons with disabilities feel excluded from the larger groups (Nasreen & Tate, 2007). They feel isolated in the community and suffer from many conditions. They say that the perception of people is still negative towards them (90.5%), and they are considering as a curse (47.6%). The atrocities they witnessed pushed them into mental trauma. Overall, 91.4% of respondents say they are suffering from trauma and they lack motivation to carry on their lives. It is noteworthy that a 78.8% of respondents felt most vulnerable while living in Myanmar as there was no safety and security of their lives. But in Bangladesh they are getting support for them as well as their families. Community people are not considering them as curse which is the biggest transformation in their lives now.

4.2 Accessibility of persons with disabilities to basic services

Fulfilling basic needs of the forcibly displaced population are the topmost priority of aid agencies. Persons with disabilities face diverse obstacles to satisfy their needs (Murphy et al., 2007). For assessing their QOL, accessibility to health, education, WASH services (water, sanitation, hygene), shelter facilities are evaluated to explore the concurrent humanitarian response mechanism. From the very beginning of their entrance into Bangladesh, Rohingya people are getting enough food and shelter support from donor agencies. Again, health care and recreational facilities are also emerging with the passage of time. But still there is deficiency of employment opportunities, education and other social service, which hinders their overall quality of life. Table 3 reveals only 30.5 % of the respondents are attending learning centres while only 32.4% persons with disabilities are getting work opportunities.

Table 3: Present and future humanitarian need assessment

Humanitarian Assistance	**Frequency**	**%**
Food Aid	105	100
Shelter	105	100
Non-food Items (specify)	77	73.3
Health care services	55	52.4
Hygiene kits/ Dignity kits	51	48.6
Education for children	32	30.5
Employment (CFW)	34	32.4
Child Friendly Space	39	37.1
Women friendly space	42	40
Age Friendly space	44	41.9
WASH facilities	96	91.4
Gas Stove	45	42.9
Multiple	104	99
Others	13	12.4
Total (N=105)	842*	
Recommendation for further improvement		
Livelihood Opportunities	59	56.2
Cash	101	96.2
Solar Light- Fan	96	91.4
Higher Education	30	28.6
Clothing Facilities	85	81
Gas Stove	57	54.3
Block wise Street Light	64	61
Sewing Machine	54	51.4
Adequate Health services	87	82.9
Non-Food Items (NFI)	66	62.9
Smooth Transportation Route	87	82.9
Multiple	96	91.4
Others	3	2.9
Total (N=105)	885*	

*****Multiple Responses

For further improvement 96.2% of the persons with disabilities said cash support is needed as they are unable to pay for facilities in the camp. Solar facilities (91.4%), smooth transportation route (83%), adequate health facilities (82.9%) and other interventions are needed for improving their QOL. Their necessity is dissimilar from Rohingya in Myanmar as they sometimes could not access these services. Marium Khatun, 17 years old girl in camp 18 in Kutupalong said:

> I had to hide my identity for doing any medical check-up while residing at Myanmar. At times of emergency we had to suffer a lot for getting any help. Nevertheless, in the camp, I along with my mother are equipped with hygiene kits which are sort of a daydream there [Source: Case study].

Significant numbers of respondents (63.8%) still cannot receive direct health care due to the inability of going to health centres. Though, 36.2% of respondents can move directly to the centres, sometimes this is because the centres are close to their house (30.5%). On the other hand, long distance of the centres (58.1%), lack of transportation vehicle (54.3%), shortage of money (47.6%) and lack of knowledge regarding health services (43%) are the noteworthy reasons behind inaccessible health centres. Many of the respondents with disabilities still live in hill sides along with family members. Hence, it is impossible for them to receive healthcare facilities directly. Regular health check-ups (95.2%) are the most significant health service provided in the camp. Home-based medical assistance along with providing free medicines (50.5%) is also remarkable in case of persons with disabilities. These are the new dimensions used for helping out the persons with disabilities in the camps. If home-based therapy sessions, check-ups, and free medicine supply is ensured according to their need, they may attain good QOL.

Again, due to limited space, there is shortage of learning centres in comparison to the number of children in refugee camps. Despite many challenges, there are impermanent places where the Rohingya children are given religious lessons in their native language (Beyrer & Kamarulzaman, 2017). In most cases, Burmese and English are used for providing education.

Learning centres are accessible for most (52.4%) children with disabilities as they are close to their residing place (43%). Since the crisis period, attendance of both girls (80.3%) and boys have increased comparing previous condition. But still girls (4.2%) are lagging behind boys (15.5%) in terms of going to learning Centres. Participation of girls is increased due to the rise of awareness among the parents. They became to believe that for having good future they need to know how to learn. Among all the basic needs, accessibility for education got the topmost priority. Learning centres are made of handrails, with wide doors for the disabled. Moreover, humanitarian organizations are assigning persons from the affected community as teachers which is also generating employment opportunities for them. Children with disabilities sometimes use inclusive learning centres as their playgrounds where they mix with other refugee children. The inclusive culture certainly helps to expand their QOL in the camps. A significant number of respondents (61.9%) have accessible shelters. Priorities are given to persons with disabilities for building shelters on flat ground (78.7%) making it accessible. Doors with large width (11.5%), handrails for moving are also provided by some organizations that directly associated with persons with disabilities. In most cases, persons with disabilities get support from volunteers from the aid providing agencies. Often family members (90.5%) help them to build shelters. Noteworthy examples are made by persons with disabilities who are encouraged to build shelters by self-help (36.2%). As persons with disabilities need to move for essential services, accessibility to these services are needed to improve their QOL. Fewer limitatoins are faced if facilities are adjacent to their residence. They can move easily with less amount of money. But if they have to cross long distances it would become hard for them. Morzina Khanom, a 43-year-old women with disability from camp 18 said,

> I was unable to come down from my house as it is situated at hilly area. But after getting the facility of handrail; life became less complicated. I can manage myself to get down on the ground without any assistance. It is making me self-sufficient and independent [Source: IDI].

Water, Sanitation and Hygiene facilities were unplanned and insufficient in camp areas at the beginning, but eventually the situation became accessible with area mapping, need

assessments, more access points, better hygiene and waste disposal systems. The foremost problem is that the numbers of toilets are less than the number of people living in each block. If there is a person with disability in a block, the officials will try to set up a latrine adjacent his/her house so that, he/she can have easy access to it. This practise is setting an example in the camp areas to take the needs of persons with disabilities in account. Table Four shows that most (58.7%) of the respondents have accessibility to WASH facilities while 41.3% are still facing trouble. Most of the respondents with positive feedback have their facilities close to their residence (41.9%). The tube wells are also set on flat ground (32.4%) which helps physically disabled persons a lot. On the contrary, lack of area mapping (34.3%), no separate point of water collection (34.3%), and long distances (28.6%) are hampering the QOL of persons with disabilities.

Table 4: Accessibility Concerns of WASH interventions

Accessibility Concerns of WASH sector	**Frequency**	**%**
Accessibility of water distribution points		
Yes	61	58.7
No	43	41.3
Total	104	100
If yes		
Close to house	44	41.9
On flat ground	34	32.4
Correct Height	5	4.8
Assistive aids such as handrails	0	0
If not, reasons behind this (n=105)		
No prior need assessment	23	21.9
Lack of area mapping	36	34.3
Long Distance	30	28.6
Inaccessible Route	19	18.1
No separate line for persons with disabilities	36	34.3
Negligence from others	22	21
Multiple	36	34.3
Others	2	1.9
Total	204*	194.4

*Multiple Responses

A majority of respondents (64.8%) have no access to latrines of their own. That means they need assistance for using the latrines. Camps are not equipped with disability friendly latrines yet. As the general numbers of refugees are very high in comparison with them, basic WASH facilities get the topmost importance. Privacy of women and girls is a very sensitive issue among Rohingya people. Their safety and security are still the main concern of many aid providing agencies. But there is a lack of law enforcement. Many women and girls get teased and feel unsecure when moving to places especially to bathrooms. There are 58% of respondents say their privacy is insecure. Women and girls with disabilities must deal with this issue more intensely as they have to depend on others for their mobility.

The findings from several reviews disclose that Rohingya communities have been tortured unethically. The atrocities they have observed have made them psychologically hostile (Al Imran & Mian, 2014). Many Rohingya people have seen their loved ones dying in front of their eyes and all of their properties burnt and demolished. They are leading a life with uncertainty of their existence. All the time they are in thought about how to give their next generation a certain future. These unavoidable matters are making them psychologically exposed to adverse situations. Therefore, the provision of psychosocial support has been generated by many humanitarian agencies, but they still lack in number for persons with disabilities. As the accessibility of service centres, language, and service delivery is dissimilar from the general population. But if proper inclusive measures are taken to address their psychological well-being persons with disabilities could live a life with dignity, choice of control, and decision-making roles. Agencies should come forward with expertise to tackle their mental health concerns and help to improve their QOL.

Basically, persons with disabilities have the right to access all of the humanitarian actions that are taken to support refugees. The study shows that scenarios are changing around the camps nowadays. More inclusive measures are taken into account so that government and non-government agencies could provide support to the maximum number of refugees at a stretch. If inclusiveness is kept as a cross-cutting issue while planning response mechanisms, facilities and services can reach all segments of populace and that will accelerate QOL in the

camps.

4.3 Inclusive humanitarian interventions for persons with disability/(s)

Being in the most marginalized group, persons with disabilities face inequities since their birth. A significant portion of the respondents (72.4%) have not got any kind of support while living in Myanmar, they were not treated as human beings. After their arrival in the refugee camps, they are at least treated like other refugees. A lot of organizations, regardless if they are government or non-government, work for the welfare of the refugees by providing them their basic rights. But very few organizations are directly involved in working with refugees with disabilities inside the territory of camp areas. International and local NGOs should consider disability concerns as their cross-cutting issue and set an example of an inclusive humanitarian response.

Among the fundamental inclusive services, Home-Based Rehabilitation (HBR) service (57.1%) and centre- based health care service (52.4%) are in top position. HBR includes physiotherapy, health check-ups, free medicine delivery, and speech therapy sessions. Most of the persons with disabilities require assistive devices to help with their basic chores. Here, the demand for a single stick (29%) and 4-point stick (18.1%), are higher than walking frame (11.4%) and crutch (2 .9%). Special addition of home-modification services comprising toilet chair (39%), accessible toilet frames (15.2%) along with handrails (12.4%) are introduced by inclusive practitioners in the camps.

According to HBR coordinator of Centre for Disability in Development (CDD);

> CDD is playing vivid role in case of improving QOL of persons with disabilities in the camp. The work sector and number of beneficiaries are increasing day by day with need-based service allocation. Many of them became cured by regular physiotherapy service of the HBR team. We give more devices to elderly people who have fewer chances to physical improvement and more therapy to children who can develop themselves in the long run [Source: KII].

Table 5: Assistance received after moving to camp areas

Assistance received	Frequency*	%
Assistive Device		
Single Stick	30	28.6
4-point stick	19	18.1
Auxiliary Crutch	3	2.9
Walking Frame	12	11.4
Standing Frame	0	0
Artificial Limb	1	1
Wheelchair	20	19
Home –modification Services		
Handrail	13	12.4
Accessible Toilet Frame	16	15.2
Toilet Chair	41	39
Widen Doors for Wheelchair	2	1.9
Home-based Rehabilitation Services	60	57.1
Health Services (center based)	55	52.4
Others		
Home based delivery service	4	3.8
Home delivery by porter	1	1

Moreover, relief distribution lines are not fully accessible for persons with disabilities. The study reveals that 61% of the respondents stated it as inaccessible for them while 39% find it manageable. Accessibility also depends on distance, level of disability, and level of assistance required. But significant numbers of displaced persons with disabilities are finding obstacles in assembling aid. Reasons behind inaccessibility is mostly the fragile transportation route (52.4%), distant distribution points (51.4%), large populations to serve (51.4%), along with a lack of proper need assessment (44.8%) of persons with disabilities. Inclusive humanitarian interventions are not sufficient yet to reach maximum persons with disabilities in the camps. Therefore, improvement of QOL is still lagging behind estimation. More awareness and knowledge generation amid service providers are required to meet the current gaps.

4.4 Perception of general Rohingya community on inclusive humanitarian interventions

The study's emphasis on promoting inclusive humanitarian interventions means perception of general refugees regarding accepting inclusion is necessary to improve QOL of persons with disabilities. A total of 45 general population respondents are purposively selected for conducting the assessment. Basically, general Rohingya refugees have better percentage rate in case of accepting inclusive humanitarian services than persons with disabilities. A traditional conservative outlook is observed among Rohingya men. There is a noteworthy amount (64.4%) of general displaced population that think of having inclusive humanitarian interventions for supporting persons with disabilities and that more emphasis should be given to them as they required extra assistance and support. Moreover, their needs and challenges are also distinct from the general population. Some people have contradictory point of views as well. They support having common interventions as they do not see the different needs and challenges of marginalized persons with disabilities. Needs of persons with disabilities comprises more device support, distinct inclusive facilities for sanitation and hygiene sector, learning centres, health care, and relief distribution lines for improving their condition in camp areas. Hence, need-based inclusive approaches for them are indispensable as they are in more need of assistance than general refugees.

4.5 Quality of Life Assessment of persons with a disability

Actually, quality of life comprises of the basic fulfilment of services that ensures dignity, security, protection and basic human rights. Persons with disabilities lack the criteria of fulfilling quality of life in various ways since their birth. But, with assistance and need-based services, the entire condition can be directed in the positive manner. Here, Table Six measures the quality of life of persons with disabilities before and after the crisis with the support of a Likert scale (5-degree scale) questionnaire. The study shows that before the crisis their condition was significantly very poor (50%). But if we consider the present condition the table reveals that 39% of the respondents are in neither poor nor good situations. That means their quality of life is changing in the positive direction as response mechanisms are addressing the needs

of persons with disabilities. And if there are more inclusive humanitarian practitioners working their condition may be turned into good and eventually very good (Gidley et al., 2010).

Table 6: Quality of Life Assessment of persons with disability/(s)

Quality of Life Assessment of persons with disability/(s)	Frequency	%
Quality of Life Assessment (Before Crisis)		
Poor	31	29.5
Very poor	50	47.6
Neither Poor nor good	9	8.6
Good	15	14.3
Total	105	100
Quality of Life Assessment (After Crisis)		
Poor	16	15.2
Very poor	15	14.3
Neither Poor nor good	41	39
Good	33	31.4
Total	105	100

If persons with disabilities get access to information, aids, and essential services they can upgrade their level of independency. Likewise, home delivery services of humanitarian aids and home-based medical services are more required for women with disabilities. Inclusive interventions are not only centred on persons with disabilities as the provision of inclusiveness will generate welfare among all the Rohingya displaced people in camps.

5 Discussion

The overall humanitarian response the for persons with disabilities require more inclusive attention from practitioners to meet the need of emerging population. Owing to communication or physical barriers, persons with disabilities face numerous hurdles, undesirable attitudes or additional obstacles in accessing assistance and security. Moreover, they are habitually seen as submissive recipients of aid rather than dynamic participants. Most of the respondents (61%) felt excluded in their community while 39% of them still consider

themselves as a part of community. There are countless reasons behind this high rate of social exclusion. Not inviting them in social gathering (44.8%), not taking their opinions (32.4%), treating them as a curse (32.4%) are some of the well-known reasons of feeling excluded in the community. Therefore, a sense of acceptance from general refugees is necessary to ensure improving their quality of life.

Ensuring accessibility of persons with disabilities to essential services is another vital matter of concern for humanitarian actors. Most of these people living with disabilities have mobility crisis and dependency on others. The level of disability disproportionately hampers the female portion of the community more rigorously than males. Women respondents with disabilities are more susceptible to a severe level of disability (76.5%) compared to men (23.5%) with disabilities. Women with disabilities are usually more dependent (61.9%) in terms of assistance than men with disabilities (38.1%). A need-based assessments prior to implement any intervention should be done to understand the desire of persons with disabilities. In decision-making roles and having choice should be possible for disabled refugees. Taking such points into action, persons with disabilities will have a life with quality.

Most importantly, the range of inclusive humanitarian interventions should be expanded by practitioners. An emphasis on home-based rehabilitation services should be given along with accessible basic facilities. Psychosocial support can improve quality of life of persons with disabilities. Whenever they see themselves as a part of the community, a sense of belonging will emerge. Again, due to mobility crisis, many women with disabilities lack the service of psychological therapy. Home-based therapy system should be given more emphasis in this regard (Silove et al., 2007). However, humanitarian stakeholders are working hard to ensure the quality of life of every refugee in need of durable solutions. Prospects for mainstreaming inclusive humanitarian interventions can provide adequate facilities for assuring quality of life for persons with disabilities more extensively. The Bangladesh government should set minimum standards for humanitarian actors for inclusive interventions as a crucial segment of every action. All over the globe, persons with disabilities are receivers rather than providers. To eradicate this traditional outlook, an inclusive need-based-approach should be

used to improve their condition by reimaging them as contributors. Inclusiveness should be more practice oriented than being only being policy-based.

6 Way forward for mainstreaming inclusive humanitarian response

Inclusive humanitarian interventions of accessibility, participation, and choice of control can generally improve quality of life of persons living with disabilities. Relocating their shelters to safe places, making distribution points adjacent, and disability mapping can ensure active participation and remove dependency. Accessible services make them resilient survivors with capability to deal with adverse situations. For the upcoming challenges, changes in humanitarian interventions should be made strategically. Scarce resources should be entitled to them following a more right based and inclusive approach. They should be treated as resilient survivors not helpless victims. Recommendations include:

- Construct physical infrastructure with accessibility for persons with disabilities by conducting disability mapping.
- Improve disability disaggregated information database to include persons with disabilities within baseline interventions. Knowledge management practices on disaster or extreme weather management must be inclusive and strengthened for persons with disabilities.
- Integrate separate queues, adjacent distribution points, and support to carry relief items for persons with special needs.
- Regardless of gender, protection monitoring interventions should be undertaken to spread the culture of safety. Women with disabilities need to be aware how to combat gender-based inequalities as well as violence. Specialized income generating programs should be available for them.
- Assistance should be generated to persons with disabilities to overcome with communication difficulties with accessible information in simple understandable ways.

- Adequate psychosocial support should be provided to them in order to remove social barriers.
- Distinct ability-based livelihood recovery schemes can alter their vulnerable economic condition.
- Deliver refugees with disabilities and their folks with information about their rights as disabled persons and what amenities and services are obtainable for them.
- Guide the priority list for supplying food relief and nutrients considering the vulnerability and distinct needs of persons with disabilities.
- Inclusive vulnerability capacity-assessment, inclusive early warning system, inclusive search and rescue followed by mock drill is needed for inclusive disaster risk reduction activities.
- Post-Distribution Monitoring (PDM) should be institutionalized for assessing whether persons with disabilities are getting proper support or not. Their feedback is needed to be incorporated for improving future programs.

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