



# POLICY INSIGHT: Effective channels for COVID-19 communication and treatment in Cox's Bazar<sup>†</sup>

AUGUST 7<sup>TH</sup>, 2020

Photo Credit: Abdullah Al Mashrif/IOM, Maruf Hasan/The IRC

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## Abstract

The Cox's Bazar Panel Survey (CBPS) tracks representative samples of Rohingya refugees and host communities in Cox's Bazar district in southern Bangladesh. A phone-based follow-up survey from April 2020 reveals: i) gaps between COVID-19 awareness and protective behavior; and ii) the primary sources of health information and treatment that constitute promising targets for interventions. The vast majority of refugees and hosts are knowledgeable about respiratory hygiene and potential sources of virus transmission. However, many continue to leave home regularly, suggesting that mere awareness of COVID-19 risks is not enough to ensure behavioral change in accordance with public health recommendations.

These results suggest public health communication has largely succeeded in disseminating basic knowledge about the disease but faces a new challenge in affecting behavior change. New campaigns must encourage people to seek treatment and highlight the importance of protective measures via trusted sources. Religious leaders might be best positioned to encourage safe religious observance while social networks can both spread information and enforce norms. Pharmacists, as an important part of the basic health infrastructure in Cox's Bazar, are key to treatment and surveillance. But, given the significant remaining uncertainties, continued research and innovation will be required to achieve the community-level adoption of protective behavior needed to overcome the pandemic.

<sup>†</sup> We gratefully acknowledge the support and partnerships provided by the Yale MacMillan Center Program on Refugees, Forced Displacement and Humanitarian Responses (PRFDHR), the Gender and Adolescence: Global Evidence (GAGE) consortium, which is funded by UK aid from the UK government; the World Bank; the Yale Research Initiative on Innovation and Scale (Y-RISE) at the MacMillan Center; IPA's Peace and Recovery Program; and the UN High Commissioner for Refugees (UNHCR). The opinions expressed in this publication are those of the authors. This publication does not necessarily reflect the views of the donors.

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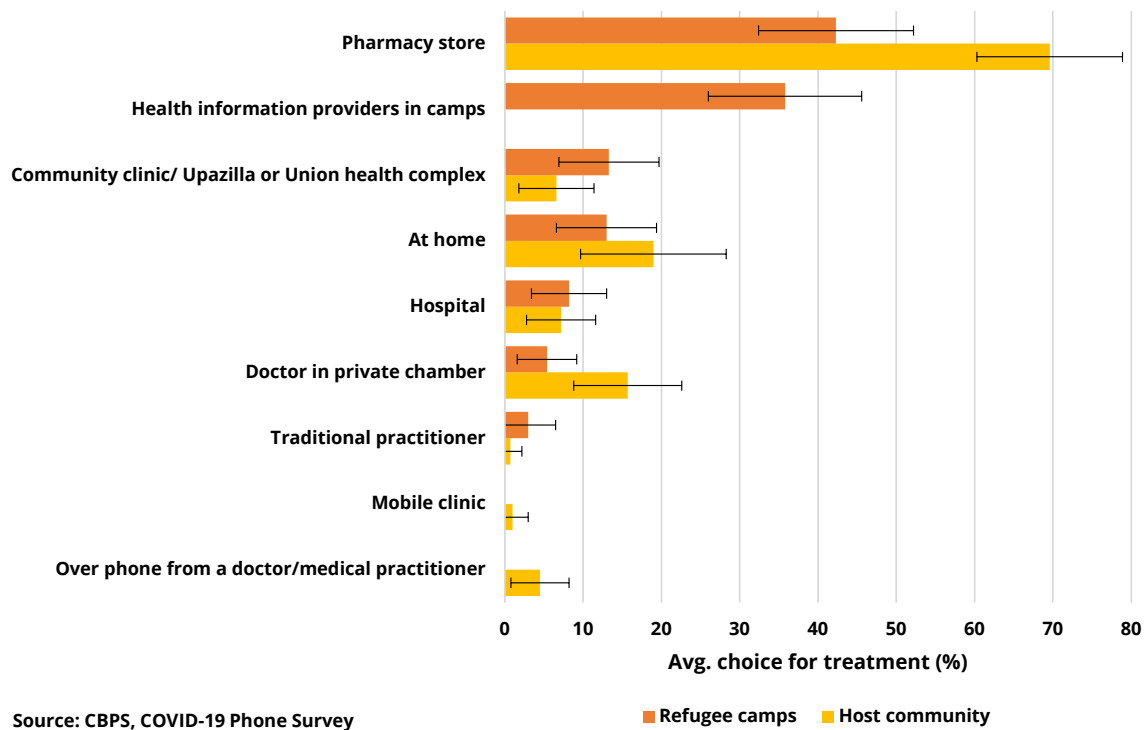
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## Main Findings of COVID-19 Phone Survey

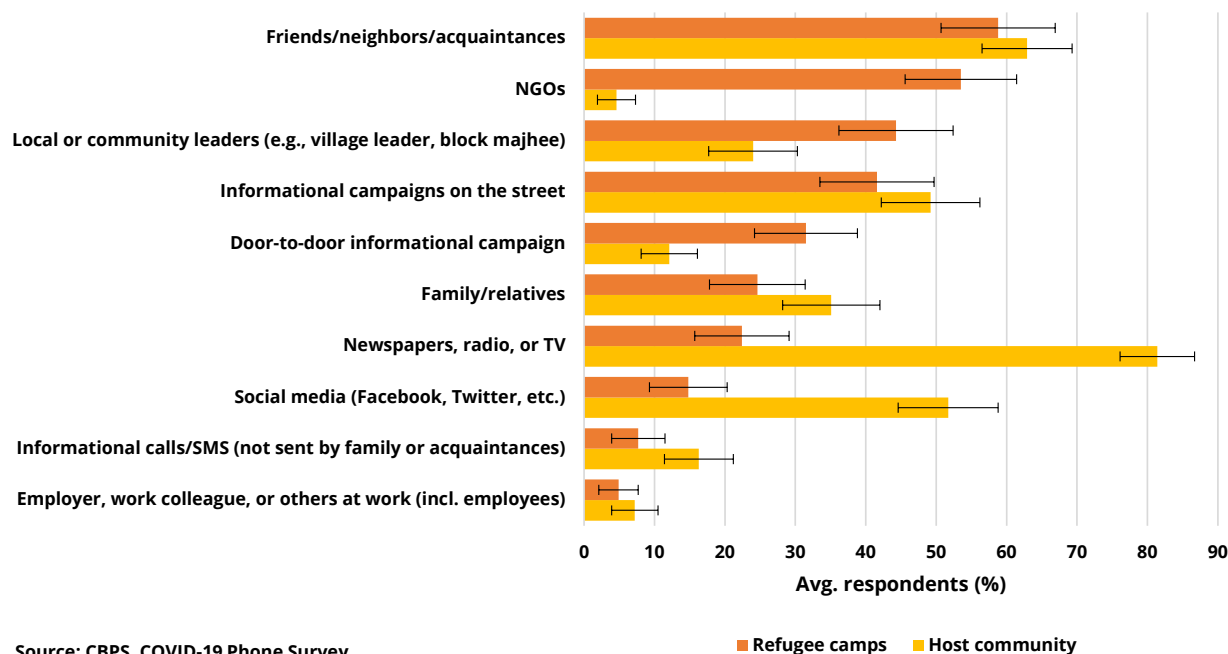
[1] For those who experienced at least one symptom of COVID-19, pharmacies were the first stop in their quest for advice and treatment. Pharmacies are the preferred health provider of choice, with nearly 70% of hosts and 42% of refugees reporting visiting a pharmacy after developing symptoms (Fig 1). Among refugees, health information providers in camps are the second most-common health provider (36% visited one to treat their symptoms). The majority of refugees and hosts did not go anywhere besides these two treatment sources after developing symptoms. Any future health surveillance should include pharmacies, and not only rely on cases reported through formal hospitals and clinics.

Figure 1. Treatment seeking behavior (April 2-16, 2020)



**[2] Trusted sources of advice on COVID-19 prevention vary greatly across refugees and hosts, but information provided by friends and acquaintances is important for both.** Between 59% and 63% of respondents trust information on COVID-19 provided by friends, neighbors, and acquaintances (Fig 2). Among refugees, NGOs are also trusted sources (54%), followed by local leaders (e.g., block majhees; 44%) and informational campaigns on the street (42%).<sup>1</sup> Among hosts, newspapers, radio, and TV are the most trusted sources of information (81%), followed by social media (52%) and informational campaigns on the street (49%). In any public health information campaign aimed at hosts (local Bangladeshis), it is important to incorporate traditional media such as TV and newspapers or broadcast social media. In contrast, reaching Rohingya refugees will require a more personalized approach through NGOs, local leaders, and word-of-mouth dissemination.

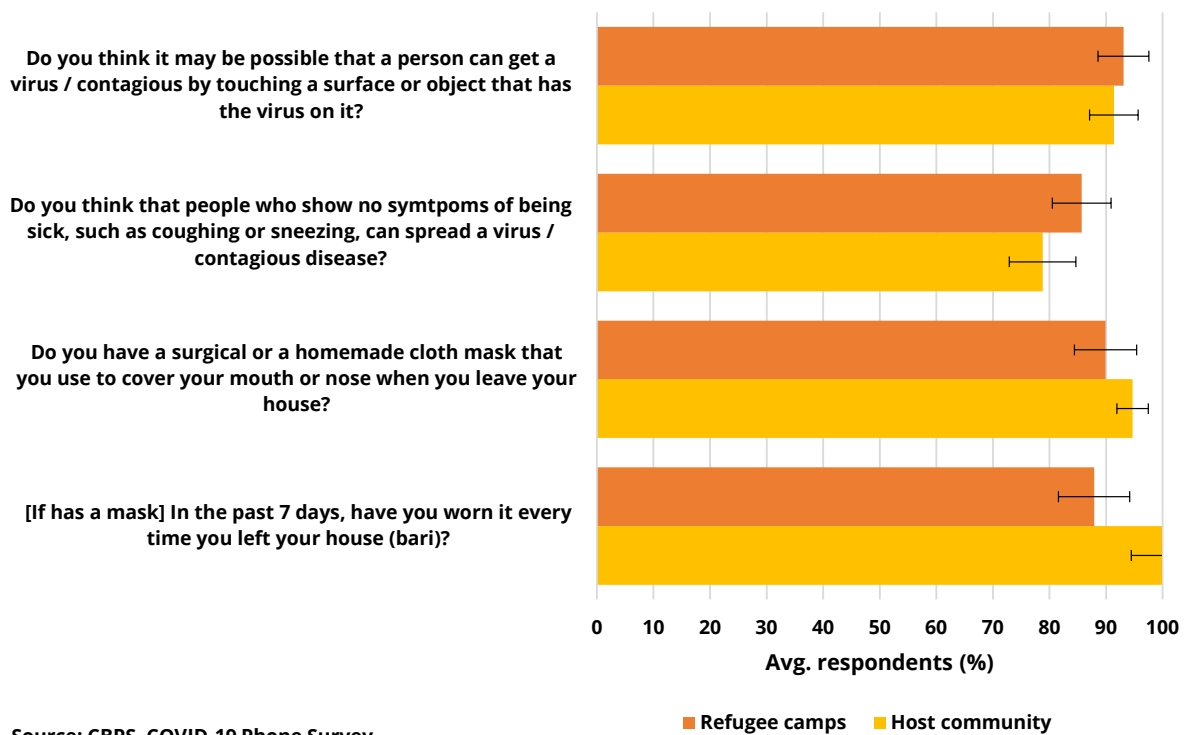
**Figure 2. Trusted sources of information on COVID-19 prevention and advice (mid-April 2020)**



<sup>1</sup> In conducting the Cox's Bazar Panel Survey (CBPS), eight refugee camp blocks had to be dropped from the sample due to mass refusals. These occurred in all of Kutupalong RC, all of Nayapara RC, and one block of Camp 16, seemingly caused by a general distrust of NGOs. Hence, survey results on refugees' trusted sources of advice only represent the attitudes of refugees in other camp locations. See further information on the Methodological note below and CBPS (2019).

**[3] The vast majority of refugees and hosts report good respiratory hygiene knowledge and believe that contaminated surfaces and asymptomatic carriers are sources of transmission; they also identify the most at-risk groups.** More than three-fourths of respondents in camps and host communities believe that exposure to asymptomatic carriers and contact with surfaces with the virus on it can infect them (Fig 3). Moreover, between 90% and 95% (refugees and hosts respectively) have a mask to wear outside of their home, and more than 85% of those who own one such mask reports having used it every time they left their home in the past week (April 9-16, 2020). These findings suggest that nearly 9 in 10 respondents believe the risk of droplet transmission is high. Additionally, when asked who is more likely to die of COVID-19, the majority of respondents identified the elderly as the most at-risk group, followed by those with pre-existing illnesses and children (ACAPS, May 2020).

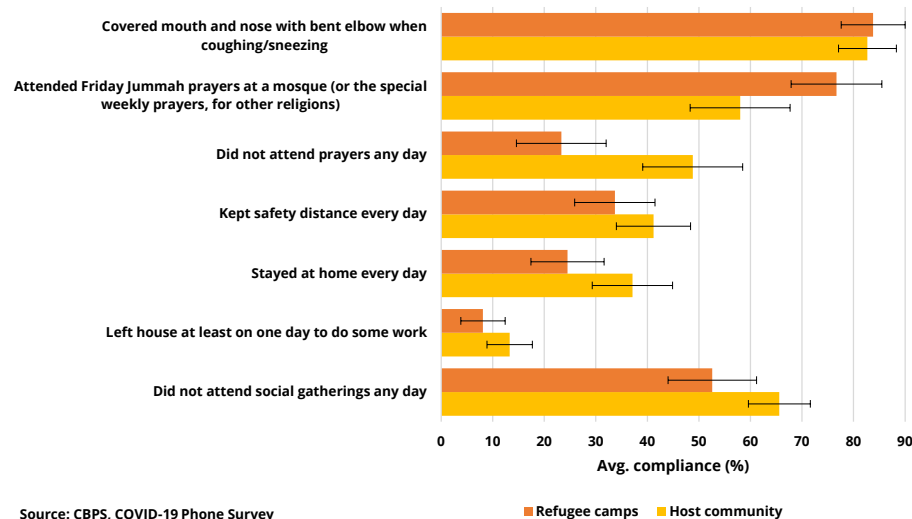
**Figure 3. Knowledge and attitudes towards COVID-19 (mid-April 2020)**



**[4] In spite of knowledge of good hygiene and viral transmission, social distancing and other recommended public health precautions are not widely practiced.** In contrast to levels of understanding about transmission and prevention, there is very little knowledge among hosts and refugees about whether and what kinds of treatments for COVID-19 exist; most respondents believe either no treatment is possible at health facilities, or they simply responded “don't know.” Moreover, around half of all respondents reported spending at least one day away from home in the two weeks prior to the survey (April 2-16, 2020), revealing that they still leave home regularly in large numbers despite awareness of the risks. Negative perceptions around healthcare and a distrust of responders is further exacerbating responses to the pandemic, particularly in certain refugee camps where there is low trust in NGOs – specifically Kutupalong RC and Nayapara RC (ACAPS, April 2020).

**[5] Attendance to religious events threatens efforts to slow the spread of COVID-19, especially in camps.** 77% of refugees and 58% of hosts report having attended a weekend religious event in the week prior to the survey (April 9-16, 2020) (Fig 4). Only 23% of refugees avoided attending prayers on other days, compared to 49% of hosts. Refugees were also more likely to attend non-religious social gatherings (only 53% avoided social events, compared to 66% of hosts), and less likely to keep the safety social distance with non-household members every day (34% versus 41% hosts). In a separate but related [Policy Insight document](#), we expand on the role of religious observance and religious leaders in the COVID-19 response (PRFDHR, 2020).

**Figure 4. Social distancing in mid-April 2020 (last 7 days)**



Insights [3] - [5], in combination, suggest that public health information campaigns must go beyond disseminating basic knowledge about the disease, which is already widespread. Instead, we now need to focus on treatment possibilities, encouraging people to seek healthcare, and the importance of continued social distancing, especially avoiding social and religious gatherings. That message should come from trusted information sources on religious matters, such as Imams. Our passive observation during follow-up visits suggests that actual mask usage rates in the streets are now lower. Ensuring consistent mask usage will likely require encouragement, monitoring and enforcement beyond information dissemination.

## Response in Bangladesh and Beyond

Efforts have already been made by organizations such as the Communication with Communities Working Group, the Inter Sector Coordination Group, and others to communicate key COVID-19 messages across host and refugee communities in Cox's Bazar (CwC and ISCG 2020). These messages have primarily been delivered through in-person training sessions led by NGOs or religious leaders, loudspeaker announcements, and information service centers. As of July 8, 2020, over 800,000 refugees have been reached through communication sessions, and almost 600,000 people in camps and host communities have received COVID-19 messages from the NGOs working with the CwC.<sup>2</sup> These efforts should be expanded so that messages are delivered by pharmacists, across the media, and further passed on between friends and neighbors afterwards.

COVID-19 messaging has taken similar forms in other refugee contexts worldwide, including India, Libya, Iraq, Ethiopia, South Africa and many others. UNHCR is actively training and supporting health care workers in refugee sites, where contagion is especially high due to overcrowding and low access to sanitation (UNHCR 2020). Furthermore, UNHCR is educating community health workers in camps about key COVID-19 messages, which the health workers then distribute face-to-face or via WhatsApp messages or social media. Emphasis has been placed on ensuring that COVID-19 advice and communication is culturally and linguistically appropriate, and information has been made available through hotlines, community outreach workers, and web-based platforms. Tailoring COVID-19 communication to the most effective channels in each context – along with delivering information through multiple means – is critical for yielding behavioral change that could curb the spread of the virus among refugees.



Rohingya camp, Bangladesh

Credit: **Abdullah Al Mashrif/IOM**

<sup>2</sup> For a full list of participating NGOs, see COVID 19: Risk Communication and Community Engagement Updates (CwC and ISCG 2020).

## Policy Recommendations and Future Research

- » Refugees and hosts are aware of symptoms and public health recommendations such as washing hands, wearing masks, and social distancing, but awareness has not been enough to stimulate widespread adoption. Thus, there is a need to develop and evaluate creative new approaches to not just propagate information but to induce behavior change. One such approach might be personal appeals from trusted members of the community.
- » To be effective, communication and behavior change strategies must recognize that trusted sources of health information vary. For refugees, education campaigns carried out by NGOs and local leaders may be the most effective, whereas for hosts, information disseminated via newspapers, radio, TV, or social media will have more impact.
- » However, both communities report that peers are a primary source of information. This suggests that social networks might be usefully leveraged. Beyond spreading information, social networks might also contribute to behavior change through the enforcement of norms like mask wearing or social distancing.
- » It is important to identify and, as necessary, educate frontline healthcare workers. Beyond their position of regularly responding to concerns and providing treatment, their frequent interactions with potentially sick individuals increases risk for themselves and for other patients. But who is on the frontline will vary from place to place. In Cox's Bazar, these include pharmacy and, for refugees, NGO staff who are individuals' first stop for medical advice and treatment.
- » Messages that encourage social distancing during religious gatherings are particularly relevant to decrease the risk of COVID-19 contagion.

The Yale MacMillan Center, in partnership with Innovations for Poverty Action (IPA) Bangladesh, are actively testing several communications and influence strategies throughout Bangladesh. We are also developing a related project with UNHCR to disseminate information and affect behavior change among refugee and host communities in Cox's Bazar.

## Methodological Note

The Cox's Bazar Panel Survey (CBPS) is a partnership between the Yale MacMillan Center Program on Refugees, Forced Displacement, and Humanitarian Responses (Yale MacMillan PRFDHR), the Gender & Adolescence: Global Evidence (GAGE) program, and the Poverty and Equity Global Practice (GPVDR) of the World Bank. The survey was executed jointly by Innovations for Poverty Action (IPA) Bangladesh and Pulse Bangladesh (Cox's Bazar) between April and July 2019.

The CBPS is a longitudinal study tracking 5,020 households across Cox's Bazar that is divided almost equally between refugee camps (n=2,493) and host communities (n=2,527). The Primary Sampling Units (PSUs) in host communities are mauzas, the lowest administrative unit in Bangladesh. Mauzas were stratified into areas within 15 kilometers from camps and areas farther away from camps. The PSU for refugee communities were camp blocks, as defined by the International Organization for Migration (IOM) Needs and Population Monitoring Round 12 (NPM 12).

The follow up phone-based survey had a sample size of 1,255 households, of which 909 were reachable by phone and 899 consented to be surveyed. Rohingya refugees (n=367) and host population (n=532) in Cox's Bazar were randomly drawn from the CBPS. It was administered between April 11 and 17, 2020 to assess the health status, health behaviors, and livelihoods of households across Cox's Bazar.

A symptoms checklist was conducted to assess COVID-19 risk based on the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) guidelines. The three most common symptoms featured on the WHO dedicated COVID-19 website on April 27, 2020 were used to produce the preferred measure of COVID-19 risk: having at least one of the symptoms (fever, dry cough, and fatigue or tiredness).

Questions also covered returning migration, employment, and food security. Additional questions on health knowledge and behaviors were administered to a random subsample (n=460).

Graphs 1-4 above, derived from the results of the Cox's Bazar Covid-19 Phone Survey, include 95% confidence intervals.



## References

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The Yale Research Initiative on Innovation and Scale (Y-RISE) advances research on the effects of policy interventions when delivered at scale ([yrise.yale.edu](http://yrise.yale.edu)). The Program on Refugees, Forced Displacement, and Humanitarian Responses (PRFDHR) is an intellectual hub for research, teaching, and policy recommendations that takes a people-centered approach to the refugee experience ([Refugee at Yale MacMillan.edu](http://Refugee.at.Yale.MacMillan.edu)) The Gender and Adolescence: Global Evidence (GAGE) programme is funded by UK Aid and is a longitudinal mixed methods study focused on what works to fast-track social change for young people 10-19 years in low and middle-income contexts, including the most disadvantaged adolescents whether refugees, adolescents with disabilities or ever married girls and boys ([gage.odi.org](http://gage.odi.org)). For more information please contact [gage@odi.org.uk](mailto:gage@odi.org.uk). Innovations for Poverty Action (IPA) is a research and policy non-profit that designs, rigorously evaluates, and refines solutions to global poverty problems together with researchers and local decision-makers, ensuring that evidence is used to improve the lives of the world's poor ([poverty-action.org](http://poverty-action.org)).

Awareness session with host community, Bangladesh

Photo Credit: Dushtha Shasthya Kendra/Christian Aid

