**Terms of Reference for Faith-based Leaders**

**October *2020***

**Assessing the role and impact of messaging from faith leaders on mitigating the effects of COVID-19 among the Rohingya Refugee communities in Cox Bazar, Bangladesh.**

**Background**

COVID-19 is directly impacting the most vulnerable section of the communities, including the Rohingya Refugee community who are living in a congested camp with inadequate hygiene facilities and other basic services. Approximately 1.2 million Rohingya Refugee community live in 27 camps in two sub-districts of Cox’s Bazar district. Further, loss of income or livelihood of the vulnerable groups (women headed households, persons with disability, aged people, etc.) has forced them to adopt negative coping mechanisms risking long-term implications such as relying on less nutritious foods, reducing portion size and number of meals, restricting adults consumption etc[[1]](#footnote-1).

Cox's Bazar is one of the districts where the number of COVID-19 positive cases are high (in comparison of other districts in Bangladesh, other than Dhaka). The total fatality rate is 29%. WHO has reported over 4,760 confirmed cases of COVID-19 in Cox’s Bazar, among which, 261 cases are of Rohingya Refugee community in the camps. 68 host community members and 8 refugees have died from COVID-19 as of 9th October 2020. Only critical activities (health service, WASH, food distribution, LPG distribution, and nutrition service) with limited movement are currently allowed in camps to control the risk of disease spreading. There is an increased risk of COVID-19 spreading in the Rohingya Refugee camps due to vulnerabilities like lack of handwashing facilities, limited numbers of toilets per household, a mere 5-9 health post per 20000 individuals, 15% of households with at least one person with a disability or chronic illness, etc. (source: UNHCR data). Cox’s Bazar district was placed under the red zone by the Government of Bangladesh authorities and has recently seen easing of restrictions in September 2020. There is a strong feeling amongst Humanitarian Agencies that once the authority lifts the restriction completely without considering the risks and mitigation measure, the situation, especially in camps, will turn worse and will cause a massive number of fatalities and positive cases across the host community and refugee camps.

The Rohingya Refugee communities are predominantly Muslim and their religious leaders are generally the prayer leader (Imam) or the person responsible for the call of prayer (Muazzin) in the Muslim communities.[[2]](#footnote-2) In studies carried out by WHO, BBC Media Action and ACAPs, Rohingya refugees have reported believing that COVID-19 is a punishment and test from Allah as an examination of their faith. Many Rohingya Refugee believe that the virus, not having a clear medical ‘cure’, is evidence that COVID-19 is a punishment sent by Allah to test them and their piety[[3]](#footnote-3).

There is also an inconsistent application of COVID-19 guidance to religious traditions and practices. Some mosques continue to operate as normal, some with reduced capacity, and other religious gatherings have not necessarily been halted. However, many people reported believing that it was justified to adjust prayers and other religious activities to respond to COVID-19. The influence of religion on the reaction of individuals to the pandemic is quite high. Religious leaders are a willingly accepted source of news/advice on lifestyle in these vulnerable communities and often, misinformation that is associated with religion is commonly accepted as truth. A study by IOM indicated that women’s “dishonourable” activities and failure to conform to strict understandings of ‘purdah’ (modesty) are being cited by women and men as a reason for the Coronavirus. This has led to greater policing of women, reducing their mobility, and subjecting them to gender-based violence (GBV) in terms of intimate partner violence, and restricted mobility which reduces their access to information and services. A Rapid Gender study[[4]](#footnote-4) by the ISCG Gender Hub in Cox’s Bazar found that the communities in question reported that most of them would not allow women to go into isolation and treatment with unknown men and 100% reported that the concept of mixed rooms would be unacceptable. The study also reveals that certain gender stereotypes that are reinforced by the Imams lead to the exacerbation of existing stigma against women’s participation in the COVID 19 response efforts. The leaders express concern over women not being able to maintain proper “purdah” and therefore restrict their participation entirely. This could further increase the risk of women being subjected to harsh treatment conditions or even no treatment. In addition, the lack of awareness financial insecurity has led to an increase in child marriage in the communities who are trying to marry the daughters off to relieve themselves of the daughter’s expenses[[5]](#footnote-5). Further, elderly people, people living with disabilities, and persons with the pre-medical conditions feel threatened by COVID-19 as the information that it mostly affects their demographics has been widely circulated.

However, many practices that violate COVID-19 guidance were found to be continuing or to have increased. For example, many people initially responded to the Coronavirus by increasing religious gatherings like Talim and Jammat to protect themselves with prayer. There is also the inconsistent and uneven engagement (such as involvement in awareness activities) of religious leaders and officials in relation to COVID-19. Some people reported that while initially religious leaders were engaged, this has reduced since COVID-19 essential and critical restrictions were implemented. Due to the perceived influence of faith leaders within the Rohingya refugee communities, experiences have suggested that faith leaders can support the recovery efforts of the affected countries and it contributes to a discussion on the broader role of faith in humanitarian response[[6]](#footnote-6). Faith leaders can play an important role in different manners such as create trust between the health providers and community members, replace messages of fear with messages of hope, shape the attitudes and transforming the practices of local community members, help to drive out the stigma that was destroying community coherence, engage effectively if they understand the risk associated with religious practices and take measures to change it, etc.

Christian Aid has been implementing the Disasters Emergency Committee (DEC) Corona Virus Appeal project titled “Integrated COVID-19 Response Programme for the Rohingya Refugee and Surrounding Host Communities” with Dhaka Ahsania Mission (DAM) and Dushtha Shasthya Kendra (DSK) as implementing partner NGOs. The main purpose of the project is to provide home-based health care services to COVID-19 confirmed cases and to create awareness among the Rohingya Refugee and host community people to lessen the spread of COVID-19 in the targeted area. The major outcomes of the project included (i) Increased access to home-based health care services for the confirmed COVID-19 cases, (ii) Increased knowledge of health facilities staff and Community Health Worker (CHW) in home-based COVID-19 care, (iii) Reduced misbeliefs and spread of rumours about COVID-19 in the targeted area, (iv) Improved hygiene practices to prevent COVID-19 spread in Refugee Camps and (v) Improved quality of response delivered through effective community engagement and accountability practice.

As part of the Integrated COVID-19 Response Programme for the Rohingya Refugee and adjacent host communities, Christian Aid is seeking to undertake research on the role of Faith Leaders in the Rohingya Refugee and adjacent host communities during a pandemic like COVID-19. One of the interventions of the project is to engage the religious leaders in spreading the appropriate health and hygiene messages in the community with the help of healthcare practitioners and hygiene promoters. The messaging is to include WHO, IPC, and GoB guidelines of hygiene and health practices along with ensuring that the people are seeking the necessary care as soon as they notice symptoms COVID 19. These messaging interventions are to be taken place in community congregation hubs like the local markets and also door to door as women are often unable to participate in the public gatherings and will be delivered orally by the community mobilizers in collaboration with the faith leaders. It is a generally accepted idea that faith leaders hold an influential position within the FDMN communities. Religion is a primary source of strength and support for the FDMN community, with many relying on religiousness and a sense of duty to communities and their families to help cope with the oppression they have faced throughout their lives[[7]](#footnote-7). However, there is a lack of written evidence surrounding their role and influence within the Rohingya Refugee community in relation to COVID-19 and their ability to effect change. It is also of interest to explore the negative impact they have on gender inequality and on the risk of GBV. This evidence is necessary for informing how the humanitarian network programmes respond to COVID-19 and other similar disasters. There is also a growing need of assessing the impact of information spread by the religious leaders on GBV in terms of whether their messages are effective in reducing the stigma regarding women’s participation in society or if they are in fact exacerbating the situation with their messages. It has been found that engaging religious leaders had improved the effectiveness of spreading health messages in other disaster contexts such as the Ebola crisis of 2014 where these individuals publicly partook in appropriate hygiene practices and influenced the communities to do the same.[[8]](#footnote-8) A similar hypothesis for the COVID-19 contexts is to be examined. In addition, the assessment is also to look at

ions:

**Objectives**

1. To document a nuanced understanding of the role of faith leaders in responding to the COVID-19 pandemic among the Rohingya Refugee Community in Cox’s Bazar.
2. To assess the impact and effectiveness of faith leaders’ response to COVID-19 in relation to hygiene and violence against women among the Rohingya Refugee Community in Cox’s Bazar.
3. To identify lessons from working with faith leaders in responding to the COVID-19 pandemic to adapt existing projects and programmes and to inform future programmatic responses to the effects of the pandemic among the Rohingya Refugee communities in Bangladesh.

**Research questions:**

1. What makes messaging from faith leaders to mitigate the effects COVID-19 effective among the Rohingya Refugee community in Cox’s Bazar?

1a. How has messaging from faith leaders on COVID-19 been received by the Rohingya refugee community?

1b. What are the opportunities and challenges surrounding messaging from faith leaders in response to the COVID-19 pandemic?

2. How effective are faith leaders in changing behaviours to mitigate the effects of COVID-19 within the Rohingya Refugee community in Cox’s Bazar?

2a. What impact has messaging from faith leaders had on hygiene practices ( such as handwashing, menstruation hygiene management, cleaning hands properly after toilet, etc.) among the Rohingya Refugee community in Cox’s Bazar?

2b. What impact has messaging from faith leaders had on physical and emotional violence/stigma against women and girls?

3. How has Christian Aid’s partnership approach facilitated or hindered faith leaders to respond to the COVID-19 pandemic in line with key needs as identified by local communities?

**Scope of work**

The assessment can be conducted through a hybrid mechanism where the primary phase related to data collection will be the responsibility of a national consultant, whereas for developing methodology, reporting and documentation that is the final presentation – an international firm to be recruited.

**Geographical area**

Camp No 15, 19 and surrounding host community’s villages both inside and outside of the camp in Cox's Bazar district

**Target Group**

Religious leaders, Majhi, and general groups as mentioned above and Rohingya refugees in Camps and Palongkhali union, Ukhiya.

**Target audience**

|  |  |  |  |
| --- | --- | --- | --- |
| Audience for your research  | What will they use the findings for? | What format(s) will they access the findings? | How will they access the findings?  |
| Local Government Policy makers | Reviewing budget allocations | Short summary brief  | Launch event in town hall, by invite  |
| Donors  | Granting funds appropriately  | Report, briefs.  | Digital access, social Media |
| International humanitarian network  |  Designing appropriate interventions that utilize the findings  |  Report, briefs | Digital access, hard copy of report, social Media |
| Research participants | Improving community practices | Oral delivery through project partner staff | Community gatherings in the working sites of the partners, healthcare centres.  |

***Expected Outputs from the Consultant***

**National Consultant**

A national consulting agency will oversee the primary data collection and the groundwork. They will mostly be responsible for quantitative data collection. However, the scope of work should also include qualitative data work, i.e.: conducting FGD, collect in depth interview or KII of relevant parties (faith leaders, majhis, beneficiaries etc).

The selection of national consultants will include previous experience in research among vulnerable groups and/or on sensitive topics, working with women and girls, and experience in working with faith-based leaders and involving women enumerators and data collectors. The total day for data collection is approximately 20 days including data collection (qualitative and qualitative data), and quality check.

**Time Frame**

The consultant will submit the proposal in English within 07 (seven) days of the circular. The total durations of the assignment are approximately 30 (thirty) days from the date of signing of the contract as per following flow chart:

Contract signing 10 November 2020

Draft report submission: 20 December 2020

Feedback from contract holder: 5 November 2020

Final report submission: 15 January 2021

**Ethical Considerations**

The Consultant and enumerators for data collection will comply to the policies of CA Bangladesh along with implementing strategy as well as to the Camp Management Policy and Procedures of GoB. They must maintain rules of code of conduct and procedures relating to confidentiality, consent and soliciting information from the target people while taking note of specific details. The team will also comply with the code of conduct stated on the CA "HR Policy" and the CA constitution. The enumerators will sign basic code of conduct in local language that they will understand, and all have safeguarding training/briefing

The team must ensure that this study is conducted ethically and sensitively. Vulnerable people should be protected, and potential harm from the research tools, methodology, or researchers should be avoided. The study must ensure:

* the researchers and research tools respect respondents.
* informed consent from all respondents.
* planning and conducting the research and data collection
* the participation of local community representatives in planning and conducting the research and data collection.
* community representatives and researchers can work together to make sure that the research is conducted most appropriately.
* Ensure that the community ‘approve’ the methods that are used e.g. questions that are asked, how focus groups are organised, who does the interviewing, who facilitates the focus group discussion, how the information and data is shared etc.
* Consultants submit to check that research design and methodology is ethically sound
* communities are informed of the research, possible outcomes (positive and negative), and the results of the study.
* complaints and feedback mechanisms be in place and communicated to all research participants, and that they are informed of the expected behaviours of the researchers.

# **Logistics**

All relevant logistics (accommodation, transportation, etc.) will be managed by the consulting firm. Necessary services such as translators, interpreters, drivers (for firm/Consulting firm), data processor, facilitators, computer, printer etc. associated with the study will be managed by the Consulting individual/consulting firm.

**Eligibility and profile of the Consultant/firm**

The Lead Consulting firm/agency should preferably have-

* An advanced university degree (PhD preferred) in development studies/social science/public management/Statistics/other relevant disciplines, with proven experience in the development context of Bangladesh.
* Experienced in working with multi-stakeholder platforms and processes, or other complex collaboration platforms across sectors, including health, water, nutrition, and agriculture.
* In-depth knowledge and understanding of religious dimension (specific and sensitive) vis-a-vis service delivery system, its challenges, national and local policies, and institutional arrangements.
* Understanding of conflict-sensitivity within humanitarian response.
* Solid understanding of thematic concerns in humanitarian response, such as gender, disability, localization and do no harm.
* Strong analytical and interpersonal communication skills
* Prior proven experience on leading/ conducting similar assignments (short assignment details done in the past to be shared as evidence)
* Experience in Qualitative and quantitative data collection and analysis
* Understanding on the contexts of Rohingya Refugee and host communities
* Combining qualitative and quantitative study methods, following participatory monitoring approach
* Experience in interview design and implementation
* Project/program/policy planning, monitoring and management
* Excellent documentation skills

# **Required Business Documents:**

The Consulting firm should have updated Trade Licence/RJSC Certificate, Tax clearance certificate, VAT registration certificate, TIN certificate, and a list of clients provided with relevant services. VAT and Tax will be deducted as per Government rules.

# **Mode of Payment:**

20% of the total amount will be paid at the time of signing contract, and 30% of the total amount will be paid at the time of submitting 1st draft. Rest 50% of the total amount will be paid at the time of final submission of report. All payment shall be made through account payee cheque. Deduction of VAT and Tax shall be applicable as per government rules.

**Selection Criteria:**

The selection committee will evaluate both the technical and financial proposal of the Consulting agencies based on set out evaluation criteria. A cumulative weighted scoring method will be applied to evaluate the proposal. The award of the contract will be made to the Consulting firm whose offer has been evaluated and determined as responsive/compliant/acceptable with reference to the ToR.

The following areas will serve as criteria for tech**n**ical proposal (100 marks) assessment:

* Previous experience regarding similar work (30 marks)
* Education background/Team composition and relevance to project outcomes (20 marks)
* Time-bound rollout plan (20 marks)
* Financial proposal (30 marks)

**Expressions of Interest should include:**

* Cover letter (maximum one page)
* Technical Proposal (maximum 10 pages)
* Financial Proposal (maximum one-page)

Interested individuals/agencies with relevant and proven experience shall Submit **Technical** and **Financial Proposal** by **27 October 2020** through email at Bangladesh-jobs@christian-aid.org**.** Please mention **“Hiring Individual Consultant/ Firm for Assessment on the Role of Faith Leaders in the Rohingya and surrounding host communities during COVID 19 in Cox’s bazar**" in the email subject line. Christian Aid reserves the right to accept or reject the offer in part or full without assigning any reason whatsoever.

1. Source: Joint Multi-Sectoral Needs Assessment, October 2020 [↑](#footnote-ref-1)
2. Source: Aziz, A., Urban refugees in a graduated sovereignty: the experiences of the stateless Rohingya in the Klang Valley. Citizenship Studies, 2014. 18(8): p. 839–854 [↑](#footnote-ref-2)
3. Source: OCHA. (2020). *2020 COVID-19 RESPONSE PLAN Addendum to the Joint Response Plan 2020 ROHINGYA HUMANITARIAN CRISIS.* https://reliefweb.int/sites/reliefweb.int/files/resources/covid-19\_addendum\_rohingya\_refugee\_response\_020720.pdf [↑](#footnote-ref-3)
4. Source: ISCG Gender Hub. (2020). *COVID-19 Outbreak: Cox's Bazar Rapid Gender Analysis May 2020.* [↑](#footnote-ref-4)
5. Source: International Organization for Migration (IOM) and ACAPS, 2020. Overview of Rohingya Perceptions. COVID-19 Explained, edition #1. https://reliefweb.int/report/bangladesh/covid-19- explained-overview-rohingya-perceptions-edition-1-26th-march-2020 [↑](#footnote-ref-5)
6. During Ebola response, the report showed that faith played an important role in people’s lives in Liberia and Sierra Leone where the majority of the people are practicing believers and faith leaders enjoy significant trust and respect. Reference: Keeping the Faith, The Role of Faith Leaders in the Ebola Response [↑](#footnote-ref-6)
7. Source: Shakespeare-Finch, J., et al., Distress, Coping, and Posttraumatic Growth in Refugees from Burma. Journal of Immigrant & Refugee Studies, 2014. 12(3): p. 311–330 [↑](#footnote-ref-7)
8. Source: Featherstone, Andrew. (2015). Keeping the Faith: The Role of Faith Leaders in the Ebola response. [↑](#footnote-ref-8)