

MASK WEARING, TESTING AND KNOWLEDGE OF COVID19

Survey by UNHCR and WHO

September 2020

Background

The Rohingya population settled in 34 camps in Cox's Bazar district numbers around 860,000 individuals.¹ On March 23, 2020, Cox's Bazar saw the first case of COVID-19 in the host community. The first case of COVID19 in the Rohingya population was confirmed on 14 May 2020.² At the time of this survey (September 5th – 10th 2020), there were 138 confirmed cases of, and 8 confirmed deaths from COVID19 in the Rohingya camps.³

Community engagement around prevention of COVID19 has been a core activity of the health sector since March and is supported by many other sectors. Activities are carried out by volunteers through door-door messaging and the use of multimedia approaches, key messages were developed by the risk communication group including the need for physical distancing, mask wearing, recognising symptoms and testing and treatment.

Objectives

The assessment was designed to assess the effectiveness of the intense community engagement that has been done among the Rohingya population; whether people were absorbing and developing good knowledge from the communication and information outreach, and whether they were responding (through behaviour change) to the information they were receiving.

Methodology

The survey was conducted by phone between September 5th – 10th 2020, with random samples utilizing UNHCR refugee registration database; samples were drawn from all camps. The survey used the beginning of the Ramadan fasting period (24. April) as a calendar marker for timebound questions.

The survey had 718 respondents including 333 female (46.4%) and 385 male (53.6 %) participants. A minimum of 600 respondents was needed to achieve a confidence interval of 5 and a 95% confidence level.

The questions were open ended, answers were not read out to participants. Some questions included options to indicate more than one choice (up to three).

¹ Joint Government of Bangladesh - UNHCR Population Factsheet as of 30 June 2020.

² UNHCR Briefing Note, Public health response in Rohingya refugee settlements on alert as first coronavirus case confirmed, 15 May 2020.

³ Cox's Bazar IEDRC Field Lab, Civil Surgeon Office, WHO Sub Office

Limitations

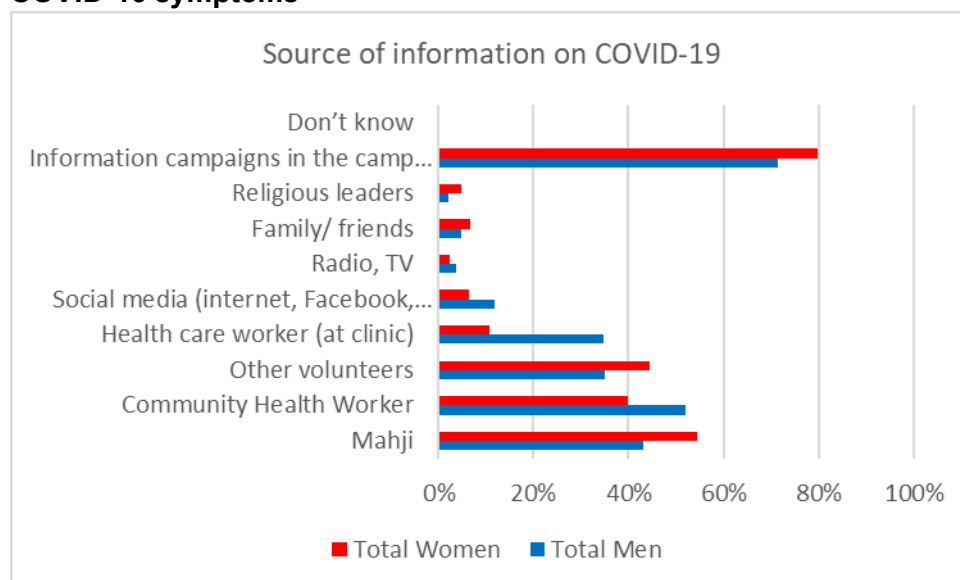
Due to COVID-19, the survey was conducted by phone, limiting thus the participants to those who have a registered phone number.

When analysing several responses in the survey, several answers to questions would suggest that they were formulated to tell the interviewer ‘what they want to hear’ or what they imagine is the ‘right’ reply. While this indicates that respondents have good knowledge of appropriate responses to COVID19, behaviour adjustment does require further time.

While some of the survey results around behavior may contradict other knowledge, these survey results should not be discounted or apparent contradictions around attitudes ignored.

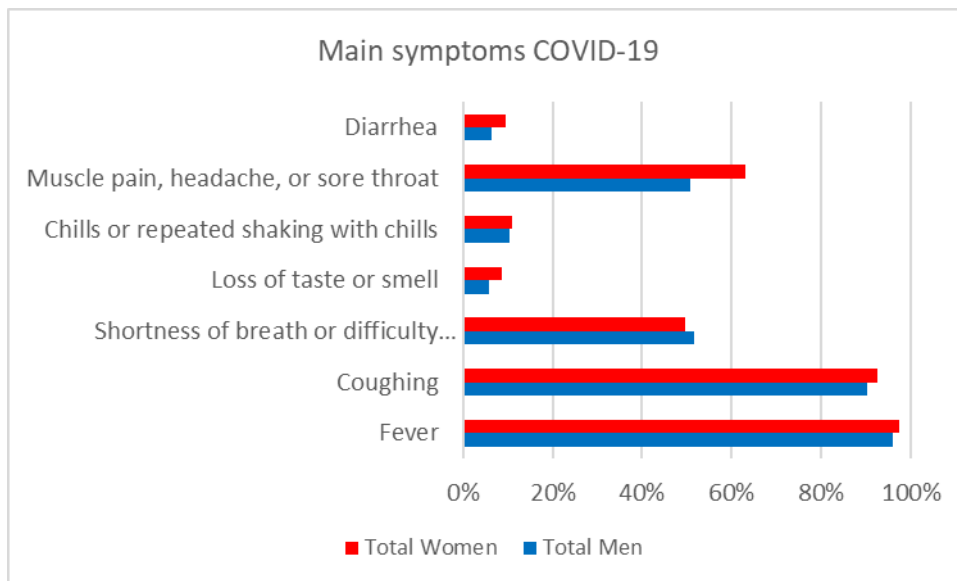
Findings

COVID-19 symptoms

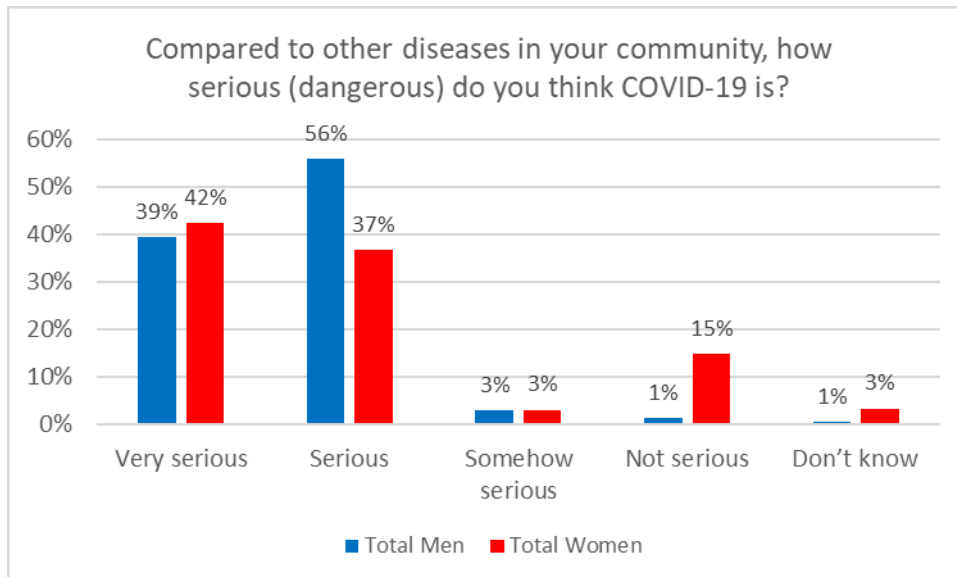


In the area of **knowledge of COVID19 symptoms**, while questions of reliable sources of information strongly indicated campaigns (miking, info hubs and camp based outreach) as the favoured source by both males and females, it was in the other areas of reliable sources that there were differences between males and females in their preferred reliable source of information.

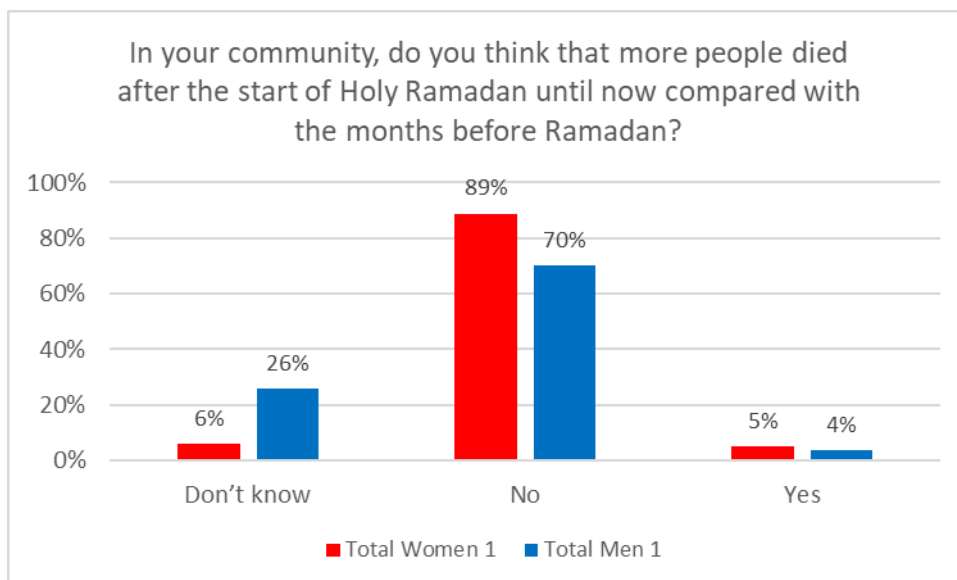
54% of women indicated that Mahjis were reliable sources (and 43% of men). 52% of men said community health workers were reliable sources (and 40% of women).



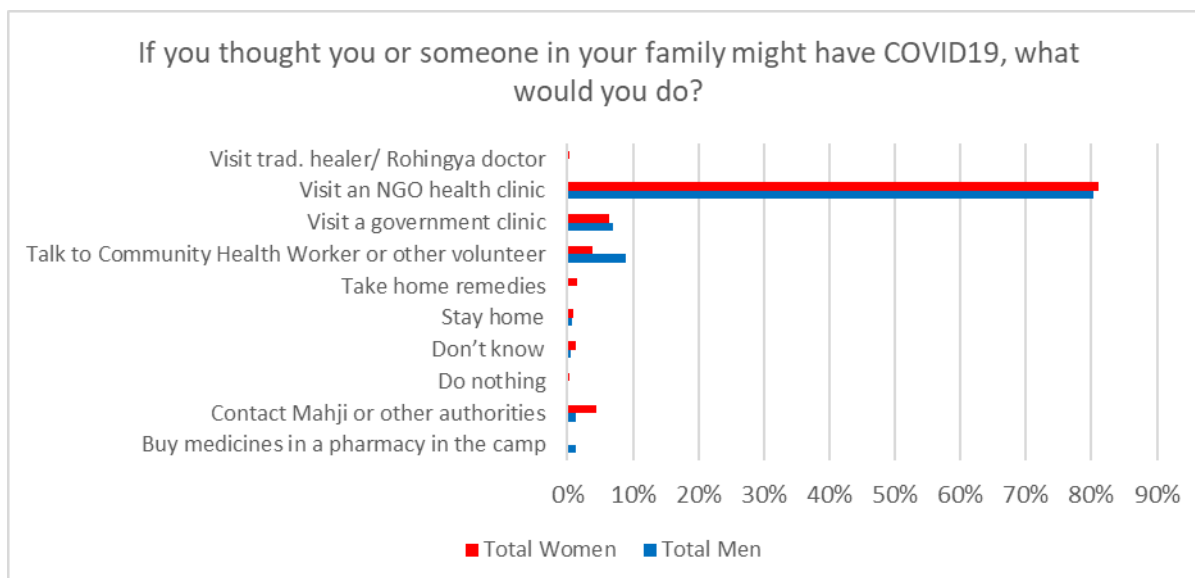
More than 90% of both men and women identified cough and fever as indicative symptoms of the disease. Approximately half of respondents identified shortness of breath/difficulty breathing and muscle pain, headache, and/or sore throat as symptoms. Lesser recognized symptoms were chills and shaking, diarrhea and loss of taste or smell.



While COVID19 was seen as “serious” or “very serious” (compared to other diseases) by both male and female respondents, more women (15%) than men (1%) viewed it as “not serious”.



The survey looked further in perceptions linked to mortality in the community in the past three months, a period that covers the time since the detection of the first COVID-19 case in the refugee camps. In average 78.8% of the respondents felt that there was no difference to the period before Ramadan, though a higher proportion of men (26%) was unsure about it.



On what actions would be undertaken by respondents if someone in their family might have COVID-19, over 80% of men and women indicated that they would visit an NGO health clinic. Previous research⁴ indicates a dislike of, and disinclination to visit health clinics by members

⁴What Matters? Humanitarian Feedback Bulletin, [Issue 10](#), September 2018

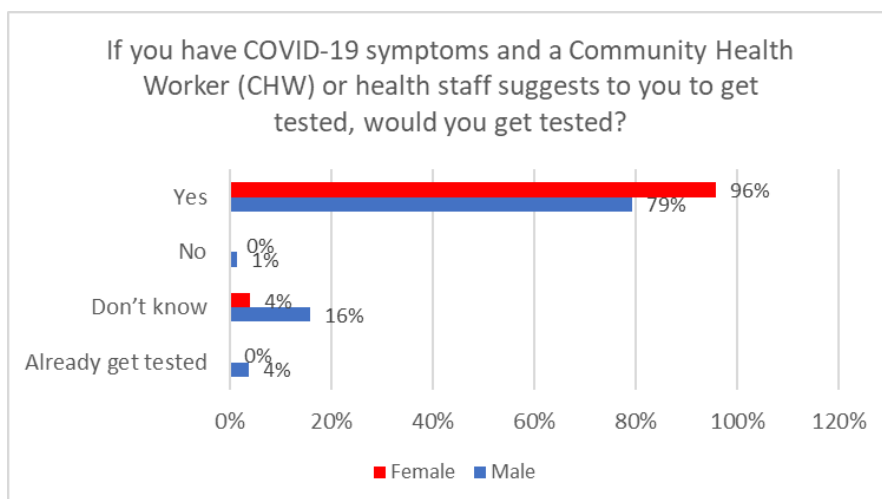
Rohingya Response Rumour Tracking, [Issue 4](#), December 2018, Common Service for Community Engagement and Accountability

[Rohingya Needs and Services](#), Ground Truth Solutions, June 2019

[Misunderstanding + misinformation = mistrust](#), Translators without Borders, September 2019

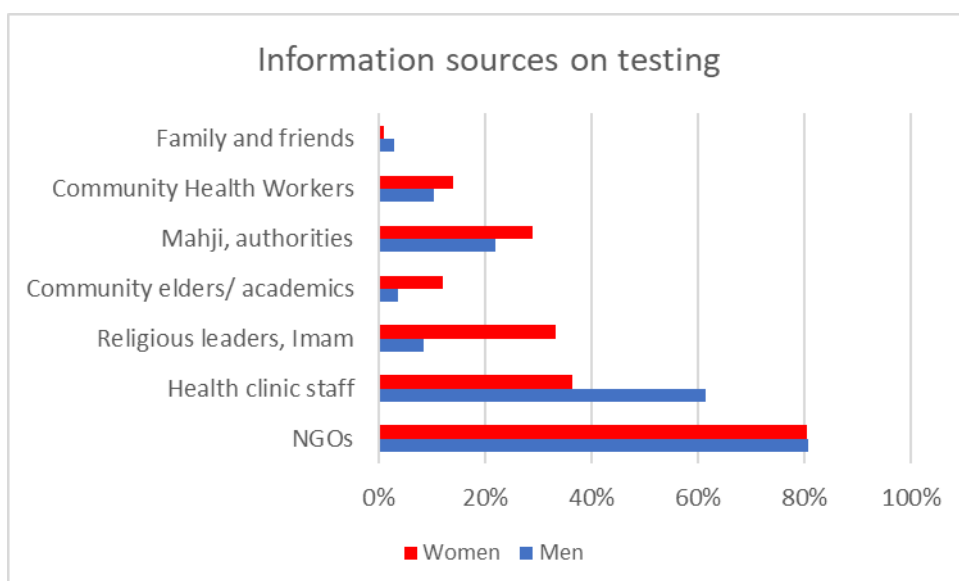
of the Rohingya community. The results could indicate that the respondents were indicating what they felt was the “right answer”, or they could indicate an increased trust in health facilities following extensive community outreach across sectors with counselling for COVID-like symptoms and information sharing about services offered in SARI ITCs and quarantine facilities.

Perceptions on testing for COVID-19



When discussing **testing for COVID19**, respondents were asked if they had symptoms and a community health worker or health staff suggested they get a test, 96% of women said that they would; 79% of men said they would.

16% of males said they didn't know whether they would get tested. Only 3% of women said they did not know if they would get tested. None of the females surveyed indicated that they had already been tested, and 4% of males indicated they already had been tested.



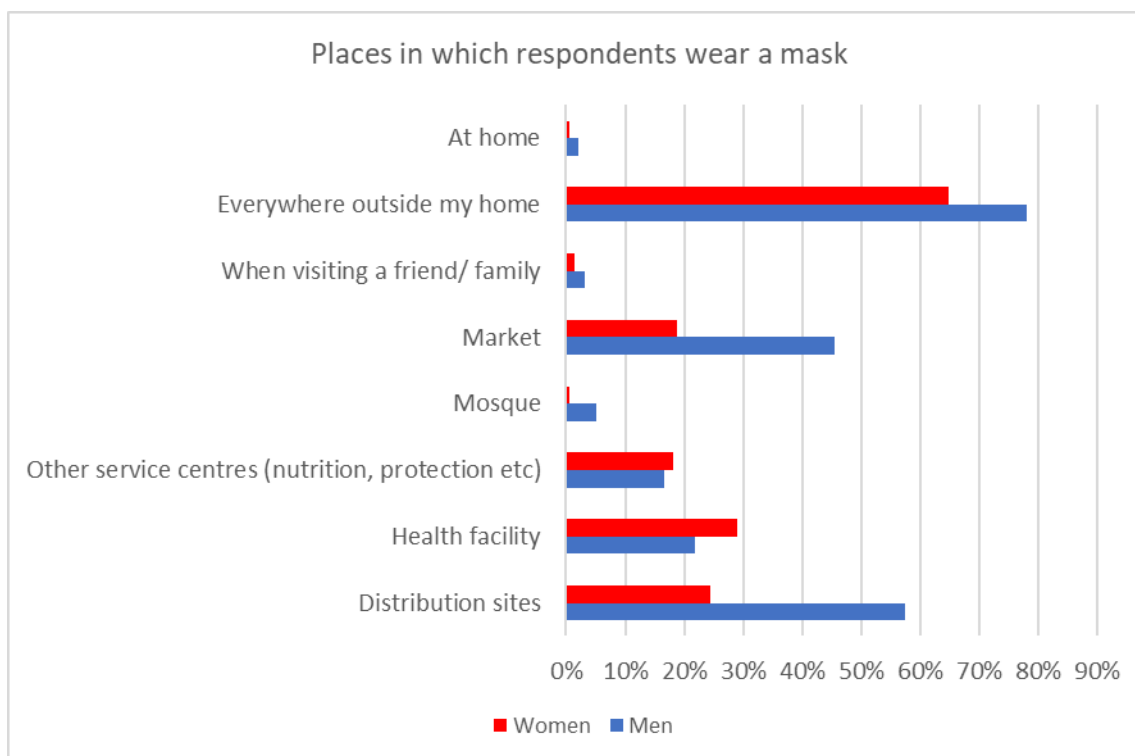
For trustworthy information around the test, again NGOs scored highly among females (80%) and males (81%).

Health clinic staff had a higher rating among males than females, while religious leaders/imams and Mahjis rated higher with women than men as reliable sources.

Wearing cloth masks

Survey results around the **wearing of cloth masks** indicate that 89% of respondents said they had more than two masks, with a strong indication (92%) that these were distributed by NGOs⁵.

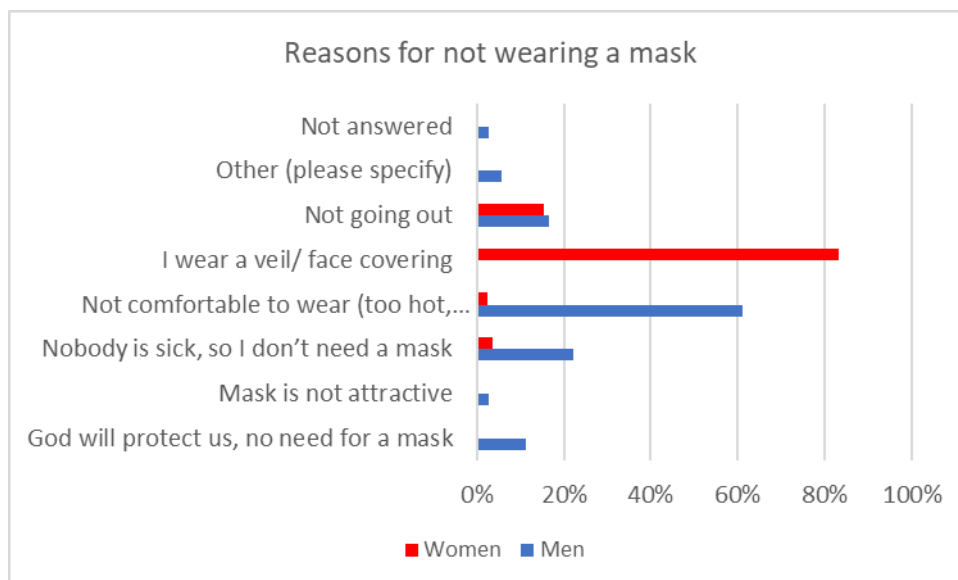
However, the indication from 83% of respondents that they always wear a mask everywhere outside of the home contradicts observations by humanitarians who regularly continue to visit camps and other discussions.⁶ It indicates that the respondents know that mask wearing is recommended but that does not translate into practice and behavior change yet.



Markets and distribution sites were noted as places where mask wearing was particularly strong for men, who are more likely to attend these public spaces. Although the large majority claimed to wear masks at all times, for those who did not, there was a difference in reasons between males and females.

⁵ Livelihood Working Group, [COVID19 Response-Mask Making Tracker](#) indicates that as of end September (after completion of this survey, only 6 camps had incomplete mask distribution).

⁶ COVID-19 Community Concerns and Questions: Update from CPJ-BracU volunteers WhatsApp Chat Hour, 23 September 2020



For males, the main reason for sometimes or never wearing a mask was that it was too hot/can't breathe (61%) and for women because they wear a veil or face covering (83%).

Recommendations

The survey indicates a good knowledge of COVID-19 related issues, with a high percentage of respondents saying that NGO communication is the most reliable source of information. This indicates some success by the humanitarian community at communication, which can be built on.

Women appear to rely on information for community leaders (Mahjis/imams) to a greater extent than men. These influencers should be included proactively in outreach from an early stage and women-specific COVID-19 information formulated for, and shared through them

The importance of mask wearing needs to be a continuing and evolving message, as it is evident from survey responses that people do understand its importance. Humanitarian workers, CiC office staff as well as community leaders should be engaged further in providing positive examples of wearing masks at all times. Facilities and distributions points should likewise be engaged further to promote the usage of masks to access services.

Women in the survey indicated that they felt that a face veil or scarf is sufficient which is confirmed by observations in the camps. More emphasis is needed to address this misperception towards consistent use of cloth masks by women and men including through various entry points such as e.g. distribution staff and community volunteers to inform women that COVID-19-specific distributed masks should be worn for proper protection.