Case Study: **Bangladesh**

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COMMUNITY PERCEPTION TRACKER IN COX'S BAZAAR DISTRICT: AN INTERACTIVE WAY OF LISTENING TO COMMUNITIES DURING THE COVID-19 PANDEMIC

Background

In partnership with UNICEF, OXFAM implemented a WASH project in Unchiprang Camp 22 in Teknaf, Cox's Bazaar District, aimed at providing life-saving WASH services to 22,503[1] Rohingya Forcibly Displaced Myanmar Nationals (5,045 men, 5,689 women and 11,769 children).Through this partnership, between August 2017 and March 2022, Oxfam supported the regular operation

[1] Joint Government of Bangladesh and UNHCR Population Fact Sheet as of 28 February 2022.

and maintenance of water and sanitation facilities, ensuring access to safe drinking-water and improved sanitation and hygiene services to help the community to mitigate public health risks.

Bangladesh reported its first three confirmed cases of coronavirus disease 2019 (COVID-19) on 8 March 2020 but it wasn't until 24 March 2020 and 14 May 2020 that the first case was reported in the host community in the Cox's Bazaar District and Rohingya camps respectively. In the months before COVID-19 hit the camps, Oxfam and UNICEF WASH staff actively engaged the community in preparation for a disease outbreak. One of the key lessons that Oxfam had learned from the Ebola response in West Africa was that the community's contribution to successfully mitigating any disease outbreak is invaluable.

Oxfam had piloted a Community Perception Tracker (CPT) during the 2018 Cholera outbreak in Haiti and adapted it for the 2018 Ebola response in the Democratic Republic of the Congo. The mobile tool facilitated a systematic collection of accurate data faster than other techniques, transforming anecdotal information shared verbally by the communities into more purposeful evidence that was documented and used to inform response activities. After deliberations, the Oxfam global humanitarian team and those in Cox's Bazaar District in Bangladesh agreed to use the CPT (which had already been adapted for COVID-19) to engage Rohingya communities in the COVID-19 response in the camp. This case study outlines the outcome of the CPT approach in Teknaf between June 2020 and December 2021.

Strategy and implementation

The CPT approach uses a mobile tool to enable staff to capture, analyze and understand the perceptions of communities during disease outbreaks. It is not a stand-alone tool; for it to work effectively, it should supplement an emergency response programme. It is currently exclusively used during epidemics but in time could be adapted to suit other types of response. Community perceptions refer to questions, beliefs, concerns and feedback, in relation to views and perspectives that arise in line with the spread of a disease.

How was the CPT implemented in Camp 22?

The CPT was introduced to the Oxfam team in Bangladesh through a series of three training sessions conducted in early June 2020. The Monitoring, Evaluation, Assessment and Learning (MEAL) team then installed the CPT (which runs on the SurveyCTO app) on the phones of all trained staff from three sectors – WASH, Gender and Protection. Implementation began within the month, as soon as all relevant stakeholders such as the Camp in Charge, UNICEF and the Inter-Sector Coordination Group had been informed.

1. **Collection**: On a daily basis, approximately 15 Oxfam staff in Camp 22 in Teknaf captured community perceptions as part of their regular project activities. With the tool downloaded on their mobile phones, staff could actively listen to perceptions in the field and complete the SurveyCTO form in real time. Data collection for a given week was deemed closed each Sunday at 5pm for analysis.
2. **First analysis**: On a weekly basis, the collected perceptions were analysed by the MEAL team, who generated infographics using Power BI[2] for reference during discussions with programme staff (Public Health Promotion, Public Health Engineering, Gender and Protection). Thanks to the design of the tool, collected data was available to programme teams on a weekly basis, allowing them to plan upcoming activities around the CPT outcomes, such as the distribution of perceptions per gender, types of perception, thematic topics, etc.
3. **Regular meetings/discussions:** Every Tuesday morning, the field programme staff in Teknaf would discuss the CPT and epidemiological data[3] in Camp 22, referring to the infographics generated by the MEAL team. The team agreed upon and documented key priority actions for the following week. During the Rohingya response, Oxfam led a COVID-19 task force which met frequently at the start of the pandemic, then later transitioned to bi-weekly meetings. This task force comprised of representatives from the programme team, management team, and support team across the two field locations, Teknaf and Ukhiya, and the coordination office in Cox's Bazaar District. The task force discussions every Tuesday focused on the trends emerging from the CPT, and the reports from field locations, to validate the priority actions agreed and identify what further support was needed from the technical sector coordinators (Public Health Promotion, Gender, Protection and Advocacy) to achieve the priority actions.
4. **Triangulation with other actors**: The technical coordinators shared the findings of the CPT within their respective coordination networks, such as the Risk Communication and Community Engagement platform (which incorporated Communication with Communities and the Health Procurement Technical Working Group), the Gender hub and the Protection cluster. They would triangulate the community perceptions received by Oxfam teams with those gathered by other organisations in other camps. For the duration of the CPT, Oxfam also shared all raw data collected with BBC Media Action, who used it alongside data from organisations working with communities in other camps to develop the What Matters? Humanitarian Feedback Bulletin on the Rohingya Response. This monthly bulletin had a far wider reach than the Oxfam CPT bulletin (see Follow-up activities, below), which staff produced for three months in late-2020.

[2] Power BI is a relatively affordable interactive data visualization software tool developed by Microsoft with a primary focus on business intelligence.

[3] COVID-19 data circulated by the Health Sector in Cox's Bazar District.

5. Adapting activities and influencing: Regular analysis of the collected data made it possible for the field teams to swiftly address simple issues emerging from the CPT, as well as improve integration within the programme team. For example, in a week where questions and concerns increased in number, the team would strategize on how to answer and respond to as many of them as possible in the subsequent week, often tailoring the information to be shared with the community in response to their perceptions. At the start of the response, most of the communities were concerned about access to masks, since the number shared by the sector was insufficient. The Oxfam WASH, Gender and Livelihoods sectors teamed up to help groups of women in the camp and the among the host community to produce cloth masks and reusable sanitary pads.

> "The medical service is not good as before COVID-19.
> – a male respondent

For more complex issues that exceeded the scope of Oxfam, the advocacy team and Public Health Promotion coordinator would liaise on how best to refer the issue to the right sector or organisation. For instance, when COVID-19 first reached the camps, communities reported a variety of potentially harmful concerns. The fear of contracting the virus was keeping people away from hospitals; even when they were at risk of dying from COVID-19, people were avoiding hospitals because of the perception that the health-care facilities in the camps had relatively poor essential services and lacked proper equipment, especially oxygen tanks (and referrals were not quick enough). Oxfam shared this feedback with the health service providers in Camp 22 and discussed ways to strengthen community engagement for increased trust in the health sector.

> "COVID-19 comes from the hospitals, so it's not safe to visit hospitals.
> – a female respondent

6. Follow-up activities: Monitoring was conducted regularly, with the COVID-19 task force reviewing the CPT progress of priority actions agreed by the teams in areas that needed improvement. In September, October and November 2020, Oxfam technical coordinators produced monthly bulletins to document the findings of the CPT, which they shared across various coordination forums. Unfortunately, staff turnover and other programmatic challenges made it difficult for the team to keep producing the bulletins.

Progress and results

Addressing misconceptions about COVID-19 at the start of the outbreak

In July and August 2020, the community had several misconceptions about COVID-19. Two common ones, which had serious potential to hinder continued programme implementation, were as follows.

There was a strong belief that COVID-19 was not in the camps, and that NGO workers (Oxfam and others) were disseminating fake news or lies about the existence of the virus. This misconception was partly due to the low numbers of cases in the camps, resulting from limited testing.

There was a concern that NGO staff, including community-based volunteers, were responsible for spreading the corona virus in the camps (since they were often moving around the camps and host towns).

Programme teams worked alongside trusted opinion leaders such as the Mahjis and Imams to increase awareness of the importance of early testing. These efforts, coupled with increased capacity for COVID-19 testing in the camps by the health service providers, led to an increased acceptance of the disease over time.

Oxfam held dialogues with various community groups (women, men, market committees, latrine user groups, etc.) to clarify the safety and prevention measures NGO workers were following and took advantage of the camp coordination meetings to remind staff from other organisations to adhere to the safety protocols while in the camps.

> "In the camp, there is no coronavirus. NGO people are earning money by working to disseminate fake news about the existence of this virus.
>
> - an elderly female respondent

> "Coronavirus cases have been found in the parts of the block where NGO people come in and work.
>
> – an elderly male respondent

> "Community-based volunteers bring coronavirus from one area to another in the block.
>
> – a male respondent

Meaningful engagement of Rohingya women on COVID-19 mitigation strategies

Throughout 2020, religious beliefs continued to have a strong impact on community perceptions of COVID-19. Most of the Rohingya community believed that COVID-19 came from Allah but had different reasons for this. Some saw it as punishment by Allah of so-called 'bad people' or wrongdoers, while others considered it a form of justice for the Rohingyas. The latter did not believe that COVID-19 was in the camps, nor that it could affect them.

As Oxfam continued to monitor the trend on religious beliefs, it emerged that these were being conflated with the stigma associated with COVID-19 infections, especially among men. People started to believe piety was a form of protection and prevention, while being a so-called 'sinner' meant more susceptibility to COVID-19. In 2020, the first year of the pandemic, other emerging

perceptions related to gender roles and rules such as staying at home, wearing a niqab and not using family planning methods to prevent COVID-19, as well as perceptions related to class, with the belief that being poor reduced susceptibility to COVID-19 since it was a disease of the rich (hence the higher number of cases in the western world). Such trends reinforced previous findings that gender-based stigmas were most likely being reinforced by COVID-19 stigmas and vice versa.

> "If a man does not complete his prayer, he will get affected by Corona virus.
>
> – a Male respondent

> "We are pious and so we will not have this disease.
>
> – male respondent

> "We maintain religious norms and wear burqas and hijabs to go out, so we will not have COVID-19.
>
> – a female respondent

Towards end of 2020 and early 2021, the perception of Allah as a source of COVID-19 persisted. Repeatedly, people linked their susceptibility to the virus to their strength of belief in Allah and dedication to Islamic religious practices. This led to divisions between those who did and did not perform five prayers a day and women who did and did not wear a veil. This led to an increase in negative gender practices, the stigmatization of people not seen to adequately practise religious rules, and the association of COVID-19 patients with a lack of religious faith. The number of perceptions giving rise to stigmatization grew in early 2021, which required the Oxfam sectors of WASH, Gender and Protection to collaborate in order to prevent further harm to vulnerable groups. In addition, it became clear that the percentage of confirmed COVID-19 cases among females in the Rohingya community was far higher than that in the host community (note: the camp population was 26 per cent women, 22 per cent men and 52 per cent children).

Both the WASH and Gender teams organised focus group discussions with women to better understand their concerns and thoughts. During the discussions, the women reported that they had received little information on COVID-19 and that they wore niqabs instead of masks. Some of them mentioned that they rarely took care of themselves because of their caring responsibilities for other people; and a few did not seek early treatment because they were afraid of being taken to an isolation centre and separated from their family. This information was triangulated with other sources by the WASH sector and it was decided that there was a need to improve engagement with women. Based on this feedback from women, Oxfam was able to adapt some COVID-19 response activities accordingly and induced other organizations to collaborate for greater impact.

Promoting masks and clarifying misconceptions around COVID-19 exposure

Women requested more detailed information on COVID-19 through messages that were tailored to address their concerns. Oxfam reached out to the Risk Communication and Community Engagement Technical working group and collaborated with its members to develop messages on the importance of wearing masks. These messages highlighted the differences between masks and

religious face coverings such as the niqab; and clarified misconceptions such as the isolation protocols and the need for 14 days separation in case of risk of exposure to COVID-19. These messages were translated into the local language and disseminated to all agencies involved in communication with communities in the Rohingya response.
The Oxfam Gender team trained the community-based volunteers in the WASH and Protection sectors to meaningfully engage females (of various age groups) on issues relating to COVID-19. The Oxfam teams working in the camps then took the messages jointly developed with the RCCE on COVID-19 and created info-kits, which they shared with women to dispel misconceptions that were causing fear and improve their health-seeking behaviour. Oxfam also strengthened the involvement of religious leaders in the COVID-19 response. Although the mosques were disseminating relevant information on COVID-19, Oxfam staff were able to facilitate sessions between religious leaders (Imams and Sheikhs) and their congregations to demystify the intersection between faith and the COVID-19 pandemic.

Lessons learned

Mitigate problems due to language barriers when developing the tool

When the CPT was first introduced to the Oxfam team in Bangladesh, the SurveyCTO app was developed in English, yet most interactions with the community took place in either Rohingya/Chittagong (for the Forcibly Displaced Myanmar Nationals) or Bangla (for the host community). This led to poor-quality data as community perceptions would often lose their original meaning due to the multiple translations. As soon as staff raised this issue, the tool was translated into Bangla, which subsequently improved the quality of data collected. It was also agreed that, for complex words that were difficult to translate, the teams would capture them as they were, in the local dialect, to allow for further discussion during the regular meetings.

Listening is a skill that takes time to develop, so be patient – and go for quality not quantity

In the first two months of implementing the CPT, teams were really motivated to collect community perceptions. However, during their first analysis, the MEAL team quickly realized that most of the data collected was unclear and needed frequent data quality assurance or cleansing. For instance, there seemed to be some confusion regarding the types of perceptions recorded, especially questions vs. concerns, and beliefs vs. practices, as well as poorly written descriptions of the perceptions. Although data quantity was important in determining trends, it soon emerged that successful data analysis, interpretation and responsive action was heavily dependent on the quality of data collected. To improve on this, the MEAL and programme teams carried out face to face practical training sessions and refreshers for the staff. One thing in particular the team had to learn was that listening is a skill which requires time to perfect. Because the CPT is not a survey where a member of staff asks questions and fills in a form, but rather listens to the community feedback then interprets it before putting it into the mobile tool, members of staff needed to fully comprehend the feedback. Moreover, listening to and reporting the community feedback without succumbing to personal bias was, the team agree, a skill that required practice and patience.

Way forward and potential application

By June 2021, a year after the response began, superstition surrounding COVID-19 had significantly reduced, with most of the Rohingya community being informed about the disease, its means of transmission and how to prevent infection. Perceptions indicated increased knowledge of handwashing with soap, the use of masks and the need to maintain physical distancing. Practices for effectively preventing the spread of COVID-19 were on an upward trend, which confirmed that the response actions taken by the team were yielding positive outcomes. The new concern from the community related to the enduring nature of the pandemic and how it was delaying other projects.

Related links

https://www.oxfamwash.org/en/communities/community-perception-tracker

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