Common Service Evaluation:

What role has the common service played in helping agencies communicate with Rohingya and host communities during the Covid-19 pandemic?

BBC MEDIA ACTION
TRANSFORMING LIVES THROUGH MEDIA AROUND THE WORLD

TRANSLATORS WITHOUT BORDERS

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Executive summary

> If there was no common service, we would have ended up with very few [communication] products, would have come up with leaflets, maybe a few radio spots if we were feeling really ambitious. It wouldn't have gone so well, and we would have felt the impact that people didn't trust health services more strongly. It would have taken us much longer to understand the rumours, and why people were not seeking healthcare. Having a partner that understands the community perspective is really important."
>
> — Humanitarian Practitioner, Management level

Introduction

It has long been recognised that humanitarian agencies have a responsibility to ensure those affected by crisis have access to reliable information; to help them participate in decisions which affect them; and to be accountable to the communities they aim to serve. The common service for community engagement and accountability, through its consortium members BBC Media Action and Translators Without Borders (TWB), aims to help agencies and sectors working to support Rohingya refugees and local host communities living in Cox's Bazar, Bangladesh to achieve this by providing a range of specialist, technical support services.

Movement restrictions implemented since the beginning of the pandemic meant that humanitarian programmes were reduced to essential services only in the Rohingya camps, community engagement efforts were restricted, and many initiatives planned for the host community were cancelled. The common service adapted its activities in a number of ways: carrying out online training sessions with practitioners; conducting telephone research with communities; shifting the focus of communication products to meet communities' information needs around Covid-19; and working with partners to use communication channels which would ensure information was still able to reach communities.

Methodology

Evaluations of previous phases of the common service project[1] have included a community level survey to understand Rohingya and host communities' access to information and communication, and in-depth interviews with practitioners working in the Rohingya response to understand whether and how they have been using common service tools and services. This year, as common service resources and attention have been diverted to focus on Covid-19, a key focus of this evaluation is to understand how the project

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1   BBC Media Action (2018) How effective is communication in the Rohingya refugee response? Available at: https://www.bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response; BBC Media Action (2021) Supporting humanitraian communication: What role does a dedicated 'common service' play in community engagement and accountability?' Available at: https://www.bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response-case-studies

has been able to support agencies and communities through the pandemic. A mixed methods study was conducted in January 2020, including a representative survey with 2678 Rohingya community members living across 15 camps, and 1050 host community members living in two upazilas. Qualitative research was carried out with Rohingya and host community members, as well as humanitarian practitioners and volunteers.

Key findings

This evaluation has shown that practitioners feel the common service played a critical role in getting important information to Rohingya communities during this time. It did this through:

- Helping partner agencies understand Rohingya communities' perspectives and concerns, and how to communicate with them, based on up to date research and a cultural understanding developed over time (using *What Matters?* as a vehicle for sharing this information, as well as providing practitioner training and bespoke advice)

- Creating and disseminating audio and visual content which is easy for Rohingya people to understand, and helps volunteers and field staff communicate effectively with them

- Working in partnership with humanitarian agencies to adapt communication strategies and make sure information was reaching people despite Covid-19 restrictions, for example adapting audio programmes to be played through mosque loudspeaker systems; training Imams to communicate on Covid-19; ensuring content is played at food distribution points and other essential services; and equipping community health workers with simple and effective communication materials about Covid-19 to use in door to door visits.

Access to information

The survey with respondents from the Rohingya and host communities showed that access to information has remained high in the Rohingya community, with 61% saying they feel informed about the kind of aid/ services available to them, compared with 59% in November 2019. However the figure has dropped in the host community, with only 25% feeling informed compared with 53% in November. This is most likely due to fewer services being available as a result of the pandemic. The data also suggests that sources of information play a role in what information is available to people: the Rohingya communities' main source of information is face to face communication with NGOs, who provide tailored information about services available, while the host community are more reliant on mass media, specifically television, which does not provide such localised information.

In both Rohingya and host communities, women report more access to information than men. Face to face, community-based communication interventions have paid off in the camps: Rohingya women are the group which feel the most informed, and indeed have the most knowledge about Covid-19, as they benefit from face-to-face discussion through door to door visits from volunteers they trust, as well as at listening groups and women friendly spaces. Advanced analysis found that Rohingya people who attend listening groups, cite volunteers as their main information source and attend food distribution

points are more likely to feel informed than those who don't, confirming the importance of face-to-face communication interventions.

Conversely the study found Rohingya men have less access to information than previously, as they are no longer able to gather in places where they used to come together to share information, such as tea shops and marketplaces. The data suggests older people in both the Rohingya and host communities also do not feel as informed as the younger generations.

Providing feedback

Although access to information in the camps has remained relatively high, the ability to provide feedback has decreased during the pandemic for both communities, with 46% of Rohingya people saying they know how to make a complaint, compared with 64% in November 2019, and 36% of the host community compared with 46% in November 2019. Barriers to giving feedback are highest for people with restricted mobility: Rohingya women and people with disabilities. In the Rohingya community whilst door to door volunteers have continued to raise awareness about Covid-19, some services have been closed leaving people unsure where to go to give feedback. In the host community, this is due to a decrease in services available in general, and less interaction with NGO staff. Consequently, a lower proportion of people feel aid agencies are taking their opinions into account compared with previous years: 71% of Rohingya people, compared with 80% in November 2019, and 42% of host community people compared with 60% in November, said they felt aid agencies were taking their opinions into account.

Reach of communication products produced by common service

Content created by the common service, including audio programmes, public service announcements and flashcards, has reached far and wide, with 75% of Rohingya and 38% of host community saying they had seen or heard at least five pieces of content shown in the survey[2]. People in both communities said they heard this content through loudspeakers, but door to door volunteers and health facilities were also important sources, especially for women. Qualitative research found Rohingya people appreciated the content as it was easy to understand, engaging, and was made specifically for them in their language with characters and religious references they could relate to.

Knowledge and action on Covid-19

And the quantitative data suggests that common service content is having an impact: Rohingya people who have been exposed to common service content about Covid-19 are more knowledgeable about preventative measures such as handwashing, mask wearing and self-isolation, and are 1.6 times as likely to have a high knowledge score[3] about Covid-19 than those who haven't. The study confirmed that

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2   Five or more pieces of content has been used to ensure the measure is robust. 94% of survey participants said they had seen the handwashing poster. This was excluded from the measure as many similar handwashing posters exist across the camps, and it was not possible to attribute this to the Common Service.

3   People with 'high knowledge' achieved a high knowledge score, which was created from three survey items: 1) Who is at most risk of becoming seriously ill with COVID-19? Correct answers: Old people and People with pre-existing health conditions. 2) What are the symptoms of coronavirus? Correct answers: Fever and Dry cough; 3) What are some of the ways that you can help to stop the spread of this coronavirus? Knew three or more correct answers

knowledge translates into action: in both communities a higher proportion of people with high knowledge felt mask wearing was important, and indeed were actually wearing a mask for the interview.

Knowledge levels about Covid-19 were similar between Rohingya and host communities, although their information sources differ. The survey found Rohingya people who have visited listening groups and food distribution points and live near certain services (mosques, info hubs and health facilities) feel better informed and have higher knowledge about Covid-19, because they are exposed to information there (including common service content). Mosques have been a particularly important source of information about Covid-19 for both Rohingya and host communities during the pandemic, as their loudspeakers have been used to share information. Otherwise for the host community, television has been their main source of information about Covid-19.

Conclusion

This evaluation finds that the common service has played an important role in informing Rohingya people were instrumental in informing Rohingya people about Covid-19. Getting information out in the right places (mosques, through face-to-face volunteers) was important, and language and format also played an important role: without communication materials which Rohingya people could understand, knowledge would not have been at the same level as the host community, which has access to nationwide sources of information about Covid-19.

This study has found that face to face communication is an effective way of sharing information in the camps, and has been particularly successful at reaching Rohingya women. The common service must now work with partners to ensure men, and older people are accessing information they need despite Covid-19 restrictions. The common service should consider what is the best way to serve the host community going forward, based on an understanding of their communication needs and preferences, tapping into their existing information infrastructure. And across both communities people articulated information needs outside of Covid-19 which should not be overlooked, such as keeping children safe from common diseases, economic security and the security situation in Myanmar. The common service can also play a role in improving access to feedback mechanisms for people in both Rohingya and host communities, especially women and people with disabilities, working with existing networks of volunteers who are trusted by their communities.

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Introduction

Context

Cox's Bazar in Bangladesh is home to the largest refugee population in the world. An estimated 855,000 stateless Rohingya refugees currently reside in Ukhiya and Teknaf Upazilas[1]. The vast majority live in 34 extremely congested camps, including the largest single site, the Kutupalong-Balukhali Expansion Site, which is host to approximately 626,500 Rohingya refugees. Following violence targeted towards Rohingya people in Rakhine state in Myanmar, October 2017 saw the largest influx of Rohingya refugees to Bangladesh. Over the last three years, the 'host' community, Bangladeshis living around the camps, have also been economically affected by the influx of refugees to the area, which has resulted in tension between the Rohingya and host communities. As requested by the Bangladesh Government, humanitarian agencies responding to the crisis aim to support an estimated 444,000 host community members as well as the Rohingya refugees living in the camps.

When the global Covid-19 pandemic began in March 2020, to control the spread of the virus, the Bangladeshi Government Refugee Relief and Repatriation Commissioner's (RRRC) office issued an official letter to restrict the movements around the refugee camps, allowing only essential services to continue[2].

These orders limited the non-essential services around the camps and reduced the number of humanitarian staff and volunteers travelling to the camps for various purposes. During this time, only Covid-19 related awareness sessions were being allowed in the camps, which were carried out by Community Health Workers and volunteers, whilst maintaining all the safety measures. These restrictions remain in place at the time of publishing this report. As of 8th May 2021, there have been 11 deaths in the camps reported as a result of Covid-19[3].

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1   Joint response plan midterm review, 2020: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/jrp_2020_final_in-design_200422.2mb_0.pdf

2   Letter from Office of the Refugee Relief and Repatriation Commissioner, dated 24 March 2020

3   Cox's Bazar - IEDCR Field lab, Civil Surgeon Office and WHO sub Office

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Project: The common service for community engagement and accountability

The common service for community engagement and accountability is funded by UNOPS (back funded by FCDO) and ECHO. It aims to ensure Rohingya and host communities' have access to life saving information that helps them make appropriate decisions about their lives; and to support the humanitarian community be more accountable to the affected population. The common service plays a role in the humanitarian response as a trusted, independent consortium that delivers support, guidance and knowledge to a range of sectors in support of improved community engagement and accountability for the Rohingya response.

Since the common service began in 2017, the objectives of the project have remained to ensure:

1. Individuals, families and communities have improved access to coordinated, timely and responsive two-way community engagement in their preferred language on critical lifesaving and life-enhancing actions that they can take.

2. Systematic accountability is improved through common standards and principles for collecting and analysing feedback; and a collective mechanism for collating and analysing diverse sources of feedback to inform decision making processes at the sector and country levels.

Changes to common service implementation because of the Covid-19 pandemic

As a result of the Covid-19 pandemic, several key changes to the common service overall strategy took place during this phase:

- The original plan for the common service during this phase was to begin to take a more thematic approach to its work, looking specifically at themes – education, health & nutrition, peace-building & social cohesion, and governance and refugee participation in decision-making; and cash and vouchers. However, as the onset of the Covid-19 pandemic coincided with the start of this phase of the common service, the thematic focus which has dominated has been Covid-19 in accordance with the needs of the Rohingya and host communities at this time.

- Movement restrictions and containment measures were implemented in the camps in an attempt to control the spread of the virus. The restrictive measures have impacted humanitarian programmes - many were reduced to critical services and assistance only with limited number of staff allowed to access the camps each day. This has negatively affected the accessibility and availability of many services. The common service has continued its activities in this response, but has made adjustments such as shifting focus

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to responding to the information and communication needs around Covid-19, conducting training with humanitarian practitioners through online rather than face to face methods and limiting activities (such as filming and research) in the camps. Regular research with communities through much of this period has been conducted by telephone, although research for this evaluation was conducted face to face.

- Given that reduced numbers of humanitarian staff have been able to access refugee camps, there has been increased engagement with religious and community leaders; and grass-roots community organisations within the Rohingya community in order to gather first-hand perceptions from the community; as well as provide tools and training to support community leaders to disseminate information and collect feedback directly with their own communities. A separately funded pilot project was also set up, creating a secure system of content 'hotspots' that these leaders can use to download common service audio and video communication tools to their phones, without the need to access the internet.

Common service activities

Common service key activities during this phase have included the following:

Creation of a range of audio and visual communication products across various themes, with a particular emphasis on Covid-19.

- In the first quarter of the year (April-June 2020) the common service produced more than 60 communication tools designed to help communication and improve knowledge and awareness on Covid-19 for the Rohingya and host communities as well as health workers themselves. In response to a request from WHO and the health sector, BBC Media Action produced video content for health workers on infection prevention and control that was used as part of training sessions to ensure they could reduce the risk of contracting Covid-19 as front line responders. Audio products targeting community health volunteers were also produced, with several agencies using this audio with community health volunteers in their health facilities across camps.

- In the second quarter (July-September 2020) there was continued production of guidance, tools and community-facing communication products, including multi-media content designed for use with refugees and host communities. Twenty-two reactive pieces of content were produced in response to agency and sector requests, including community-facing material on Covid-19 awareness, prevention, and mitigation; a tip sheet for new food distribution protocols; re-opening of registration, case management principles, child protection and immunization.

- *Aa'rar Foygam* (weekly podcast) was being played at listening groups in the camps. The audio programmes use Rohingya community voices as well as experts who provide information in a way that is easy to understand. During the pandemic, the common service shifted from making Aa'rar Foygam which is 15 minutes long, to a shorter version, Soiyi Hota, which is 6 minutes long to allow for distribution via smart phones and loudspeakers.

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Ongoing language training, support and translation

- The language glossary was updated with terms that the community use when discussing Covid-19 to support humanitarians in effective community engagement. These covered topics including Covid-19 response (mitigation, mask usage, hand washing, mask distribution, contact tracing, protecting older persons, cleaning and disinfecting, symptoms, praying in mosques, dignified burial, management of Covid-19 waste in the hospital, referral pathways, essential services, home based care), cyclone preparedness, equal household roles and GBV, child protection, social cohesion, livelihoods for the host community, shielding information and religious affairs directives.

- Translators without Borders continued providing support for the translation, editing and simplification of community-facing documents for a range of agencies, sectors and working groups within the response. This included production of Rohingya and Chittagonian audio products and Bangla and Burmese written products, working from base content provided by sectors and agencies in English and/or Bangla. Beyond direct translation, the requesting sectors and agencies have been supported in tailoring new and existing messaging, ensuring that English or Bangla original documents apply plain language principles for ease of comprehension.

Training practitioners in community engagement and accountability:

- Capacity strengthening through online training sessions have been largely focused on supporting practitioners to communicate during Covid-19. These included: effective community engagement during Covid-19; effective community engagement and campaign design; Rohingya language and glossary for fieldworkers; interpersonal communication during Covid-19; Rohingya language and culture; audio tutorial on community engagement with Imams during Covid-19; techniques for dealing with rumours during Covid-19. The common service also provided mentoring support to individual Rohingya community leaders on community engagement, and content was disseminated to them to share with their communities. All training sessions included sessions on accountability.

Ongoing community feedback research and analysis

- The *What Matters?* community feedback bulletin[4] continued to be produced, informed by NGOs providing their community feedback data for analysis, as well as formative and audience feedback research studies being conducted to generate insights. These studies explored (using remote data collection methods) issues such as community's experiences and perspectives relating to the impacts of Covid-19 in the camps, community needs around shelter and understanding perspectives and tensions around social cohesion between Rohingya and host communities.

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4   All editions of *What Matters?* are available at: http://www.shongjog.org.bd/

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Evaluation methodology

Evaluations of previous phases of this project[5] have included a community level survey to understand Rohingya and host communities' access to information and communication, and in-depth interviews with practitioners working in the Rohingya response to understand whether and how they have been using common service tools and services. The third evaluation, which sought to employ more complex evaluation methods and make extensive use of multiple data sources, provided causal evidence of the impact the common service has at community, practitioner and organisation levels.

This phase 4 evaluation has more of an emphasis on community level perceptions, collected through a population-based survey. As well as measuring and reporting on the key project indicators, the evaluation seeks to understand the contribution the common service has made to helping agencies support communities to cope with Covid-19. It seeks to understand what has been effective in reaching and engaging audiences, in increasing their knowledge, changing attitudes, and encouraging them to take action to keep themselves and their families safe.

The evaluation uses mixed methods and aims to triangulate data where possible. More detail on methods is outlined below.

Population based survey

A face-to-face population-based survey was carried out in January 2021 to provide robust data to report on key project indicators about access to information and accountability, as well as measure reach of common service content in target communities and explore if there is an association between exposure to common service products and specific outcomes those products have aimed to address, with a focus on supporting Rohingya and host communities to cope with Covid-19.

The survey included a representative sample of Rohingya community (n=2678, across 15 camps) and host community (n=1050 across two upazilas). Every participant was over 18 years old. For the host community, the sample was chosen to represent the gender balance in each upazila, based on data provided by the Bangladesh census (projected population). For the Rohingya community, the sample in each camp was chosen to reflect the gender balance in each camp, based on data provided by UNHCR. The camps were selected based on the original hypothesis, which was that outcomes would be better for people living in camps where agencies which had been supported by common service activities during this phase of the project were working most. The five camps which were considered to have a high level of common service support were selected. Nineteen camps were considered to have a medium level of common

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5   BBC Media Action (2018) How effective is communication in the Rohingya refugee response? Available at: https://www.
     bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response
     BBC Media Action (2019) What contribution is the common service making to community engagement and accountability
     in the Rohingya response? Available at: http://www.shongjog.org.bd/news/i/?id=0993b68f-be04-46dd-a76f-b0a54e60504b

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service support, and ten camps were considered to have a low level of support. Five camps were randomly selected from the medium and low lists using a lottery method. During analysis phase the data was weighted to ensure that the results presented are representative to the Rohingya camp population as a whole.

Qualitative research with practitioners and community members

Key informant interviews were carried out with four management level practitioners from organisations the common service worked in partnership with during this phase of the project.

In depth interviews were carried out with field level practitioners, including three with NGO staff, and three with community health workers.

In depth interviews were carried out with sixteen men and women from Rohingya community and five men and women from the host community. Five interviews were also conducted with representatives from Community Based Organisations, and Imams.

Comparison of key indicators over time

Every year the common service reports to a set of indicators, which are in line with the project's objectives, and have remained similar since the beginning of the response in October 2017. The table below provides data against these indicators for the most recent phase of this project (survey data collected for this evaluation in January 2021). It also includes data reported against these indicators in previous years, so a comparison can be made over time. These indicators are discussed in the findings section below.

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Table 1: Progress against key project indicators, measured over time

Impact indicator 1
% of people who feel humanitarian organisations take their opinion into account when providing services/support

Baseline	Target	Community	Survey Question		Info needs assessment (Oct 2017)[1]	CS1 evaluation (July 2018)[2]	Data published in CS3 Evaluation[3] (GTS April and Nov 2019)[4]		CS4 evaluation (Jan 2021)
							GTS Apr 19	GTS Nov 19	
65%	85%	Rohingya	Do you feel aid providers take your opinion into account when providing aid services? (CS4 & GTS Survey)	Overall			78%	80%	71%
				Male			77%	77%	68%
				Female			78%	84%	73%
		Host	Do you feel agencies/aid providers take your opinion into account when providing services/support? (CS4 & GTS Survey)	Overall			65%	60%	42%
				Male			57%	60%	38%
				Female			62%	70%	45%

Impact indicator 1
% of people who report that they have comprehensive access to information, in a language they understand, to make decisions for them and their family (measured for both refugees and host communities, disaggregated by gender, age and disability)

Baseline	Target	Community	Survey Question		Info needs assessment (Oct 2017)	CS1 evaluation (July 2018)	Data published in CS3 Evaluation (GTS April and Nov 2019)		CS4 evaluation (Jan 2021)
							GTS Apr 19	GTS Nov 19	
4%	75%	Rohingya	Do you feel you have the information you need to meet your own and your family's needs? (CS4 & GTS Survey)	Overall	23%	84%	58%	66%	84%
				Male				64%	80%
				Female				68%	87%
			Do you feel informed about the kind of aid/services available to you? (CS4 & GTS Survey)	Overall		63%	53%	59%	61%
				Male			57%	59%	49%
				Female			47%	59%	73%
		Host	Do you feel you have the information you need to meet your own and your family's needs? (CS4 & GTS Survey)	Overall					58%
				Male					56%
				Female					59%
			Do you feel informed about the kind of aid/services available to you? (CS4 & GTS Survey)	Overall				53%	25%
				Male				54%	22%
				Female				51%	27%

1   Internews (2017) Information needs assessment, Cox's Bazar Bangladesh. Available at: https://internews.org/wpcontent/uploads/legacy/201711/Internews_Coxs_Bazar_Publication%2030Nov_web.pdf

2   BBC Media Action (2018) How effective is communication in the Rohingya refugee response? Available at: https://www.bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response

3   BBC Media Action (2021) Supporting humanitarian communication: What role does a dedicated 'common service' play in community engagement and accountability? Available at: https://www.bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response-case-studies

4   Ground Truth Solutions (April & November 2019) Systematic feedback for Rohingya and host communities in Bangladesh. Available at: https://groundtruthsolutions.org/our-work/feedback-rohingya-bangladesh/

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Impact indicator 2
% of people who do not face any barriers to giving feedback (measured for both refugees and host communities, disaggregated by gender, age and disability)

Baseline	Target	Community	Survey Question		Info needs assessment (Oct 2017)	CS1 evaluation (July 2018)	Data published in CS3 Evaluation (GTS April and Nov 2019)		CS4 evaluation (Jan 2021)
							GTS Apr 19	GTS Nov 19	
42%	65%	Rohingya	Do you know how to make suggestions or complaints about the aid you receive? (CS4 & GTS Survey)	Overall			59%	64%	46%
				Male			63%	64%	46%
				Female			54%	64%	46%
			Are there any barriers that are currently preventing you from giving feedback or making a complaint? % of people who answer **'there are no barriers'** (CS4 Survey)	Overall		42%			51%
				Male		51%			66%
				Female		33%			35%
		Host	Do you know how to make suggestions or complaints about the services or support you receive? (CS4 & GTS Survey)	Overall			37%	46%	36%
				Male			28%	40%	33%
				Female			46%	52%	38%
			Are there any barriers that are currently preventing you from giving feedback or making a complaint? % of people who answer **'there are no barriers'** (CS4 Survey)	Overall					31%
				Male					38%
				Female					25%

Impact indicator 3
% of [community] people who report enhanced knowledge on rights and entitlements or systems for dispute resolution

Baseline	Target	Community	Survey Question		Info needs assessment (Oct 2017)	CS1 evaluation (July 2018)	Data published in CS3 Evaluation (GTS April and Nov 2019)		CS4 evaluation (Jan 2021)
							GTS Apr 19	GTS Nov 19	
n/a	45%	Rohingya	Do you know anything about your rights as being a person living in the camps? (CS4 Survey)	Overall					62%
				Male					54%
				Female					70%
			Do you know what aid/services you are supposed to receive in the camps? (CS4 Survey)	Overall					69%
				Male					65%
				Female					73%
		Host	Do you know anything about your rights as a citizen of Bangladesh? (CS4 Survey) Do you know anything about your rights as a citizen of Bangladesh? (CS4 Survey)	Overall					55%
				Male					47%
				Female					63%

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Key findings

As this was a mixed methods study, findings from the population survey and the qualitative research with communities and practitioners have been incorporated throughout. The findings are split into three sections.

1. Access to information about services and rights during the pandemic

The findings in this section are linked to the log frame indicators and are about people's general access to information they need, information about services and about their rights and entitlements. Access to information and knowledge about Covid-19 will be covered in a later section.

Access to information has decreased for the host community since the pandemic, but remains high for the Rohingya community, especially women who feel more informed than previous years

Despite movement restrictions and service closures imposed due to the Covid-19 pandemic, access to information remains high within the Rohingya community, with 84% in this survey saying they feel they have enough information to meet their and their families' needs, compared with 66% in a Ground Truth Solutions survey[1] carried out in November 2019 (see indicator table above). Overall, feeling informed about services has remained constant for Rohingya people since that survey, with 61% saying they feel informed about the kind of aid/services available to them, compared with 59% in November 2019. However there has been a substantial increase for Rohingya women, with 73% saying they feel informed about services compared with 59% in 2019. Simultaneously there has been a decrease for men, with only 49% saying they feel informed about services, compared with 59% in 2019.

For the host community, access to information has decreased dramatically, with only 25% saying they feel informed about services available to them, compared with 53% in November 2019. Host community women feel better informed than men, but there is not as big a difference as in the Rohingya community (27% compared with 22% of host community men). Only 58% of host community people say they have the information they need to meet their families' needs, compared with 84% of Rohingya community people.

The drop in access to information for host communities may be due to a drop in services available, and less face to face communication has meant less access to information tailored to their needs.

The onset of the Covid-19 pandemic meant many humanitarian agencies, including common service organisations, had to cancel the interventions they had planned for the host community due to movement

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1   Ground Truth Solutions, November 2019

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restrictions and a focus on essential relief being provided in the Rohingya camps. The lack of services available to the host community is likely to explain why people feel uninformed, compared with the Rohingya community where essential services continued to be provided.

The qualitative and quantitative data suggests information sources also play an important role, and point to the benefits of tailored, face-to-face communication. The Rohingya community may feel more informed because they receive most of their information face to face, compared with the host community who is more reliant on mass media, particularly television, for information (see figure 1 for main sources of information for each community). Information provided face to face, within the community, tends to be tailored to needs of the person receiving it, unlike information received via mass media. People can ask questions when information is provided face to face, listening groups provide a forum for discussion and deepening understanding, which may also mean people feel better informed, and feel that they have enough information to meet their needs.

The importance of a trusted channel of information was emphasised in the qualitative research, which found that people in both communities trust information which is given to them by NGOs, as they believe it is being provided for their benefit. They trust the NGO staff and volunteers, as they believe they are working to help them, and they have built up a relationship with them overtime.

> " We trust the audio which the [agency] volunteers play to us because we know them, they come to our block regularly, and we know they are working to help us."
>
> — Rohingya female community member

Figure 1: The main sources of information for the Rohingya and host communities
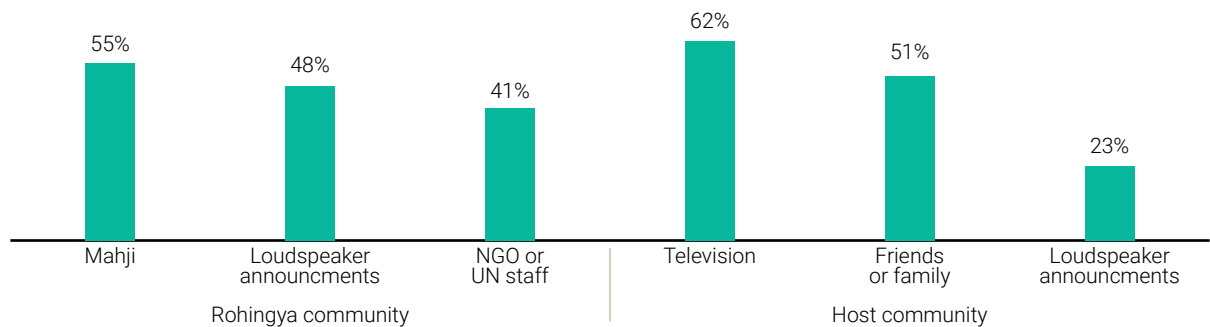
Q: Since the pandemic started, what are your main ways of finding information? (multiple choice)

Table 2: Significant results of regression analyses

Rohingya community	Times as likely to feel informed about services available
Female (versus male)	3
Food distribution point visitors	1.7
Listening group attendees	1.6
Cited volunteer as main information source (when asked how receive information from NGOs)	1.6
People who interact with NGOs on weekly basis	1.3

*[see annex 1 for details of statistical test]*

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Advanced statistical analysis carried out with data from the Rohingya community shows that people who are more exposed to face-to-face interaction with NGOs or volunteers, are more likely to feel informed about services available to them than those who don't have frequent interaction (see table 2). Regression analysis looks at the influence of certain variables on a particular outcome, while taking account (or controlling of) other relevant variables. In this study, regression analysis found that people who attend listening groups, and people to cite volunteers as their main information source, are 1.6 times as likely to feel informed about services available as those who don't, even when taking into account other variables in the model. It also found that those who attend food distribution points are 1.7 times as likely to feel informed.

Figure 2 confirms people in Rohingya communities have more frequent interaction with NGO workers than those in the host community, where there are less services available in general, and interventions like listening groups and door to door volunteers are also less common.

Figure 2: How often people in both communities interact with NGO workers in the Rohingya and host communities
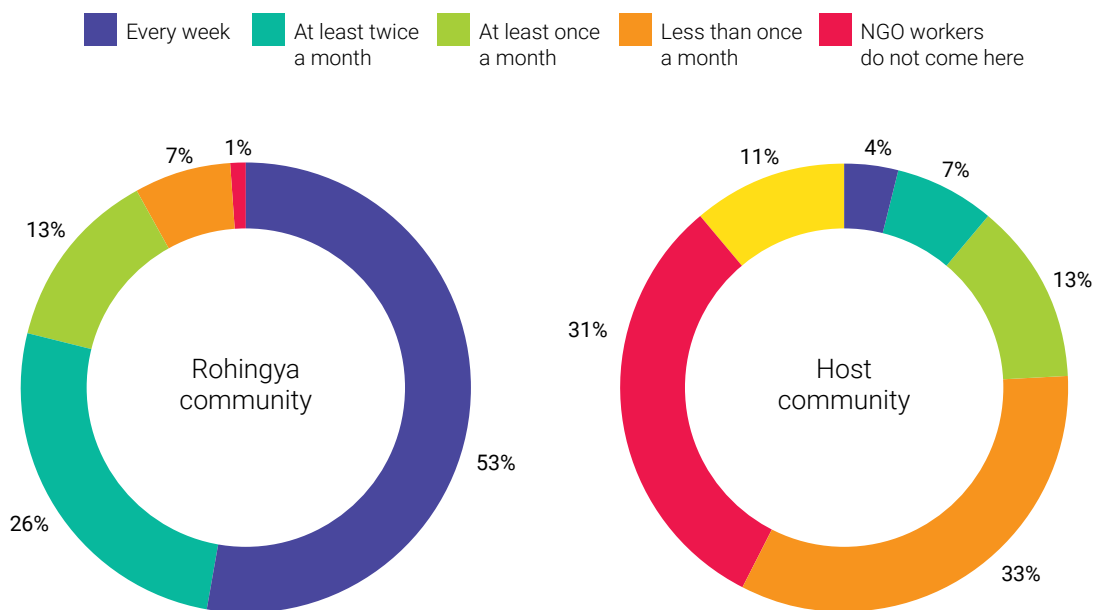
Q: How often do you interact with NGO workers?

Although there is a difference between the Rohingya and host communities in how informed people feel about services, when it comes to Covid-19, there is little difference, with 60% of the Rohingya community and 58% of the host community saying they feel quite or well informed about coronavirus in general. They also have similar levels of knowledge around Covid-19. This may be because information about Covid-19 is being shared everywhere, through mass media as well as face to face communication, and is not as location specific.

As mentioned previously although visits to the camps were restricted at the beginning of the pandemic, community health workers and volunteers were able to continue face to face interventions as raising awareness about Covid-19 was considered a priority, and face-to-face communication was considered the most effective way to reach Rohingya people, along with loudspeaker announcements.

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Face-to-face provision of information in the camps has worked to ensure Rohingya women are well informed, while men's access to information has reduced due to restrictions on public gatherings.

Rohingya women have been previously underserved in terms of access to information: as women are expected to stay at home, they move around the camps much less than men, and therefore have access to less sources of information. This resulted in agencies focusing on communicating with women, through employing volunteers to visit door to door, holding women only listening groups, and sharing information at Women Friendly Spaces (WFS). The results of these efforts began to be seen in the common service phase 3 evaluation, where the proportion of Rohingya women who felt informed about aid or services increased substantially from 47% in April 2019, to 59% in November 2019. Qualitative research at that time found that women appreciated the increase in volunteers visiting their homes in the camps, as they were able to learn information, ask questions and give feedback.[2]

Figure 3: Proportion of men and women from each community who feel informed about what kind of services/aid are available to them
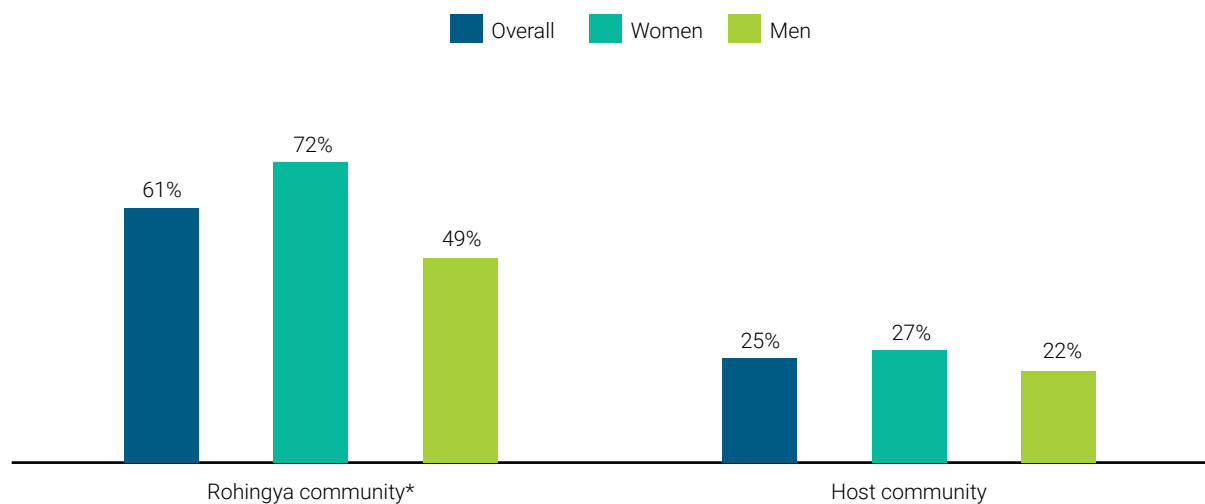
Q: Do you feel informed about the kind of aid/services available to you? Yes.

  * *There is a significant difference between men and women feeling informed in the Rohingya community, but the difference is not significant for the host community.*

The data from this survey conducted in January 2021 shows that despite the pandemic, a high proportion of Rohingya women - 73% - feel informed about aid and services. As the log frame table shows, Rohingya women are the group which feel most informed about services available to them, are most likely to feel they have enough information to meet the needs of their family and feel most informed about Covid-19 – 65% of Rohingya women said they feel quite or well informed about coronavirus in general, compared with 55% of Rohingya men, 58% of host community men and 57% of host community women. And the data indicates they are the most knowledgeable about how to protect themselves from the virus: 47% of Rohingya women achieved a high knowledge score in the survey, compared with 33% of Rohingya men, 44% of host community women and 29% of host community men. Access to information and knowledge about Covid-19 is discussed further later in this report.

2   BBC Media Action (2021) Supporting Humanitarian Communication: What role does a dedicated 'common service' play in community engagement and accountability?' A case study from the Rohingya Response, Cox's Bazar.

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Rohingya men are more mobile than women: they move around the camps and usually have access to information from a wider variety of places than women. However, during the pandemic, men have not been allowed to gather at places where they would previously meet to discuss and share information between themselves, such as tea shops, markets, and mosques, which were first closed, and then policed to ensure social distancing is taking place. This may result in men feeling less informed than they previously did.

For Rohingya women, whose movement is usually restricted to their own block, their main sources of information have always been very local (community leaders or mahjis, and door to door volunteers), and these have continued during the pandemic. Rohingya women tend to access organised sources of information more than men, where information is shared systematically, such as regular door to door visits from volunteers, listening groups (77% of women attend listening groups compared with 67% of men), and women friendly spaces (an estimated 99 safe spaces for women and girls exist across the 34 camps)[3]. Figure 4 shows a higher proportion of Rohingya women cited door to door volunteers as their main way of receiving information from NGOs (58% compared with 45% of men).

Figure 4: Main ways of receiving information from local actors amongst men and women in each community

Women | *Men* | *Women* | *Men*

Rohingya community | Host community
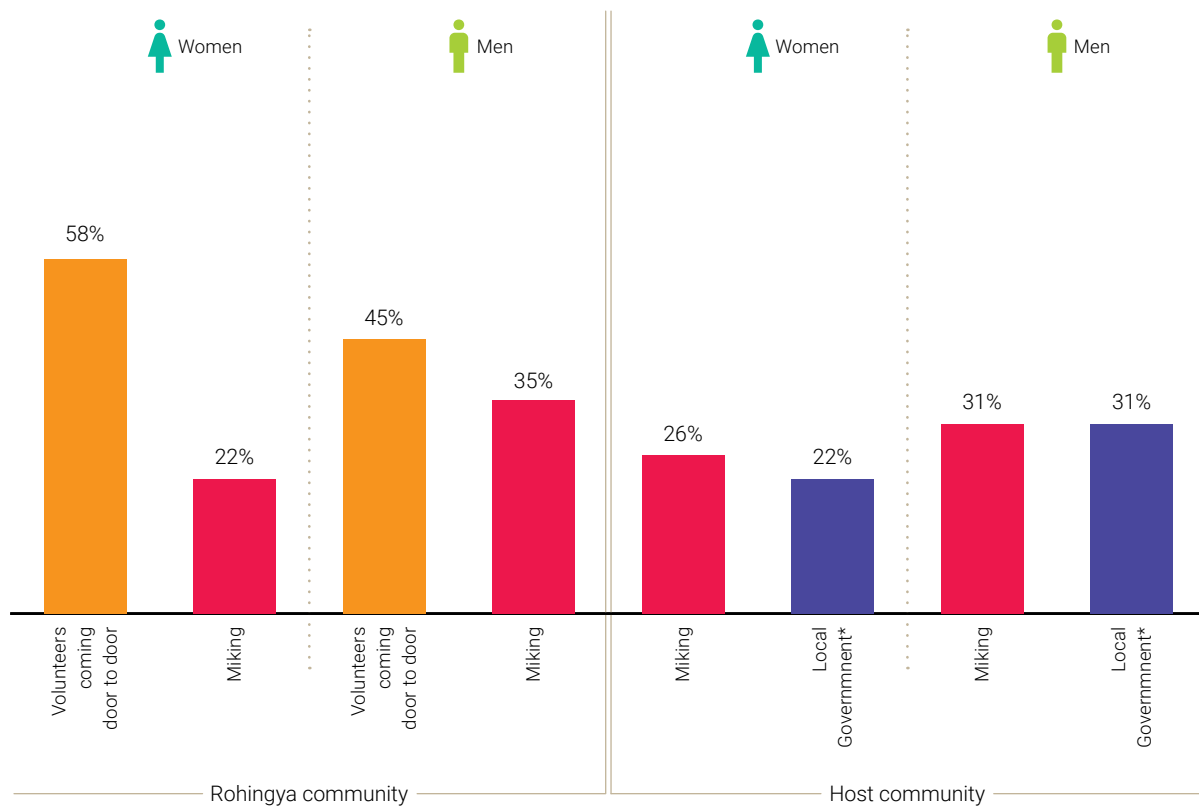
* Union Parishad Chairman / Member / Chowkidar / Village Police

Q: What are the main ways you receive information from or communicate with NGOs/UN staff/ Government?

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3   Site Management Sector facilities mapping exercise

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Previous research with the Rohingya community[4], and indeed in Bangladesh more broadly, found that women tend to be more interested in information about keeping their families safe and healthy, while men are more focused on information about news and politics. As much of the information shared during the pandemic has been about keeping people safe from Covid-19, this information might resonate more with women than men, and may also contribute to women feeling more informed than men.

People in the oldest age group in both Rohingya and host communities feel less informed than younger people

In both communities, a lower proportion of people in the over 60 year old age group say they feel informed about services available to them (see figure 5). This age group also feels the least informed about Covid-19 (see figure 6), and indeed has lower knowledge scores about Covid-19 than younger age groups: 32% of Rohingya over 60s got a high knowledge score about Covid-19 in the survey, compared with 42% of the age groups 30-39 and 40-49 years old. The same was true in the host community, where 31% of over 60s got a high knowledge score compared with 41% of 30-39 year olds.

This indicates that either outreach efforts are not reaching older people, or they are less engaged or have more difficulty understanding the information being provided.

There was some indication of this in the qualitative research as well. A female representative from a community based organisation (CBO) explained that older people were not as interested in the audio content she was sharing, and would often leave the group half way through. Both male and female CBO representatives said that elderly people had difficulty remembering the information which was shared through the audio programmes.

Figure 5: Proportion of Rohingya and host community people who feel informed about services available, by age group
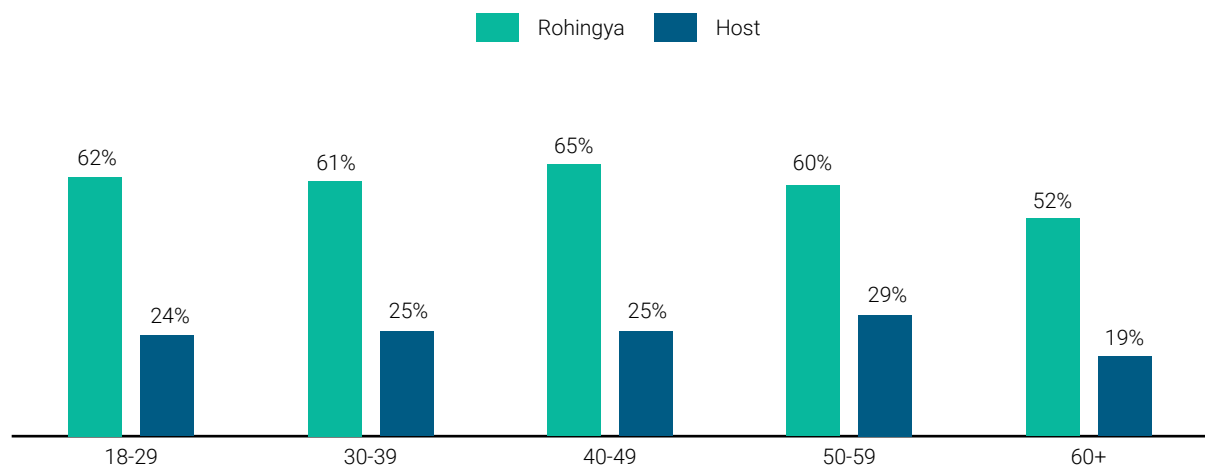

Q: Do you feel informed about the kind of aid/services available to you? Yes.

4   BBC Media Action (2018) Research Report: How effective is communication in the Rohingya refugee response? Available at: https://www.bbc.co.uk/mediaaction/publications-and-resources/research/reports/asia/bangladesh/rohingya-response

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Figure 6: Proportion of Rohingya and host community people who feel well informed about Covid-19, by age group
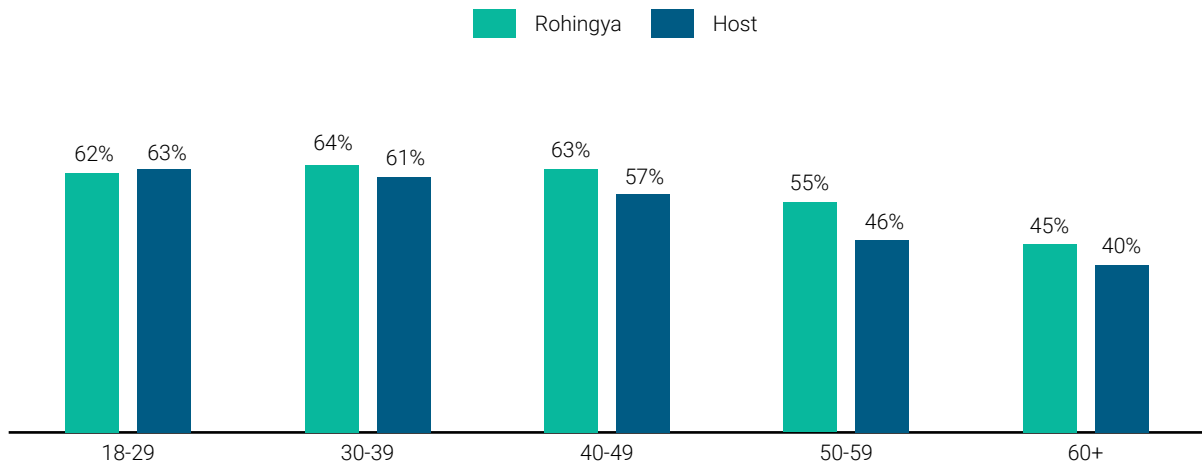

Q: Overall, how well informed would you say you are about coronavirus in general?
Answer: Very well informed OR Quite well informed

Rohingya communities do not report significant language challenges communicating with aid providers

Data from this survey suggests understanding between aid providers and Rohingya communities is high, despite language differences between local staff, who usually speak Chittagonian, which is different to Rohingya. Ninety-one percent of Rohingya people interviewed said aid providers provide information to them in a language they understand, and 81% said they do not face any language related challenges in communicating with aid providers.

Figure 7: Main language used to communicate with Rohingya participants

14% Bangla

20% Chittagonian

66% Rohingya dialect
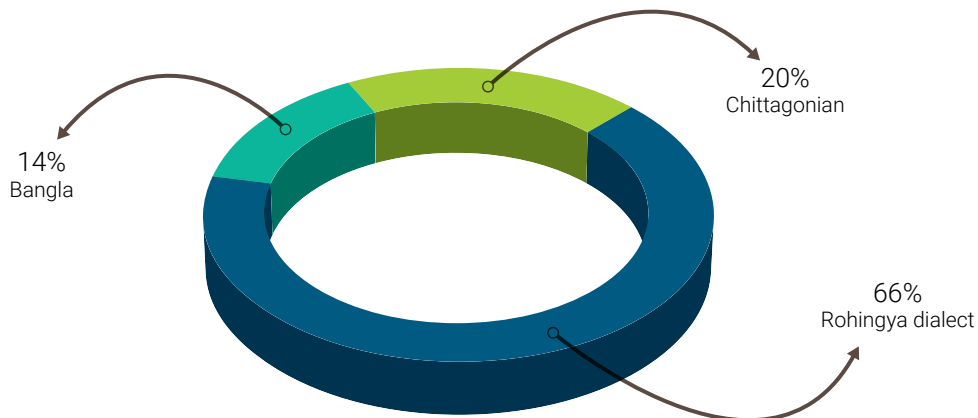
Q: What is the main language aid workers use to communicate with you?

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As shown in figure 7, when asked about what language aid workers use to communicate with them, two thirds (66%) said Rohingya. This is probably because many of the volunteers working in the camps are Rohingya people themselves, and the majority of communication materials being used in the camps are in the Rohingya language. It may also be because host community staff and volunteers are more familiar with Rohingya language and terminology, as a result of training and the glossary tool provided by the common service.

Data from qualitative interviews with field level practitioners suggests common service language training made field level staff and volunteers aware of differences between Chittagonian and Rohingya dialects, which they then used when communicating with Rohingya communities.

> " Program officers, community mobilizers and CFRM (complaints and feedback response mechanism) help desk officers got the training. After receiving the training, they memorised the words from the glossary. Because they got the community engagement training, that's why they know for effective community engagement, using the right language is important."
>
> — Field level practitioner

Rohingya and host community women report feeling more informed about their rights than men in both communities.

Rohingya women are the group who report feeling most informed about their rights. When asked 'Do you know anything about your rights as being a person living in the camps?', 70% of Rohingya women said yes compared with 54% of Rohingya men. Host community women also feel more informed about their rights than host community men, with 63% saying they feel informed about their rights as a citizen of Bangladesh compared with 47% of host community men.

These results contrast with a qualitative research study carried out by BBC Media Action in December 2020[5], which found that women and girls have limited knowledge of rights due to limited access to education. The same study found that people who are involved with different NGOs (working as volunteers or in other capacities) and have some education have a better understanding of rights-related issues.

The evaluation survey found there is not a big difference in either community for people with disabilities. In the Rohingya community 59% of people with disabilities said they know something about their rights, compared with 63% of non-disabled people. The scenario is also similar for the host community (53% of people with disabilities, compared with 56% of non-disabled people).

In terms of entitlements, overall 69% of the Rohingya people said they knew about the aid/services they were supposed to receive, and more women knew about this than men (73% vs 65%).

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5   BBC Media Action (December 2020) Understanding rights, issues around participation and future aspirations within the Rohingya community. [Not currently available online].

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When they were asked about what services or goods they are entitled to free of charge, almost all of them knew about food. More men knew that they were entitled to shelter for free than women (90% vs 72%) whilst more women knew that they were entitled to health care than men (80% vs 75%).

Figure 8: Proportion of men and women in each community who know something about their rights
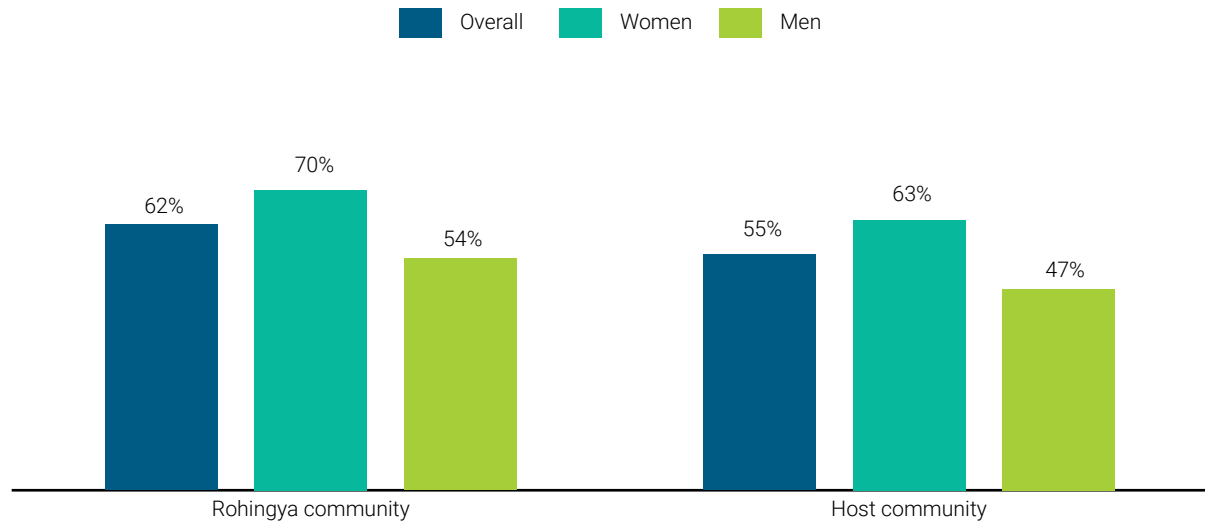

Q: Do you know anything about your rights as a person living in the camps / as a citizen of Bangladesh? Yes

2. Giving feedback and making complaints

There has been a decrease in Rohingya and host community's knowledge about how to provide feedback due to restriction of services during the pandemic

A comparison of key log frame indicators overtime shows there has been a substantial decrease in the proportion of Rohingya people who know how to provide feedback since the pandemic started, with 46% saying they know how to make suggestions or complaints about the aid or services they receive, compared with 64% in the Ground Truth Solutions survey in November 2019. Common service staff who manage the common complaints database also noticed a drop in the actual number of complaints and feedback being received by agencies at the start of the pandemic (see figure 9).

Figure 9: Number of community feedback received by the common service for the common complaints database, by year
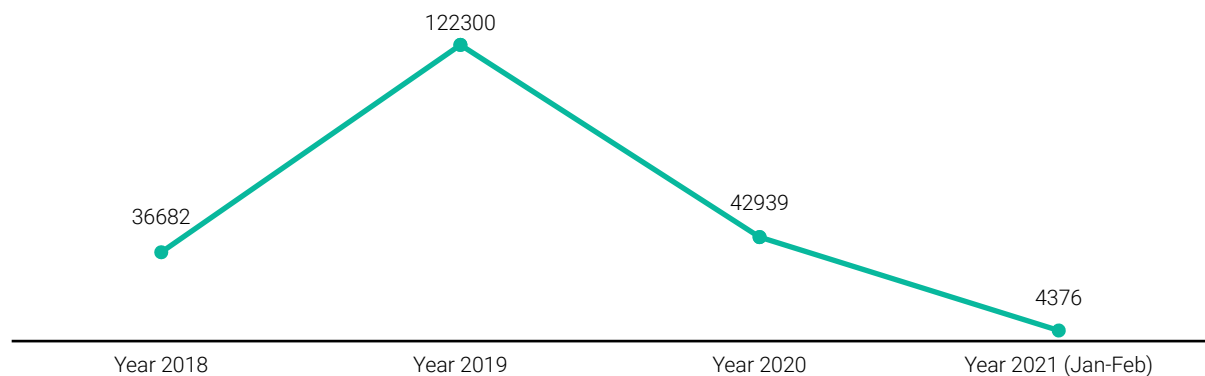
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As of March 2020, movement and activity in the Rohingya camps was restricted to essential services. Covid-19 information and awareness sessions were allowed to continue (maintaining safety measures), but non-essential visits to the camps by humanitarian staff and volunteers were prohibited. This would explain why Rohingya people living in the camps felt they had access to information (through Covid-19 awareness sessions), but no longer knew how to provide feedback, as agencies were not operating complaints mechanisms in the same way as before, and services where people would previously have provided feedback were closed (e.g. information hubs, feedback desks).

> "[The start of the pandemic] was really challenging as we had to find a way to communicate with people about changes in programmes. Previously we had relied on communicating in person, through our field partners and volunteers. With the restrictions this was no longer possible."
>
> — Management level practitioner

Knowledge about how to give feedback has always been lower in the host community, due to less services being provided, less provision of feedback mechanisms, and less frequent contact with NGO staff. As provision of services for the host community has decreased even further as a result of the pandemic, there has also been a decrease in the proportion of people who know how to give feedback: with 36% now saying they know how to make suggestions or complaints about the aid or services they receive, compared with 46% in the Ground Truth Solutions survey in November 2019.

With two-way communication between humanitarian agencies and communities being restricted by the pandemic, as well as a reduction in services being provided, it follows that there has been a decrease in both communities in the proportion of people who feel aid providers are taking their opinions into account (see figure 10). In the Rohingya community, the figure remains relatively high, with 71% of people saying they feel aid providers take their opinion into account when providing aid services, compared with 80% in the November 2019 Ground Truth Solutions survey. There has been a bigger drop in the host community, from 60% in November 2019, to 42% following the pandemic.

Figure 10: How much people feel their opinion has been taken into account by aid providers while providing aid or services
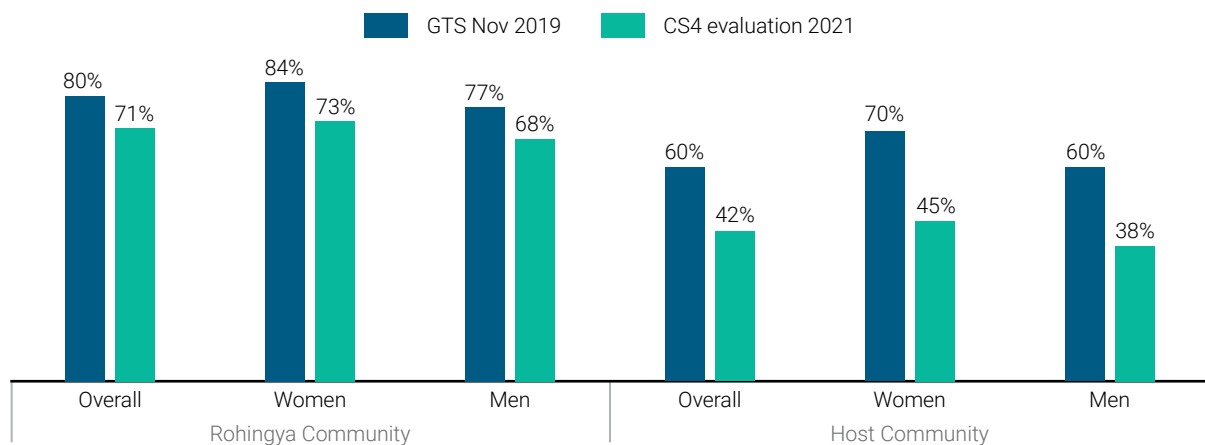

Q: Do you feel aid providers take your opinion into account when providing aid/services? Yes, all of them or Yes, some of them

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In both communities, women and people with disabilities face the highest barriers to giving feedback

Although there is no difference between Rohingya women and men's knowledge about how to give feedback (46% of both said they know how to make suggestions or complaints), a much higher proportion of Rohingya women (65% compared to 34% of Rohingya men) face barriers to giving feedback (see figure 11). Barriers are also higher for host community women, but the difference is smaller.

Figure 11: Proportion of people who faced at least one barrier in giving feedback
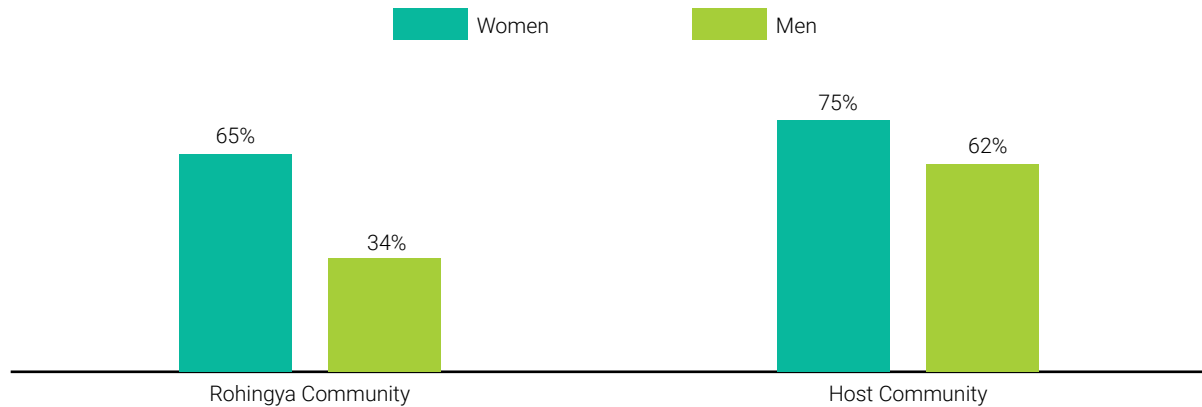
Q: Are there any barriers that are currently preventing you from giving feedback or making a complaint?

In both communities, a lower proportion of people with disabilities say they know how to make complaints (31% compared with 51% of non-disabled people in the Rohingya community; and 32% compared with 39% of non-disabled people in the host community). A higher proportion also say they face barriers to giving feedback. However, when it comes to actually giving feedback, 17% of disabled people in the Rohingya community have given feedback compared with 7% of non-disabled people (see figure 12). The situation is similar in the host community, with 15% of people with disabilities having given feedback compared with 11% of non-disabled people. This may be because people with disabilities feel they need to request additional support, and therefore have raised complaints.

Figure 12: Knowledge about, and actually making complaints amongst people with disabilities
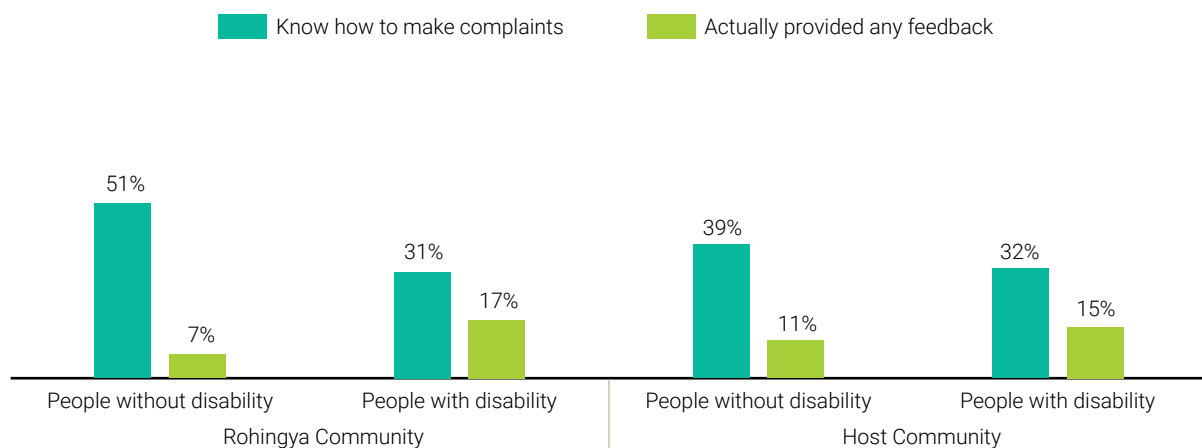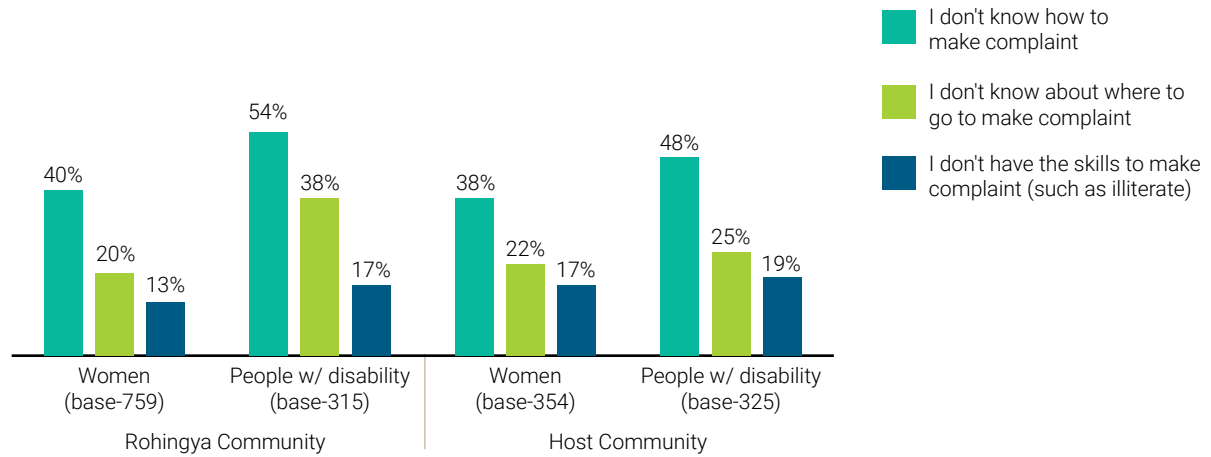

Q: Do you know how to make suggestions or complaints about the aid/services you receive?
Q: Have you or your family provided any feedback or complained about anything since the pandemic started (Apr-Dec)?

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Women and people with disabilities said they faced similar barriers to making complaints: not knowing how to, not knowing where to go, and not having the skills to make a complaint.

Figure 13: Barriers to making complaints for women and people with disabilities

Legend:
- I don't know how to make complaint
- I don't know about where to go to make complaint
- I don't have the skills to make complaint (such as illiterate)

Rohingya Community:
- Women (base-759): 40%, 20%, 13%
- People w/ disability (base-315): 54%, 38%, 17%

Host Community:
- Women (base-354): 38%, 22%, 17%
- People w/ disability (base-325): 48%, 25%, 19%

Q: Are there any barriers that are currently preventing you from giving feedback or making a complaint?

Women and people with disabilities may not know how or where to make complaints, due to restrictions on their movement, but also due to what people consider as being a formal complaint. For example, although Rohingya women discuss issues with door to door volunteers or NGO staff at Women Friendly Spaces they may not consider this as providing feedback officially. The qualitative and quantitative data suggests that Rohingya men are more likely to visit the Camp in Charge (CiC) office, or visit organisation's offices, where they feel they can make complaints or provide feedback officially.

Moreover, the survey data shows that men are more likely to provide feedback than women: 6% of Rohingya women have given feedback personally, but 10% say someone in their family has. Amongst Rohingya men, the figures are the other way round: 9% have given feedback personally, while 3% say someone in their family has.

3. Who is common service content reaching, and through what channels?

As mentioned in the introduction, the common service creates audio and visual communication materials in response to the needs of the community, and on request of humanitarian agencies. The materials are shared on the Shongjog website (www.shongjog.org.bd) and available for anyone to use with Rohingya and host communities. It is difficult to track how widely the materials are being used, and, unlike when a programme is broadcast on a certain television or radio channel, this makes it difficult to determine how many people have seen or heard the content which has been created.

For the first time since the project started, this survey tried to measure how many people are being reached by common service content in the Rohingya camps and in the host community, and through what channels.

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Survey participants were played or shown ten pieces of content, and asked if they had heard or seen it, and where. The content included audio PSAs; Soiyi Hota audio programmes and flashcards about Covid-19 and cyclone preparedness. Qualitative research with community members sought to understand community members perspectives on the common service content they had seen or heard.

Common service content reached 75% of the Rohingya community and 38% of host community members

The survey found that 75% of the Rohingya community said they had seen or heard at least five of the pieces of common service content which were played or shown to them.[6] A higher proportion of men (82%) have been reached than women (69%).

Within the host community, 38% of people said they had seen or heard at least five pieces of the common service content[7], with a smaller difference between men (44%) and women (32%). In both communities, there was little difference between people of different ages who had been reached.

In the Rohingya community, as expected, a higher proportion of people who attend listening groups, and who visit food distribution points, have been reached by common service content.

In both communities, a higher proportion of people who interact frequently with NGOs, and live close to services (info hubs, health facilities and service centres) were reached by common service content. This suggests that people living close by are either more likely to visit the services, or be reached by outreach from that service, and be exposed to content being played or shown there.

Figure 14: Proportion of men and women from each community who have seen or heard at least five pieces of common service content
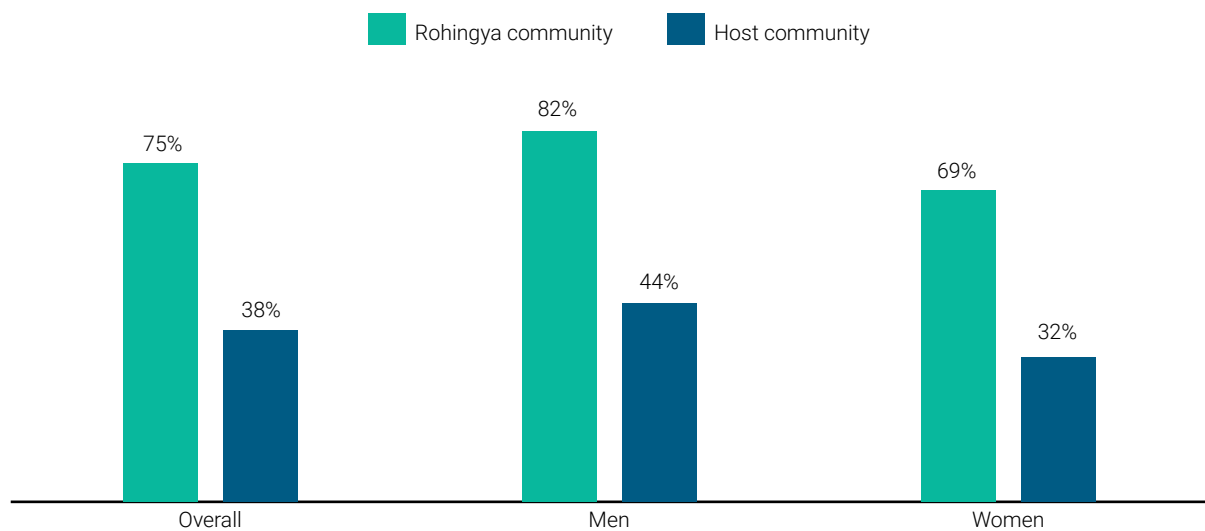
6   Five or more pieces of content has been used to ensure the measure is robust. 94% of survey participants said they had seen the handwashing poster. This was excluded from the measure as many similar handwashing posters exist across the camps, and it was not possible to attribute this to the Common Service.

7   It is possible that participants from the host community were confirming that they had seen/heard information similar to the content which was played to them in the interview. As the audio content was made for a Rohingya audience, it is in Rohingya language, and is therefore unlikely to have been shared with the host community.

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Figure 15: Proportion of Rohingya community reached by at least five pieces of common service content depending on attendance/proximity to certain services
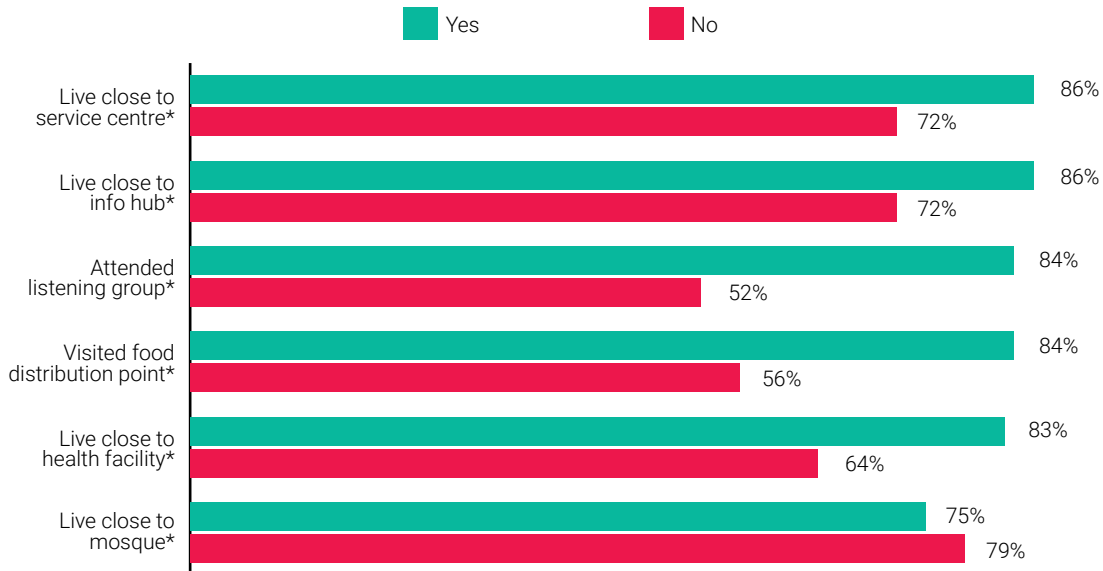
* using chi-square test, the difference is found to be statistically significant to p>0.05 *[annex 2 for detailed table]*

Figure 16: Proportion of host community reached by at least five pieces of common service content depending on attendance/proximity to certain services
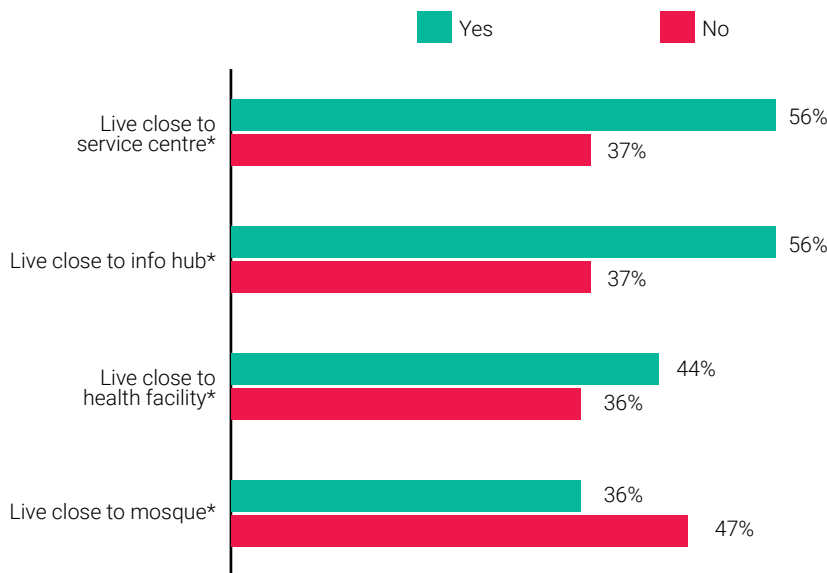
* using chi-square test, the difference is found to be statistically significant to p>0.05 *[annex 3 for detail table]*

People in both communities are hearing common service content through loudspeakers, but door to door outreach and health care facilities are also important channels for women.

When asked where they had seen or heard these contents, "miking" (loudspeaker) was the most frequently given answer by men and women in both communities (see figure 17).

As mentioned previously, when access to the camps became restricted due to the pandemic, staff working for the common service and other organisations realised the best ways to disseminate
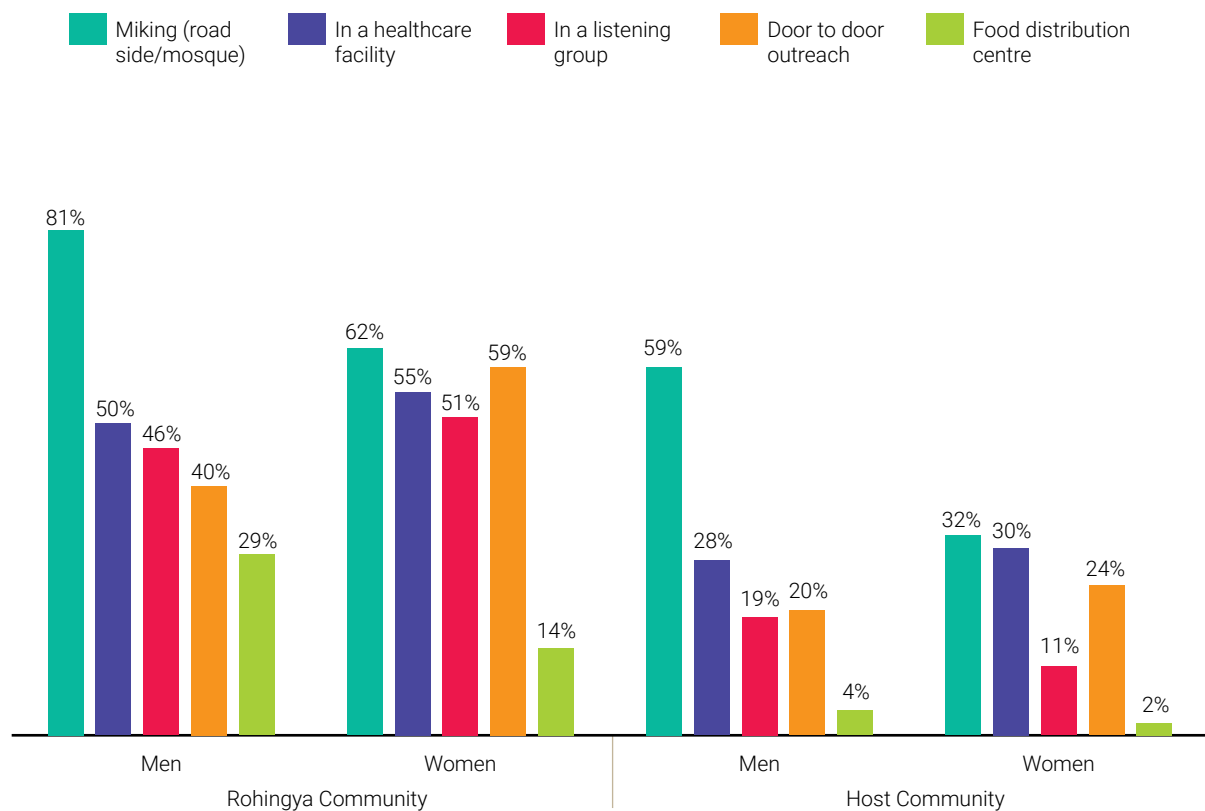
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information to the Rohingya community would be through existing volunteer networks in the camps, as well as loudspeaker announcements from mosques and other community places. The common service had previously conducted communication training with Imams in the camps, but had not been systematically using loudspeaker announcements from mosques as a dissemination channel. During the pandemic that changed: partner agencies began playing content (made by the common service and others) through loudspeakers situated in different places, and liaising with mosques to play content through their loudspeaker systems. As mentioned previously, the common service adapted their original weekly podcast programme, Aa'rar Foygam, to a short 6 minute version, Soiyi Hota which made it easier to play through loudspeakers.

For women in both communities, health facilities and door to door outreach were also important channels where they had seen/heard the content, as well as listening groups for Rohingya women. As expected, a higher proportion of men in the Rohingya community had been exposed to the content at food distribution points than women (29% of men compared with 14% of women), as men more often collect food for the family.

Figure 17: Proportion of people who saw/heard common service content in different locations

Common service content reaching far and wide

The common service has supported different humanitarian agencies with training and bespoke communication and accountability support in different phases of the project. Across the 34 camps where Rohingya people live in Cox's Bazar, different agencies provide services in different camps. As mentioned in the methodology, this study hypothesised that outcomes would be better for people living in camps

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where agencies which had been supported by common service activities during this phase of the project were working. We hypothesised that people living in camps where agencies were highly supported by the common service would more likely be reached by common service content, and therefore be more knowledgeable, than those in camps which received little or no direct support.

Figure 18: Proportion of Rohingya community exposed to at least 5 pieces of common service content, living in differently supported areas

High supported camps	Medium supported camps	Less supported camps
71%	82%	73%
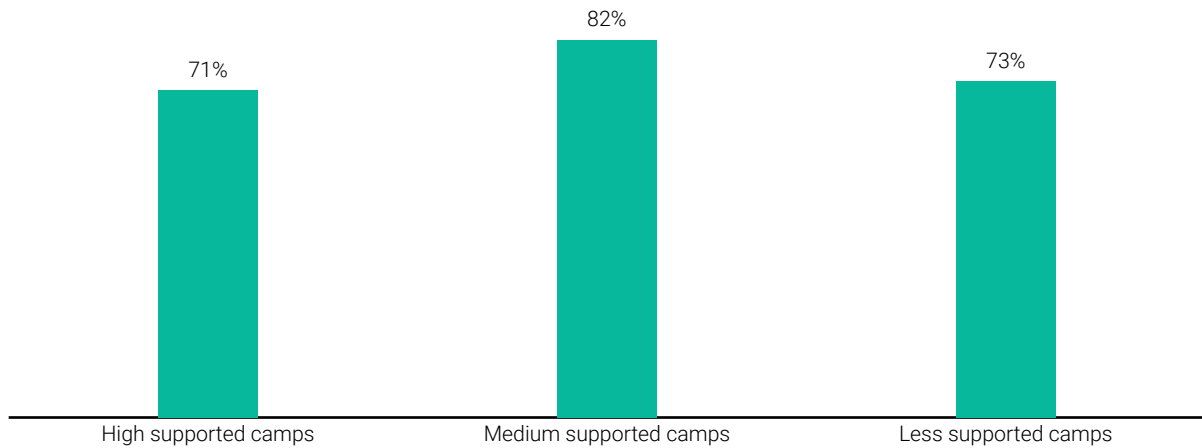
The data has shown this not to be the case (see figure 18). The camp support level has not made a difference to the proportion of people who have been reached by common service content, or to people's knowledge outcomes.

This could be because organisations and practitioners across the response were able to access common service products, which are available for all to use on the Shongjog website. From June 2019 to March 2021, the Shongjog website had 19,375 unique users and 56,548 page views, showing the scale of its use. Indeed the data shows that listening groups – a key place where common service content is shared-

exist across all the camps, not just in those where supported agencies are working. Secondly, some of the big agencies which the common service has provided technical communication support to during this phase of the project, such as UNHCR, WHO and WFP, work through partner organisations who work across all the camps, and share common service content in listening groups, health facilities and at food distribution points – the main places where the survey data shows that Rohingya people have seen or heard the content. Community Health Workers, who were trained by the common service to use audio content and the visual flipchart, travel door to door and cover 90% of households in the camps, which could be another reason reach was so high.

> " What I found really useful was the Shongjog website. I used it a lot to find different materials. I used it to check what existing posters had been created, make sure we weren't reinventing the wheel. This was especially useful during Covid when we needed to be able to communicate quickly with people and get communication out there quickly."
>
> — Management level practitioner

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4. Access to information, knowledge, attitude, and action on Covid-19

As outlined in the introduction, much of the work carried out by the common service during this phase was focused on supporting humanitarian agencies to communicate effectively with communities, particularly Rohingya communities living in camps, about Covid-19. This section looks at what seems to have influenced people's access to information about Covid-19, as well as their knowledge, attitude and practice in terms of keeping themselves safe.

Two thirds of people in the Rohingya and host communities feel well informed about Covid-19, despite getting their information from different sources

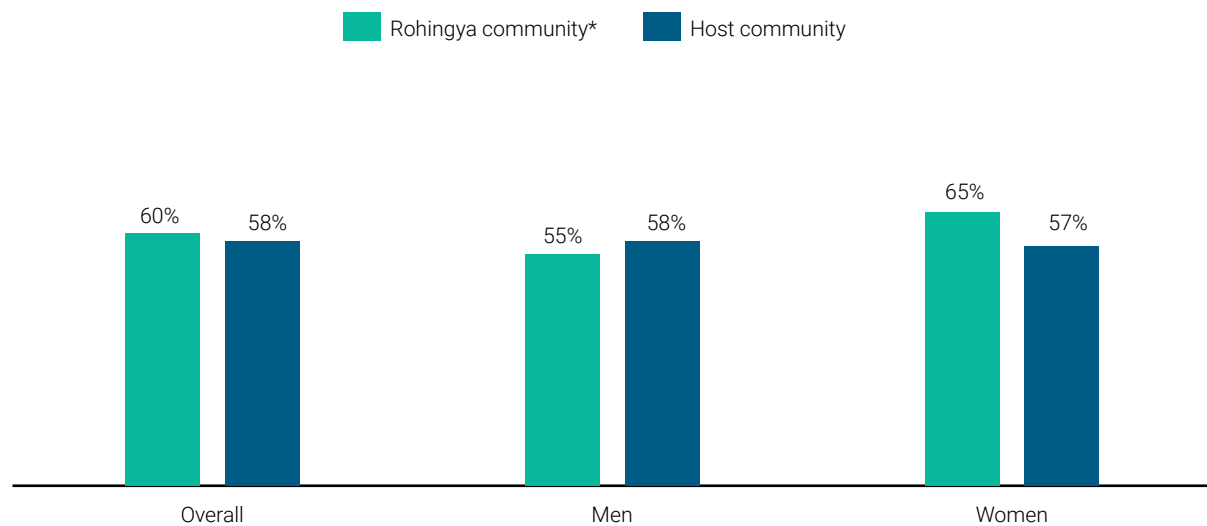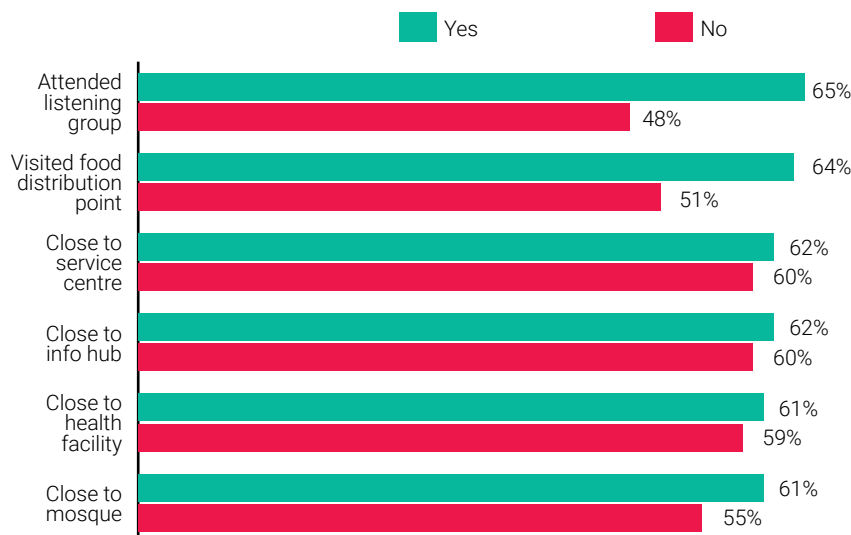**Figure 19: Proportion of people who feel informed about Covid-19**

Figure 20: Proportion of Rohingya community feel informed about Covid-19 depending on attendance/proximity to certain services

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Figure 21: Proportion of host community feel informed about Covid-19 depending on attendance/ proximity to certain services
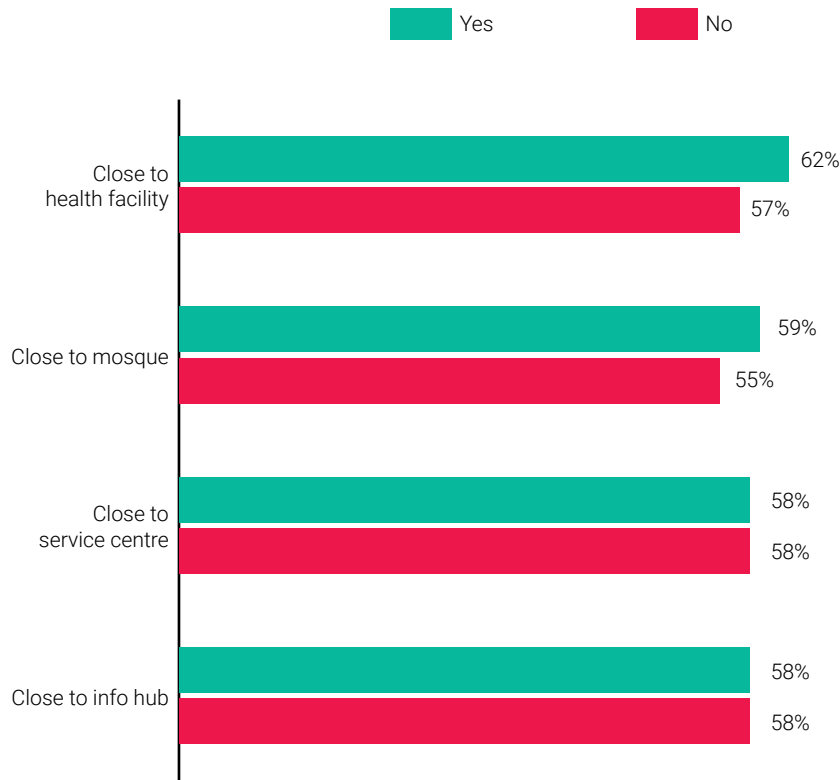
Q: Overall, how well informed would you say you are about coronavirus in general?

Unlike information about aid and services, a similar proportion of people in the Rohingya and Host communities, almost two thirds, feel quite or well informed about Covid-19. As mentioned previously, Rohingya women are the group who feel the most informed (65% compared with 55% of Rohingya men, 58% of host community women and 57% of host community men), most likely due to their reliance on face-to-face communication, and possibly having greater interest in information about keeping their families safe than their male counterparts. People in the oldest age groups feel less informed about Covid-19 than younger people in both communities (see figure 6 on page 15).

The qualitative research also found that people in both communities feel well informed about how to protect themselves from Covid-19 and they are not confused about information they receive, suggesting the information they receive from different sources is consistent. For example, there was consistency in what people mentioned as the main ways to keep themselves safe: washing their hands with soap (which they said they didn't do before but have been doing since the start of the pandemic); wearing masks in public; keeping distance from people and avoiding crowds.

> " We know what to do to keep ourselves safe. I know all the symptoms and what to do if someone gets affected by Covid. Affected people must be taken to the hospital with help of an NGO worker and they must stay isolated. Some NGOs visit our houses and talk about Covid."
>
> — Rohingya community female

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Figure 20 shows that in the Rohingya community, a higher proportion of people who attend listening groups and food distribution points, and live close to mosques, feel informed about Covid-19. In the host community, the story is different: people who live close to health facilities and mosques report feeling well informed.

The qualitative research also found people's sources of information about Covid-19 were different. Rohingya community participants main and trusted information sources were predominantly community based. For women, loudspeaker announcements and NGOs were the main source of information on Covid-19, and they talked about the flashcards and audio programmes (made by the common service) which volunteers had shown them or played at listening groups. As well as loudspeaker and NGOs, Rohingya men mentioned the Camp in Charge (CiC), audio programmes played at food distribution points, Imams and Facebook.

Host community participants also mentioned miking (from mosques and vehicles), and television news as key information sources. Host community women also mentioned door to door visits from Community Health workers as an important source of information. This may explain why proximity to mosques and health services mean people in the host community are better informed about Covid-19.

> " Mostly we trust whatever the Camp in Charge (CiC) says. Because CiC knows everything. When he says something to Imam and then Imam announce it with the mike of the mosque that is the most authentic news."
>
> — Rohingya man

> " I know how to keep myself and my family safe from Covid, one NGO worker comes every week in our area and talk with us about Covid, Covid vaccination, pregnant women's regular check-up. She also told us to call national emergency helpline if we need more information about Covid."
>
> — Host community female

People feel well informed about Covid-19, but also have information needs unrelated to the pandemic which should not be overlooked

Qualitative research found that men and women from both communities feel well informed about how to protect themselves from Covid-19 and are not confused about the information they have received. Some host community participants asked questions about when they would get vaccinated, and when the pandemic would be over. People are worried about the impacts of the restrictions on their lives: men and women in both communities raised concerns about their children's education, which has been put on hold due to the pandemic, and men in both communities were concerned about earning money as they couldn't move around due to the current restrictions.

Women in both communities said they had questions about how to keep their families safe from diseases such as diarrhoea and cholera, highlighting that prevention of other common health issues are as much of a priority as keeping safe from Covid-19. Rohingya men and women said they wanted to know when they would be able to go back to Myanmar. Some of them are concerned about the education system, which is different to how it is in Myanmar.

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Host community concerns focused on issues they have been facing since the Rohingya community arrived, such as the impact this has had on their land ownership, businesses and ability to earn money.

Survey data confirms that both communities are concerned about the security situation in Cox's Bazar, and for Rohingya people, the security situation back in Myanmar is their primary concern (see table 3 below). Both Rohingya and host women say they need to know where to access water, whereas host community men want to know where to get work and financial support. Host community women are the only group who mention corona virus prevention measures as a priority information need, along with how to access education.

> " Here many young people came who read till 9th/10th grade in Myanmar. As here in Bangladesh this grade is not available for the Rohingya community, where could we get some computer training so that it could help us. We discuss this within our peer groups."
>
> — Rohingya man

Table 3: What is the main thing you need to know about right now? Top three information needs for each group

Rohingya men	Rohingya women	Host men	Host women
• Security situation in Myanmar	• Security situation in Myanmar	• Security situation here	• Corona virus prevention measures
• Security situation here	• General news on what is happening here	• How to get money / financial support	• How to get access to education
• General news on what is happening here	• How to access water	• How to find work	• How to access water

Knowledge about Covid-19 is at a similar level between Rohingya and host communities, despite differing information sources

This survey asked several questions to test participants' knowledge about Covid-19, including about risk factors and preventative measures. A knowledge score[8] was created from three survey items:

Forty percent of Rohingya people have high knowledge about Covid-19

advanced analysis shows this is more likely amongst those who were exposed to common service content, attended listening groups or food distribution points, or live close to certain services. Within the Rohingya community, 40% of people have 'high' knowledge about Covid-19, 47% of women and 33% of men.

---

8 Q: Who is at most risk of becoming seriously ill with COVID-19? Correct answers: Old people and people with pre-existing health conditions.
Q: What are the symptoms of coronavirus? Correct answers: Fever and dry cough.
Q: What are some of the ways that you can help to stop the spread of this coronavirus? Knew three or more correct answers.

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Figure 22: Proportion of people who have high knowledge on Covid-19 among men and women in both communities

Rohingya community   Host community

	Overall	Men	Women
Rohingya community	40%	33%	47%
Host community	37%	29%	44%
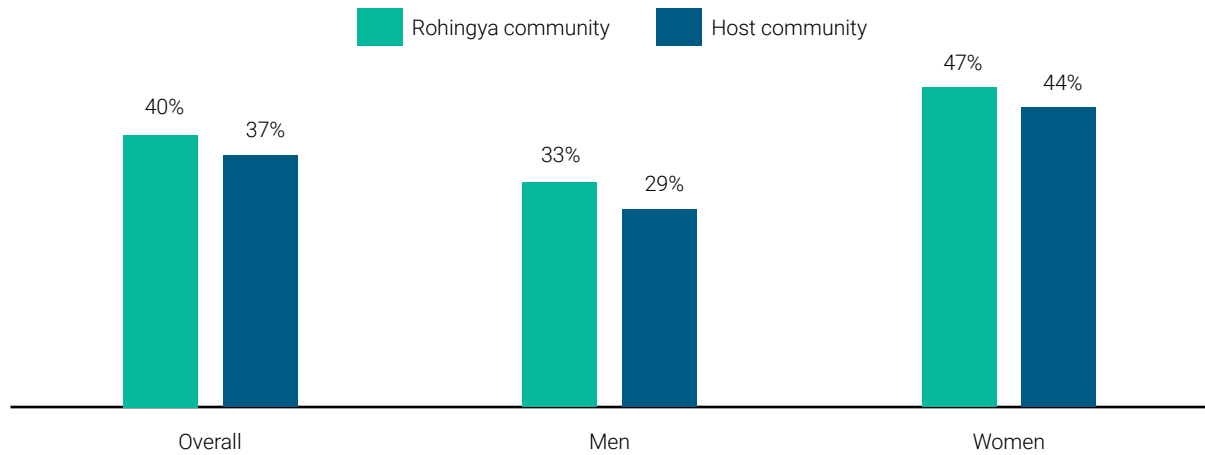
'High knowledge' score calculated as explained above.

Figure 23: Proportion of Rohingya community who have high knowledge about Covid-19 depending on attendance/proximity to certain services

Yes   No

	Yes	No
Close to service centre*	58%	34%
Close to info hub*	58%	34%
Close to health facility*	46%	32%
Attended listening group*	44%	30%
Visited food distribution point*	42%	35%
Close to mosque*	42%	21%
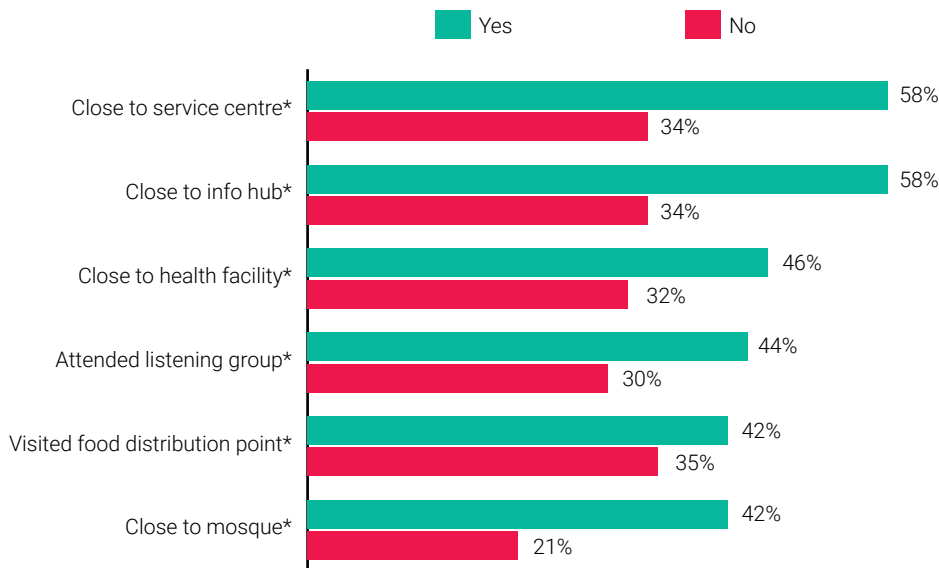
* using chi-square test, the difference is found to be statistically significant to p>0.05 *[annex 4 for detail table]*

Figure 24: Proportion of host community who have high knowledge about Covid-19 depending on attendance/proximity to certain services

Yes   No

	Yes	No
Close to health facility	38%	36%
Close to mosque*	39%	28%
Close to service centre	42%	36%
Close to info hub	42%	36%
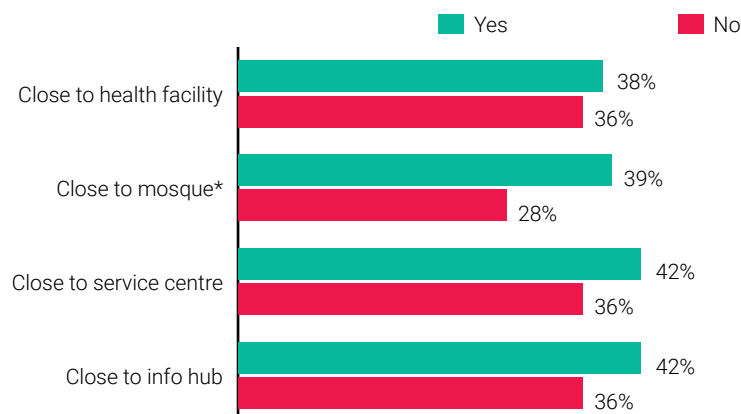
* using chi-square test, the difference is found to be statistically significant to p>0.05 *[annex 5 for detail table]*

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Table 4: Regression analyses

Rohingya community	Times as likely to have high knowledge
Living close to mosque	3.2
Living close to info hub	2.5
Female (vs Male)	2.2
Cited volunteer as main info source	1.7
Exposed to common service content	1.6
Living close to health facility	1.5
Food distribution visitor	1.3
Listening group attendee	1.3
Cited loudspeaker as main info source	1.1

[see annex 6 for details of statistical test]

Regression analyses show that Rohingya people who were exposed to Common Service content about Covid-19 were 1.6 times as likely to have high knowledge than those who weren't (see table 4).

People who attend listening groups or food distribution points are also more likely to have high knowledge, which is to be expected as we know that people are hearing or seeing content about Covid-19 (created by the Common Service and others) at these places.

Living close to different services also makes a difference, with living close to a mosque making the biggest difference. People who live close to a mosque are 3.2 times as likely to have high knowledge about Covid-19 as those who don't. Given that the highest proportion of Rohingya people said they receive information through miking, and mosques have increasingly taken a role in sharing information about Covid-19 via loudspeakers, this could explain the difference. As mentioned above, Rohingya men in the qualitative research cited imams as a key information source about Covid-19. One field level practitioner

> In 2019 imams from 6 camps were trained on community engagement. In 2021 we provided training for 13 imams, and they got the training of the trainers so that they can train other imams. And in the Rohingya community as imams cannot reach the women that's why we have provided training to 302 female religious teachers from 26 camps through partner organisation. They are not religious leaders; they only teach Arabic and talk about different issues to the community. They also got a training in 2021 and mostly they talk with the women and girls from the community."
>
> — Field level practitioner

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explained that religious leaders have taken an important role in sharing information about how people can keep themselves and each other safe from the pandemic, following training provided by the Common Service:

It should be noted that information about services and aid provision would not have been shared via mosques, which is why no association was found in the data between living close to a mosque, and people's access to information about services. But mosques are sharing information about Covid-19 protection measures, hence people being 3.2 times as likely to have high knowledge if they live close to a mosque. More information about the role the common service has played in supporting imams to communicate on Covid-19 and other issues is on page 44.

Similarly, information about Covid-19 (common service content and others) will have been shared by information hubs, health facilities, and service centres throughout the pandemic, which people who live close are more likely to have accessed, particularly giving the restrictions on people's movement through the pandemic. This may explain why living close to these services means people are likely to have higher knowledge about Covid-19.

The story in the host community is different: knowledge about Covid-19 is at similar level, but environmental factors and exposure to common service content make little difference

A similar proportion of the host community (37%) have high knowledge about Covid-19, and again this is higher amongst women (44%) than men (29%) (see figure 22). However, in the host community, environmental factors and exposure to common service content about Covid-19 have not made a significant difference, apart from living close to a mosque: 39% of host community people who live close to a mosque have high knowledge about Covid-19, compared with 28% who don't (see figure 24). Mosques were also used to disseminate information in the host community, by NGOs but also other organisations, as Government advice was to use mosques to broadcast information about Covid-19.

When we look at the host communities' main information sources this makes sense. Looking back at figure 1, the host community rely on mass media sources for their information, especially television. In comparison the Rohingya community are more reliant on face-to-face communication, from NGO staff and volunteers and community leaders, which is more location dependent. For both communities, miking has been a big source of information on Covid-19, which is why a higher proportion of people who live close to a mosque have high knowledge about Covid-19 in both communities.

Adaptable communications initiatives in the camps have played a key role in providing information about Covid-19 which Rohingya communities understand

Loudspeaker and face to face initiatives have been instrumental in informing Rohingya communities, especially women about how to keep themselves safe from Covid-19

The data shows that, unlike the host community, the Rohingya community have limited access to mass media sources and receive most of their information through face-to-face communications interventions in the camps – from NGO staff and volunteers, through loud-speaker announcements, and through

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hearing/seeing communication materials at listening groups or services they visit (food distribution points, health facilities, information hubs).

The quantitative and qualitative data suggests that information being shared at these places is playing a role in helping Rohingya people feel better informed, and shows that people who attend these places, and are exposed to relevant content, have higher knowledge about Covid-19. Face to face initiatives from trusted NGO staff and volunteers have been particularly effective at reaching Rohingya women, who are now the group who feels the most informed and is most knowledgeable about Covid-19.

Data suggests that common service content, which Rohingya communities have found understandable and relatable, has played a role in increasing their knowledge about Covid-19

Quantitative and qualitative data collected in this study suggest it is unlikely that knowledge about Covid-19 would be as high in the Rohingya community, were it not for tailored communication materials in the Rohingya language to help NGO staff and volunteers communicate effectively with the community.

> We work in both communities, but there is information and materials more readily available to use with the host community. We have easier access to communication materials, other ways to understand perceptions in the host community, so the collaboration with the common service has been mostly targeted toward Rohingya, where we didn't have those existing resources."
>
> — Management level practitioner

The common service is not the only organisation which has been creating and disseminating Covid-19 content in the camps, but the data suggests that common service content has played an important role.

As mentioned above, advanced statistical analysis found that Rohingya people who had seen or heard common service content about Covid-19 are 1.6 times as likely to have obtained a high knowledge score about Covid-19 than those who hadn't. Some examples of differences in the data between those two groups are as follows:

- When asked 'What should someone do if they have symptoms of coronavirus?', 72% of Rohingya people exposed to common service Covid-19 content mentioned the most important answer, 'Isolate themselves away from others', compared with 49% of unexposed Rohingya people.

- When asked 'How should you wash your hands to prevent the spread of coronavirus?', 47% of people who were exposed to the content mentioned three or more things to do[9] when handwashing compared with 31% of unexposed Rohingya people.

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9   Things to do when hand washing which were included in the survey question were: Wash hands frequently; wash hands for at least 10 seconds; use soap and water; wash hands at critical times; wash hands after touching surfaces.

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Figure 25: Knowledge on specific Covid-19 prevention measures within the Rohingya community, by exposure to common service Covid-19 content

Legend:
- Not exposed to content
- Exposed to content

Know important aspects of handwashing
- Not exposed: 31%
- Exposed: 47%

Know need to self isolate if have symptoms
- Not exposed: 46%
- Exposed: 72%
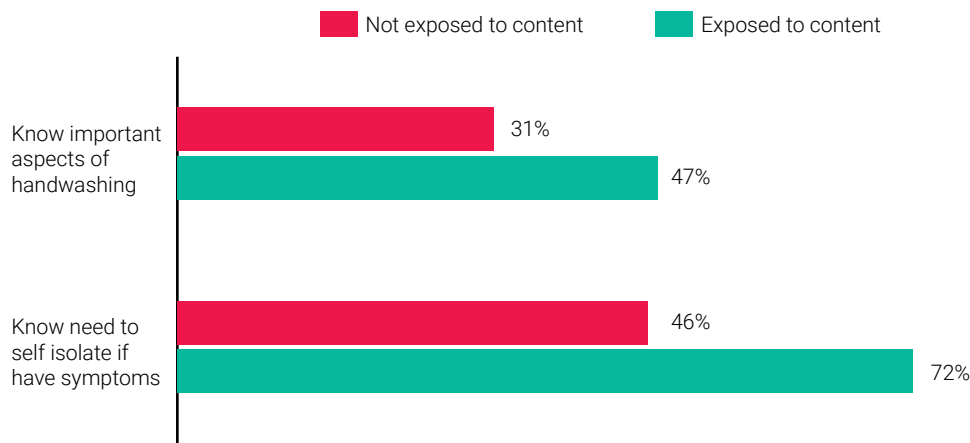
Q: 'What should someone do if they have symptoms of coronavirus?' Answer mentioned: Isolate themselves away from others
Q: 'How should you wash your hands to prevent the spread of coronavirus?' Answer: Mentioned three correct considerations

Qualitative research found Rohingya community members appreciated and were engaged by common service content for a number of reasons.

- **It's targeted:** Audio programmes are in Rohingya language, so they understand them, and they also feel the programmes are made specifically for their benefit

> " When we share audio with community members they get happy, because these audios are all made in Rohingya language. Also these reflect what happens in the camps. Sometimes there are characters like general community people or doctors talking together, and community members like this too."
>
> — Female representative from Community Based Organisation

- **It's easy to understand:** The images on the flashcard and flipchart, combined with explanations from volunteers, made the information easier to understand

> " I have seen the flashcard about distancing, I heard the audio and get to know about wearing mask, washing hands. Volunteers showed us the flashcard two or three times, and those were easy to understand. I also heard the Soiyi Hota program and understood it, it was on Covid."
>
> — Rohingya man

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- **It's relatable:** The audio programmes reflect their surroundings and what happens in the camps, meaning they can relate to the characters and the information being shared

> " Community members do not give their feedback about the content directly at the health centre. But as it is in the Rohingya language, they can understand it. They did not use mask earlier and did not wash their hand properly, but now they are doing it. And they also maintain the distance in the health facility."
>
> — Field level practitioner

- **It is in line with their values:** inclusion of religious leaders, as well as quotations from the Koran, meant content resonated with community members

> " People did not want to believe Covid is a real thing, so they [Common Service] made some videos and imams were shown using masks in the video and it used habits and quotations from the qu'uran – this makes people take it seriously. This worked well. That really resonated with the community."
>
> — Field level practitioner

- **It's entertaining:** Female participants particularly mentioned the audio drama *Aa'rar Kissa*[10], which, although is not about Covid-19, engaged them through the characters and storylines
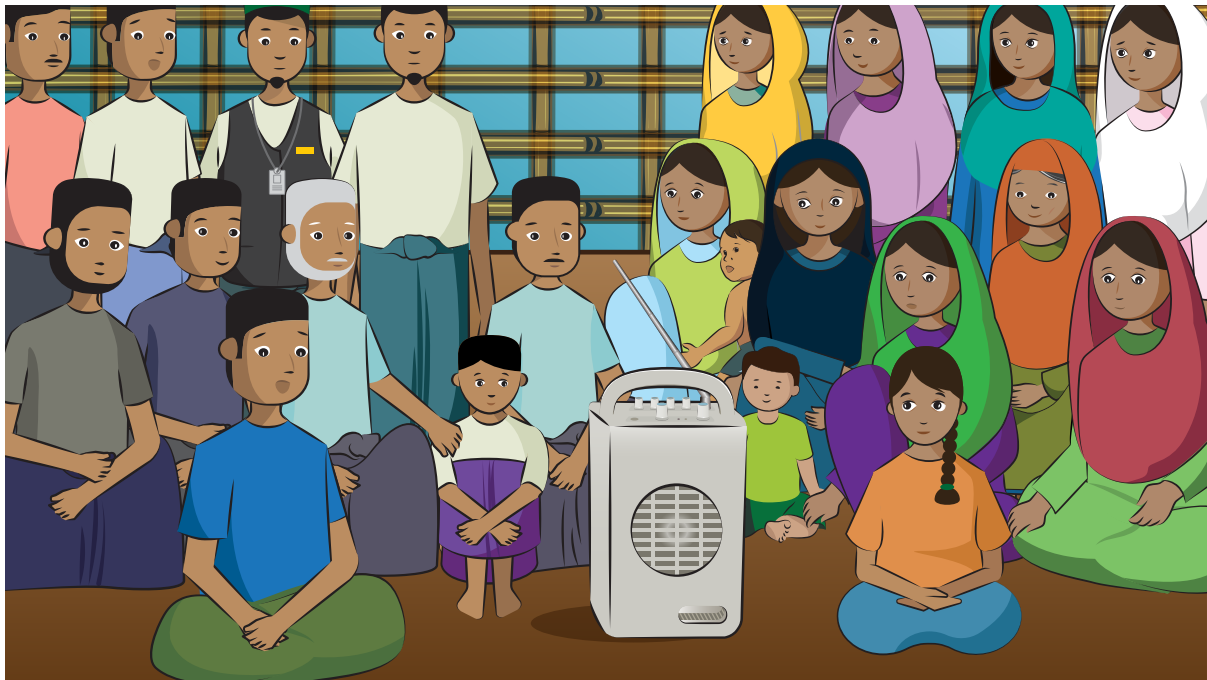
Artistic renedition of a listeners' group enjoying *Aa'rar Kissa*

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10 A Rohingya language radio drama developed by BBC Media Action to tackle issues of gender based violence in the Rohingya community, played at listening groups and Women Friendly Spaces.

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People with higher knowledge about Covid-19 feel mask wearing is important, and indeed were wearing a mask during the interview

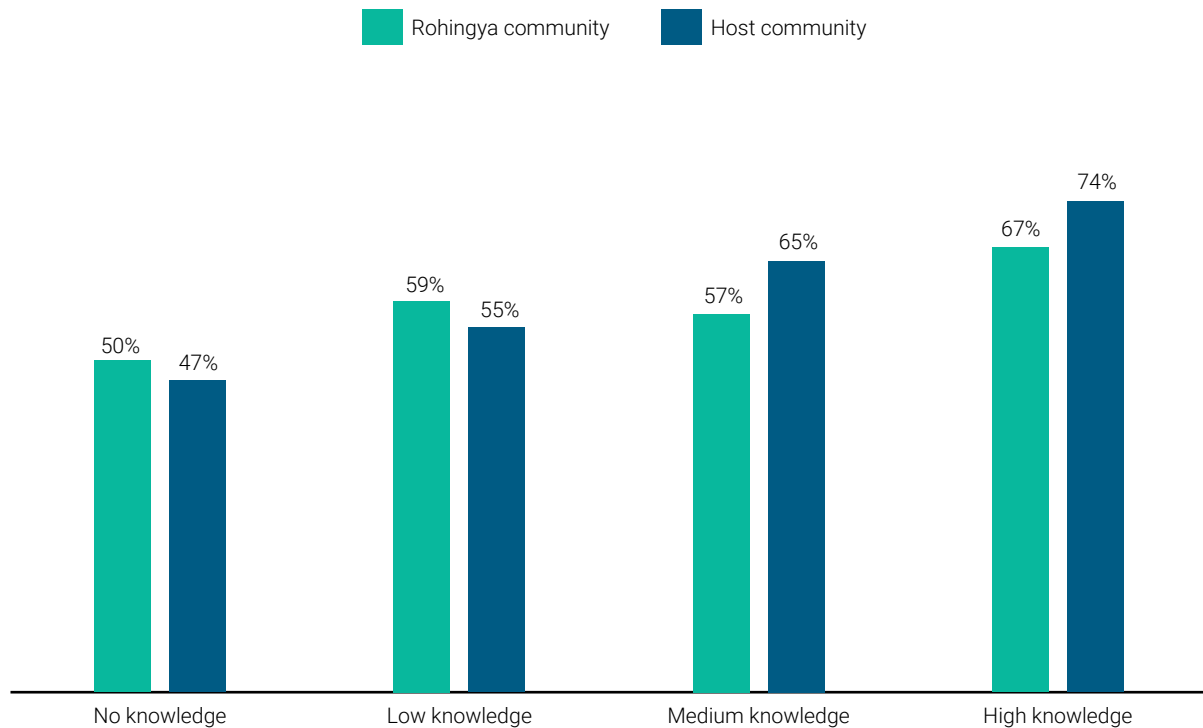The data indicates that knowledge is linked to an intention to act. Figure 26 shows that in both communities, a higher proportion of people with high levels of knowledge feel mask wearing is very important. A higher proportion of people with no or little knowledge either think mask wearing is not important or say they don't know.

Figure 26: Proportion of people who feel mask wearing is important, by their knowledge level

Legend: Rohingya community / Host community

	No knowledge	Low knowledge	Medium knowledge	High knowledge
Rohingya community	50%	59%	57%	67%
Host community	47%	55%	65%	74%

Q: How important do you feel it is to wear a face mask to help prevent the spread of Coronavirus/ COVID19?

Enumerators carrying out this survey were asked to note down whether participants were a) already wearing a mask when they approached; b) put on a mask when they approached; or c) did not wear a mask at all for the interview. This was to give an indication of what people do in practice.

The data suggests that knowledge about Covid-19, and attitude towards mask wearing, is linked to whether people decide to wear a mask or not.

As figure 27 shows, 89% of Rohingya people with high knowledge about Covid-19 were wearing a mask in the interview, compared with 48% of people with no knowledge. The difference is less marked for the host community, where 89% with high knowledge wore a mask, compared with 75% of people with no knowledge.

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Figure 27: Proportion of participants with different level of knowledge about Covid-19 who wore a mask for the interview
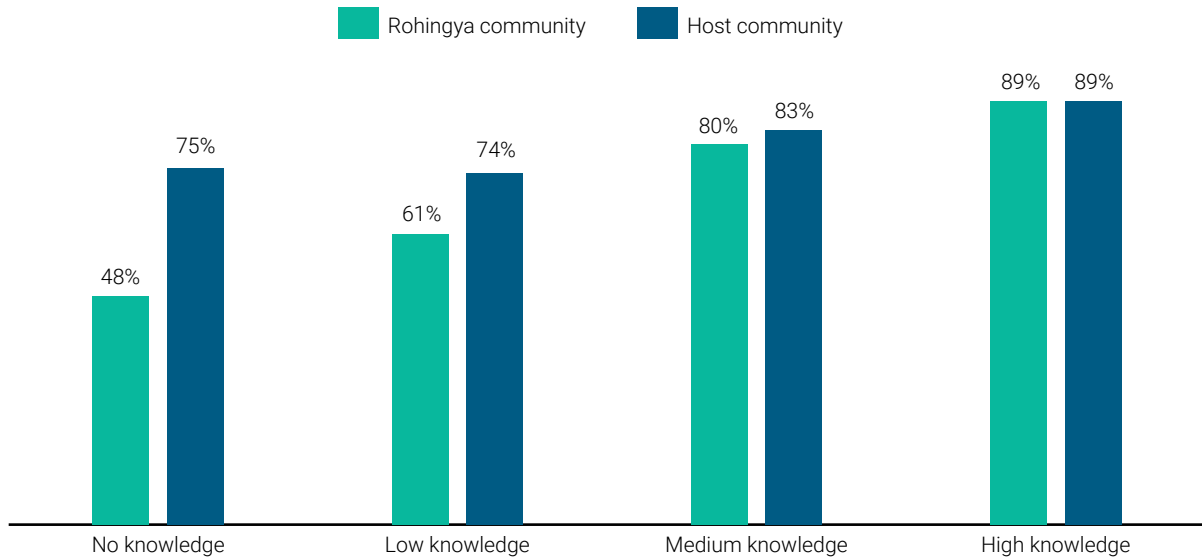
Q: Was the participant wearing any mask when we approached for the interview? Yes OR No, but put a mask on when approached.

The story is similar for attitude towards mask wearing within the Rohingya community, although not in the host community (figure 28).

Figure 28: Proportion of people with different attitudes towards mask wearing who were a mask during the interview
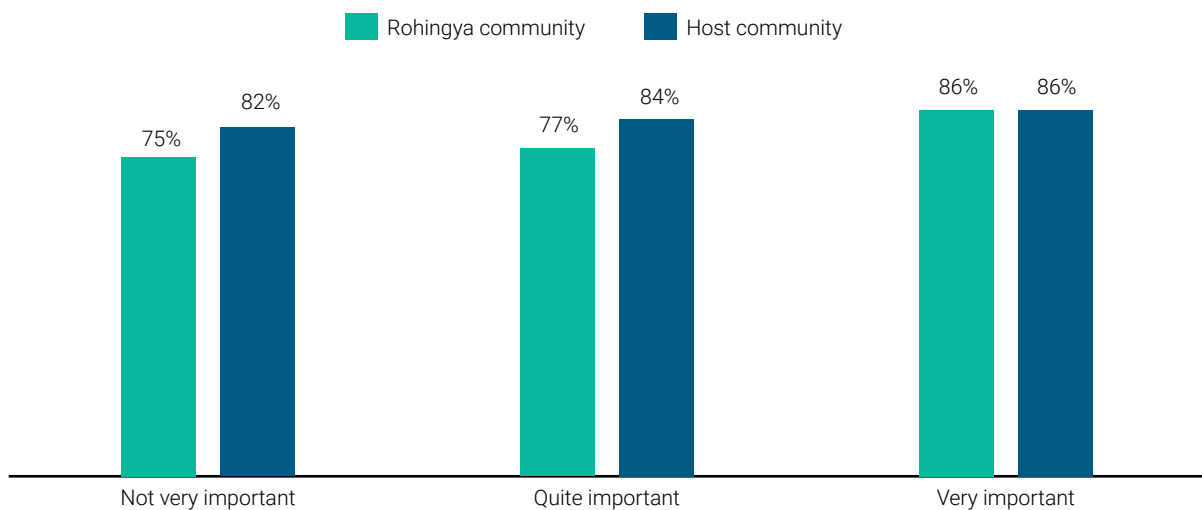
Q: Was the participant wearing any mask when we approached for the interview? Yes OR No, but put a mask on when approached.

Interestingly, although Rohingya women had higher knowledge about coronavirus, a higher proportion of Rohingya men thought mask wearing was very important (77% compared with 46% of women) and were wearing a mask during the interview (85% of men compared with 80% of women). This could be because women leave the house less often, and therefore do not need to wear a mask as frequently as men. Also when Rohingya women leave their block, they are usually wearing a niqab which covers their face, so they may also perceive it is not necessary to wear a mask, despite advice from WHO saying it is still necessary.

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# How is Covid-19 information reaching communities and leading to action?

Findings from this study point to different hypotheses about how information leads to action in each community, which are laid out in the diagrams below. Rohingya people receive information in Rohingya language through loudspeaker announcements from mosques, by attending listening groups and visiting services in the camps, or through door-to-door communication where they interact with NGO workers and volunteers. The evidence suggests that common service content/ communication materials play an important role. Information they receive through these interactions / at these facilities, leads to higher knowledge about Covid-19. This leads to feeling that taking preventative measures, such as mask wearing, is important. And this leads to wearing a mask when near other people.
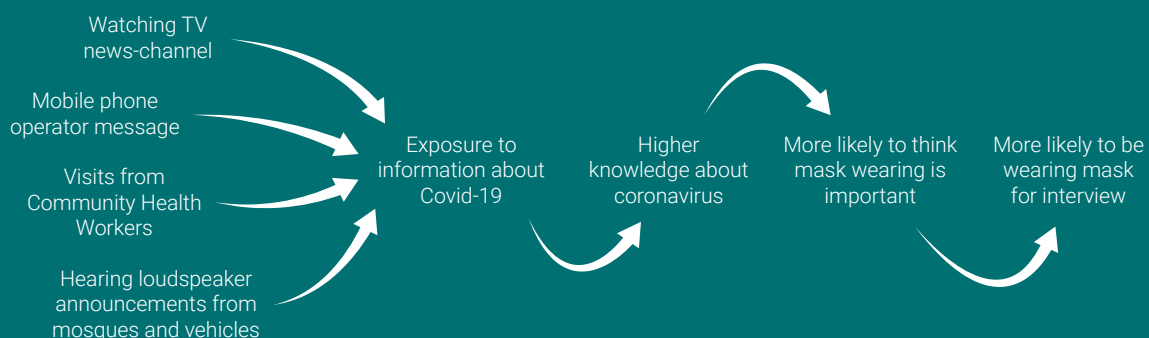
How is Covid-19 information reaching the Rohingya community and leading to action?

Attending listening groups /
food distribution points /
info hubs / health services

Receiving door to door
visits from volunteers

Hearing loudspeaker
announcements
from mosques

Exposure to
Rohingya language
communication
materials on
Covid-19

Higher
knowledge about
coronavirus

More likely to think
mask wearing is
important

More likely to be
wearing mask
for interview
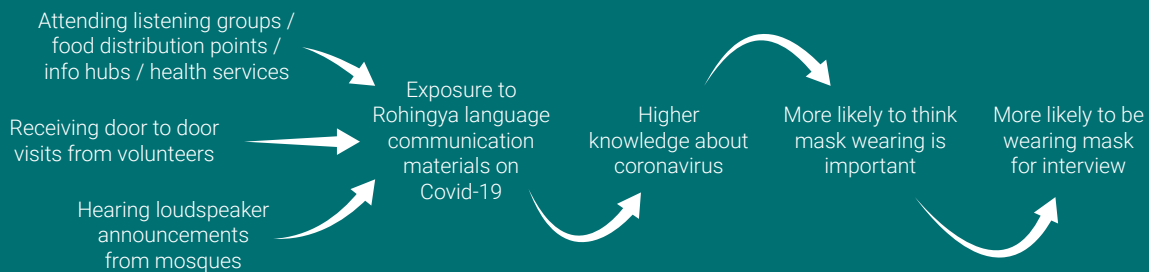
The host community diagramme is slightly different, as the host community receives information about Covid-19 from a wider range of sources than the Rohingya community, many which are national level, such as television news channels, and messages from mobile phone operators. Some sources are similar, such as loudspeaker announcements from mosques, and visits from Community Health Workers. There is little evidence that common service content plays a role here, as most of it was not targeted towards the host community, and there are fewer channels through which this content would be disseminated within the host community (i.e. no listening groups, food distribution points, info hubs).

How is Covid-19 information reaching the host community and leading to action?

Watching TV
news-channel

Mobile phone
operator message

Visits from
Community Health
Workers

Hearing loudspeaker
announcements from
mosques and vehicles

Exposure to
information about
Covid-19

Higher
knowledge about
coronavirus

More likely to think
mask wearing is
important

More likely to be
wearing mask
for interview

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What role do practitioners feel the common service played in helping agencies communicate effectively with communities during the Covid-19 pandemic?

Evidence from the qualitative research with humanitarian practitioners suggests the common service has played a critical role in supporting communication between agencies and communities during the pandemic in three main ways:

a. Through helping practitioners **understand community perceptions and priorities, and enabling them to advocate for change** to their programmes and communication when required

b. Through **knowing how to communicate effectively** with the communities, and sharing this knowledge with agencies through advice, training, language tools, and effective communication materials

c. Through **working in partnership** with agencies to develop effective communication materials, and ensure they reach the community

A) Understanding community perceptions and priorities helped agencies advocate for change

Practitioners valued the fact that the common service helped agencies **understand communities' perceptions, preferences, priorities** and what **rumours** were spreading as the pandemic evolved.

This was predominantly through *What Matters?* humanitarian bulletin which was considered a trusted source of information, relevant to that point in time.

The fact that the methodology and data sources were clearly indicated in the publication, helped practitioners trust the information was an objective summary of issues being raised by communities.

> "What Matters has been really helpful for us to reference and advocate regarding community perceptions on issues and how they evolved as the pandemic went on. From 'what is Covid-19' at the beginning, to later how people feel about public health measures, to seeing if people are sticking to them, and then people's preferences around vaccination and distancing measures. That has been really invaluable support that has been provided."
>
> — *Management level practitioner*

> "I trusted 'What Matters' partly because of relationship we had, partly based on discussions we had: I really felt I understood the methodology. Also the way it is presented: for me it needs to be an overall view for me to trust the information, it needs to provide a balanced picture: highlights what works and what doesn't work. That was well done in What Matters. It was an objective view, rooted in what the community was saying, which helped me to put myself in the shoes of the community."
>
> — *Management level practitioner*

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As found in previous evaluations of the project, practitioners used *What Matters?* as a key source of information about community needs, which they triangulated with other sources.

> " We know from recent What Matters? that communities are open to vaccination but still have concerns about the vaccination being unsafe. This also came from other sources, so we have been able to triangulate. It's important knowledge…we don't have to start at the beginning to convince people that the vaccine is a good thing, because we know they are already open to it. But we do need to answer their questions about safety."
>
> — Management level practitioner

Practitioners also gave **examples of changes** they had made or advocated for, based on information in *What Matters?*

> " Feedback coming through What Matters? was that there was a lot of fear and suspicion around this linked to the mandatory nature of the quarantine. That information really helped us advocate with the government to change the policy, so people could await their test results at home rather than in an isolation centre."
>
> — Management level practitioner

B) Knowing how to communicate effectively and helping others to do so

Practitioners felt the common service helped agencies communicate effectively with communities during the pandemic through three different initiatives:

1) By developing **high quality and effective communication materials** and sharing these on the Shongjog web platform for all to use

> " When it comes to developing products, we received a tremendous amount of support from the common service to create communication on contact tracing, quarantine, isolation, immunisation, infection prevention and control. They really helped us develop different content for different channels."
>
> — Management level practitioner

2) By providing **valuable expertise** on how to communicate with Rohingya communities on different issues, based on a **deep cultural understanding** which has been built up over time.

> " The common service was held in extremely high regard – they were consulted on all aspects of communication around Covid 19. They were relied on as a sounding board, as well as for implementation of communication. We relied on the deep cultural understanding they had gained over time working on these issues. They were always ready to give advice based on their knowledge of what they knew about the community."
>
> — Management level practitioner

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3) Through **providing training**, which was highlighted by practitioners as a critical element of helping their staff to communicate effectively. Three different aspects of training were mentioned:

a) As in previous evaluations of this project, management and field level practitioners highlighted **Rohingya language training and tools** as especially useful in highlighting differences between Rohingya language and the local dialect, which led to improved communication with the community.

> " Health worker supervisors got the training and I think the glossary was the most helpful thing. Previously they used the local Cox's Bazar language, but the Rohingya language is different. After receiving the training on language and seeing the exact words in the glossary I think all the participants are more conscious to use the proper Rohingya language. This training knocked them actually."
>
> — Field level practitioner

b) Practitioners talked about the value of common service training on how to develop visual communication (signs, posters), in helping them communicate with a largely illiterate population.

> " We found the visual communication training useful for changing the mindset in how we design posters to explain things when people can't read. We used it in developing posters."
>
> — Management level practitioner

c) Practitioners also credited training and bespoke support on accountability in helping their organisations set up and maintain effective complaints and feedback mechanisms.

> " Previously we did not have any help desk center or info hub. After we started working with [common service] we were able to establish a help desk center in our organization. We visited [another partner agency] to get an idea how we can improve our feedback mechanism. And after establishing this help desk center I must say there is a huge change in identifying the service gaps. I would say now people know very well that where they will go to complain, they know where they will get the support if they need anything."
>
> — Field level practitioner

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Case Study: the flipchart
a simple but effective communication material

All practitioners mentioned the success of the 'flipchart', developed by the common service to help community health workers and volunteers to communicate with Rohingya communities about a seroprevalence survey being carried out in the camps. The seroprevalence survey, which involved taking blood from one member of randomly selected households, was carried out in December 2020, to determine how many people had been exposed to Covid-19 in the camps. Practitioners explained it was extremely challenging to convince people to give blood when they saw no immediate or obvious benefit for them, in a culture not used to giving blood. The flipchart used images (diagrammes and photos) to visually show people what they could expect from the survey, the isolation centre, as well as information about general Covid-19 prevention measures. Practitioners credited the flipchart with increasing testing rates and being instrumental in community acceptance and participation of the seroprevalence survey.

The flipchart was completely vital to the success of the seroprevalence survey. It made people feel incredibly secure that they were going in to speak to people well-armed, with good accurate material, pitched to people who didn't read. It was so great as it wasn't whizzy and complicated – they [the common service] kept it really simple because they knew what was needed. Rohingya communities have consistently said they prefer face to face communication, and the flip chart provided a tool to support face to face communication on a very complex issue."

— Management level practitioner

Everyone we talked to was convinced that this [the flipchart] is what worked to raise testing rates. We trained 1400 community health workers (CHWs), trickle down training. 130 supervisors, they trained their CHWs, across all the camps. I believe we got 100% coverage on this training."

— Management level practitioner

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Field level practitioners felt the flipchart was useful as it meant all the information was in one place and enabled them to answer questions easily. They believe it resulted in more Rohingya people getting tested, as they were able to see the images, and understand they would not be harmed. As they all used the same flipchart, information provision was consistent across the camps, reducing the risk of misinformation. The flipchart was also able to be used while people were social distancing, as they could see the images from far away.

> In the flipchart it is clearly described how the isolation centre is, how to sneeze and cough, how to wash hands. I think after watching the flipchart their knowledge of Covid has been increased, because they can understand how someone could be affected by Covid. And we are showing them practically, that's why they understand clearly."
>
> — Community health worker

> During the Covid time we had some restrictions that we could not have any gatherings because of the possible crowd of Rohingya people. For maintaining distance, we could not use audio or video, we used flipchart only. We all used the same flipchart, that's why rumour didn't spread."
>
> — Field level practitioner, CHW supervisor

The quantitative data suggests that face to face communication was instrumental in raising knowledge about Covid-19, particularly amongst women. Given the high coverage achieved in training community health workers and volunteers to use the flipchart, it seems plausible that it played an important role in informing people about how to keep themselves safe during the pandemic.

C) Working in partnership to get the right information to where it needs to be

Management level practitioners talked about the value of having a partner who really understands the community perspective in developing effective communication materials.

> If there was no common service, the messages wouldn't have been so good. We learnt that you need a combination of people – those who have the health expertise, and those understand the community perspective, and how to communicate effectively with the community."
>
> — Management level practitioner

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> " If there was no common service, we would have ended up with very few products, would have come up with leaflets, maybe a few radio spots if we were feeling really ambitious. It wouldn't have gone so well, and we would have felt more strongly the impact that people didn't trust health services. It would have taken us much longer to understand the rumours, and why people were not seeking healthcare. Having a partner that understands the community perspective is really important."
>
> — Management level practitioner

As mentioned above, the quantitative findings highlight the importance of communication materials being shared in the right places, so they reach the community. The data showed that a higher proportion of people who live close to certain services, or attend listening groups or food distribution points, were exposed to content about Covid-19, felt better informed, and were more knowledgeable about how to keep themselves safe. For the common service, getting content shared in these places would not have been possible without developing partnerships with agencies who run these services across the camps. Examples of how these partnerships were effective in practice are provided in the boxes below.

Case Study: partnering to inform people at food distribution points

The common service partnered with the World Food Programme (WFP) to share audio content at food distribution sites, where someone from every Rohingya household still needed to visit to collect food.

> " We worked with the common service to develop two radio programmes about changes to how people should collect their food, and we played these at the sites. We also played other audio programmes the common service had produced. People like having something to listen to while they wait. We kept the programmes short in case people weren't waiting very long, so they got the information they needed."
>
> — Management level practitioner

Data from the quantitative survey shows that this approach was effective: 84% of those who attended food distribution points had been exposed to at least five items of common service content, compared with 56% who hadn't. And food collectors felt better informed about services available to them: 65% felt well informed compared to 52% who didn't.

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The survey also tested people's knowledge about changes to food distribution, which was covered in the audio programmes played at food distribution points. Data showed that 46% of people who said they had heard the common service audio programme or PSA about food distribution demonstrated high knowledge, compared with 19% of people who hadn't heard either.

Case Study: partnering with trusted religious leaders to engage communities

Previous research conducted by the common service found that within the Rohingya community, religious leaders are trusted as a reliable and important source of information. The common service partnered with UNHCR on a project to train imams to communicate effectively with their communities. During the pandemic, common service content was shared with imams to play to community members.

> [Common service training] was very eye opening for them, because they can talk with people but how to communicate with their community for disseminating any messages, they get to know this sense from the training, how they can communicate effectively."
>
> — Field level practitioner

> From the training I got to know about cyclone, child marriage and Covid. About Covid I know we should wear mask, and this mask need to be 3 layers. People need to talk with maintaining distance. And when I talk about this with the community, I need to be soft spoken. I have to ask them if they are understanding or not, if not then I need to make them understand again. I disseminate this information after every prayer in the mosque. Also I announce these with the mike (loudspeaker) of the mosque. "
>
> — Imam (community religious leader)

The quantitative survey found that people who live near a mosque were 3.2 times more likely to have high knowledge about Covid-19, indicating that mosques have been a key source of information throughout the pandemic, and confirming that the approach of supporting religious leaders to communicate effectively with communities is appropriate.

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As mentioned earlier, the common service also included religious leaders in their visual and audio communication materials, which resonated with community members and created trust.

Case Study: collaborating over training videos for health workers

One practitioner mentioned the value of the collaboration between the common service and the World Health Organisation to develop training videos about infection prevention and control, targeted at health workers. The videos are available online and are frequently accessed. They have been used to train 3000 health workers working with Rohingya and host communities in Cox's Bazar, and will also be used in training health workers at national level.

" These videos have been incredibly useful. If these measures are not explained clearly, then equipment is used wrong, so they have been super useful to protect health workers and patients."

— Management level practitioner

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Conclusion and recommendations

This evaluation has found that the common service has played an important role in supporting the Rohingya community during the Covid-19 pandemic, in the following ways:

- Through **creating and disseminating audio and visual content** which is easy for Rohingya people to understand, and the data suggests has contributed to improving their knowledge about Covid-19.

- Through **working in partnership** with humanitarian agencies to **adapt communication strategies** and make sure information is reaching people in spite of Covid-19 restrictions being in place, particularly supporting face to face initiatives like the flipchart for community health workers, and adapting audio programmes to be played through loudspeakers.

- Through **helping organisations understand how to communicate** effectively with communities through language training, sharing research in *What Matters?* and providing advice to practitioners, based on deep cultural understanding and solid understanding of communities' current perspectives and priorities.

What makes the common service effective according to practitioners?

" It has the resources and ability to turn things around quickly compared to any agency on the ground.

" It is a reactive service, set up to support agencies with any communication need.

" It was able to side-step bureaucracy (which is a challenge within big agencies) and get communication out.

" They have a sense of urgency – they always see whatever you are trying to communicate as a priority.

" The team was very stable, had long standing experience, and really knew what they were doing.

" The team has a deep understanding of the Rohingya community and how to communicate with them which has developed over time.

" They know how to make quality communication materials which people understand.

" Their agility comes from being well-staffed, and the people working for them are really good at what they do. They are always available to do things, and they produce things quickly. Also they ask you the right questions: what you want, who you want to reach, who is it for?"

— Management level practitioner

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However, there are important gaps to address going forward. The ability for both Rohingya and host communities to provide feedback has fallen during the pandemic, and along with it, people's perception that aid providers are listening to their needs. Barriers to providing feedback are particularly high for women and people with disabilities. The pandemic has also meant that initiatives which were due to be carried out in host communities have not taken place, and host community members do not feel they have access to information they need, particularly about services available to them. Rohingya men also feel less informed than they previously did, as restrictions on public gathering have impacted on their usual communication channels. And older people in both Rohingya and host communities seem to struggle to access information more than younger community members, despite outreach efforts through volunteers and listening groups. People in both communities identified important information needs, beyond Covid-19, which should not be overlooked.

Recommendations

- **Focus on the host community:** The data shows the host community do not feel they have access to information they need, suggesting they are still underserved by communication initiatives, which has been compounded by the Covid-19 pandemic. The common service should consider what is the best way to serve the host community, based on an understanding of their communication needs and preferences, tapping into their existing information infrastructure.

- **Continue to support face to face communication, paying particular attention to targeting older people:** The common service should continue to advocate for, support and equip humanitarian agencies to do face to face communication in the Rohingya community, as this has been especially effective at reaching women. Face-to-face interventions targeting older people, understanding more about their particular needs and taking these into consideration, could help that group feel as informed as younger age groups.

- **Make sure men aren't missing out:** A focus on communicating with women in the response has paid off, with Rohingya women feeling particularly well informed. The common service should work with partners to ensure men are also engaged in communication initiatives.

- **Ensure information needs outside of Covid-19 are being met:** Although people in the Rohingya and host community feel well informed about Covid-19, they have other information needs which it is important not to overlook. The security situation in and around the camps is an important one for all groups. For Rohingya and host community women their information needs include keeping children safe from common diseases like diarrhoea, and how to access water. For Rohingya and host community men, these tend to be more focused on how to survive economically, and the security situation back in Myanmar.

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- **Make feedback mechanisms more accessible for women and people with disabilities:** The ability to provide feedback has decreased since the beginning of the pandemic, with highest barriers for women and people with disabilities. Equipping door to door volunteers with the knowledge and systems of how to collect feedback and refer people to appropriate services could help redress this balance. This should include efforts to overcome existing cultural, contextual or other barriers which prevent certain groups, particularly women, from providing feedback or making complaints. The common service can play a role in helping agencies to do this.

- **Support partners to continue collecting and sharing feedback with the collective feedback mechanism:** This study found that *What Matters?* is valued in the response for providing an objective view of communities priorities and perspectives. The collective feedback service is only effective if partners continue to share data with the common service. The common service should continue to support partners in setting up and maintaining feedback mechanisms, and ensuring communities can continue to provide feedback during periods of restricted movement.

- **Continue to work with partners to adapt communication approaches based on the changing situation:** This study found adaptability is key: the common service should continue to assess the best way to reach Rohingya and host communities with information as the situation develops, and continue to adapt its approach and its communication materials, partnering and working closely with humanitarian agencies and sectors, to ensure they are reaching as many people as possible.

Recommendations about communication materials:

- **Drama stands out for Rohingya communities:** In the qualitative research, Aa'rar Kissa radio drama was frequently mentioned by community members, particularly women, as audio content they remembered because they liked the characters and the storylines, even though it does not focus on Covid-19. The drama focused on GBV, and men and women said it had changed their opinion on child marriage. In a crowded communication landscape, the common service should consider using drama more often, perhaps building up Aa'rar Kissa to cover more topics, as it is already familiar and liked by community members.

- **Make sure characters look like Rohingya people:** Field level practitioners felt that when using visual images, including video and pictorial content, the characters should be relatable and look like Rohingya people, in the same dress, and in line with cultural and religious norms.

- **Continue to include religious references in content:** Field level practitioners felt that including religious leaders and references meant content resonated more with Rohingya community members.

- Field practitioners suggest that **video content** is best at engaging people, as they find it easier to watch something than just listen. This was not mentioned by community members however.

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Annexes

Annex 1: Logistic regression

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	selected respondent gender	1.102	0.090	149.014	1	0.000	3.010	2.522	3.593
	Watched 4 & less OR 5 & more contents	0.146	0.083	3.100	1	0.078	1.157	0.984	1.360
	respondents attended any listening group discussion	0.478	0.102	22.117	1	0.000	1.613	1.321	1.968
	respondents visited the food distrubution point (FDP)	0.527	0.100	27.904	1	0.000	1.694	1.393	2.059
	health facilities close to the living space	0.135	0.087	2.417	1	0.120	1.144	0.966	1.356
	People interact with NGO worker on a weekly basis	0.291	0.084	12.053	1	0.001	1.338	1.135	1.577
	Loudspeakers or megaphone announcements	-0.211	0.086	5.992	1	0.014	0.810	0.684	0.959
	Volunteers	0.439	0.090	23.663	1	0.000	1.552	1.300	1.852
	Mahji	-0.458	0.087	27.520	1	0.000	0.633	0.533	0.751
	Constant	-2.165	0.225	92.380	1	0.000	0.115		

a Variable(s) entered on step 1: selected respondent gender, Watched 4 & less OR 5 & more contents, respondents attended any listening group discussion, respondents visited the food distrubution point (FDP), health facilities close to the living space, People interact with NGO worker on a weekly basis , in2_16. Since this pandemic (Corona virus or COVID-19) started, what are your main ways of finding/sources of information? Loudspeakers or megaphone announcements, in2_21. Since this pandemic (Corona virus or COVID-19) started, what are your main ways of finding/sources of information? Volunteers, in2_1. Since this pandemic (Corona virus or COVID-19) started, what are your main ways of finding/sources of information? Mahji.

Annex 2: Chi-square test

Pearson Chi-Square Tests

		respondents attended any listening group discussion	respondents visited the food distrubution point (FDP)	Info hub close to the living space	health facilities close to the living space	service centre close to the living space	mosque close to the living space
Watched 4 & less OR 5 & more contents	Chi-square	313.558	250.899	52.966	141.883	52.966	2.675
	df	2	2	2	2	2	2
	Sig.	.000*,b	.000*,b	.000*,b	.000*,b	.000*,b	.263b

Results are based on nonempty rows and columns in each innermost subtable.

* The Chi-square statistic is significant at the .05 level.

b Some cell counts in this subtable are not integers. They were rounded to the nearest integer before the computation of Chi-square test.

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Annex 3: Chi-square test

Pearson Chi-Square Tests

		respondents attended any listening group discussion	respondents visited the food distrubution point (FDP)	Info hub close to the living space	health facilities close to the living space	service centre close to the living space	mosque close to the living space
Watched 4 & less OR 5 & more contents	Chi-square			6.527	8.783	6.527	9.024
	df			2	2	2	2
	Sig.			.038*	.012*	.038*	.011*

Results are based on nonempty rows and columns in each innermost subtable.

* The Chi-square statistic is significant at the .05 level.

Annex 4: Chi-square test

Pearson Chi-Square Tests

		respondents attended any listening group discussion	respondents visited the food distrubution point (FDP)	Info hub close to the living space	health facilities close to the living space	service centre close to the living space	mosque close to the living space
Knowledge about Covid	Chi-square	68.734	37.065	116.430	65.571	116.430	58.109
	df	3	3	3	3	3	3
	Sig.	.000*,b	.000*,b	.000*,b	.000*,b	.000*,b	.000*,b

Results are based on nonempty rows and columns in each innermost subtable.

* The Chi-square statistic is significant at the .05 level.

b Some cell counts in this subtable are not integers. They were rounded to the nearest integer before the computation of Chi-square test.

Annex 5: Chi-square test

Pearson Chi-Square Tests

		respondents attended any listening group discussion	respondents visited the food distrubution point (FDP)	Info hub close to the living space	health facilities close to the living space	service centre close to the living space	mosque close to the living space
Knowledge about Covid	Chi-square			2.755	0.984	2.755	15.210
	df			3	3	3	3
	Sig.			.431a	0.805	.431a	.002*

Results are based on nonempty rows and columns in each innermost subtable.

* The Chi-square statistic is significant at the .05 level.

a More than 20% of cells in this subtable have expected cell counts less than 5. Chi-square results may be invalid.

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Annex 6: Logistic regression

Variables in the Equation

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	selected respondent gender	0.800	0.090	78.651	1	0.000	2.225	1.864	2.655
	Exposed to the contents of COVID-19	0.454	0.158	8.268	1	0.004	1.574	1.155	2.145
	respondents attended any listening group discussion	0.278	0.106	6.920	1	0.009	1.320	1.073	1.623
	respondents visited the food distrubution point (FDP)	0.230	0.101	5.237	1	0.022	1.259	1.034	1.534
	Info hub close to the living space	0.914	0.100	83.018	1	0.000	2.494	2.049	3.036
	mosque close to the living space	1.166	0.156	56.019	1	0.000	3.211	2.366	4.358
	health facilities close to the living space	0.432	0.089	23.590	1	0.000	1.541	1.294	1.835
	Loudspeakers or megaphone announcements	0.172	0.085	4.037	1	0.045	1.187	1.004	1.403
	Volunteers	0.528	0.087	36.516	1	0.000	1.696	1.429	2.012
	Constant	-4.242	0.290	213.864	1	0.000	0.014		

a   Variable(s) entered on step 1: selected respondent gender, Exposed to the contents of COVID-19, respondents attended any listening group discussion, respondents visited the food distrubution point (FDP), Info hub close to the living space, mosque close to the living space, health facilities close to the living space, in2_16. Since this pandemic (Corona virus or COVID-19) started, what are your main ways of finding/sources of information? Loudspeakers or megaphone announcements, in2_21. Since this pandemic (Corona virus or COVID-19) started, what are your main ways of finding/sources of information? Volunteers

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