More than 900,000 Rohingya currently live in refugee camps in Cox’s Bazar in Bangladesh. This represents a complex political and humanitarian crisis with challenges for language and communication. Good language and communication practices remain vital to the Rohingya response. This report outlines key findings from focus group discussions (FGDs) with Rohingya community members and key informant interviews and one survey with humanitarian responders. It provides insights into language and communication practices in different sectors of the response and highlights the role that respectful interactions can play in delivering effective aid.

Summary: what you absolutely need to know

- Rohingya community members rely on humanitarians to learn vital information, including how to access basic needs, health and nutrition services. Good language and communication practice can facilitate this, but there continue to be challenges in the response.
- There is a gap between what humanitarians think Rohingya community members understand and what community members say they understand. Several years on, humanitarians feel that Rohingya can more easily understand Chittagonian and even some Bangla. Conversely, Rohingya community members still strongly prefer the use of the Rohingya language and say they miss out on vital information. Rohingya community members see their situation as temporary and many are not strongly invested in learning the local language.
- Use of the Rohingya language is still strongly preferred when speaking about complicated or sensitive issues, such as menstruation, sexual health, and family planning.
- Language and communication practices extend beyond what language is used and what formats are used to communicate. It is vital that empathy and respect are built into interactions between humanitarians and Rohingya community members, at all levels of the response.
Humanitarians’ language and communication practices are perceived to be most effective when they prioritize in-person listening and speaking

Rohingya community members reported many good examples of language and communication practices in their experiences of the response. This largely included examples of in-person communication with a humanitarian responder, such as community health workers or volunteers. Community members reported that good language and communication practice meant a staff person listened, answered questions, and acted after receiving feedback.

“A nutrition volunteer visited us to distribute service cards and called us to follow up. Since there are mixed staff with host and Rohingya volunteers, they can understand us and we can also understand them. When a nutrition service receiver delays for a week in collecting her services, the volunteers communicate with the block majhi to find out the particular beneficiary and find out the reason behind the delay.”
- Male FGD participant, Camp 1E

The best examples reflected good listening and consultation practices that close the feedback loop. In the WASH sector, for example, before establishing the drainage system, washroom, and bathroom in the camp, humanitarians called a meeting and asked for suggestions before starting construction (Female FGD, Camp 3). In this example, communication took place in-person and suggestions were taken up in the implementation phase.

Participants shared that NGOs could establish information hubs to ensure that all camp residents have access to the information they need. It is important that the staff at these hubs be Rohingya, as they are present in the camp 24/7, whereas Bangladeshi staff leave after 4 PM. The staff at these hubs should have access to comprehensive information about the camp’s geography and services so that they can help people with various queries. Ideally, there should be at least one information hub for every 5-10 blocks.

While in-person communication was preferred, Rohingya community members in three of eight focus group discussions indicated a preference for loudspeakers which can disseminate more basic information or news across a wide area. They specifically cited challenges that older community members face in accessing information digitally, while many others are unable to read written communication or posters. In our comprehension testing workshop, male participants shared that most people cannot read posters and may be missing out on vital information. On the other hand, if the posters had clear pictures, the main messages could possibly be communicated well. NGO logos, for example, are widely known and understood.

Survey respondents, which included humanitarian staff, demonstrated wide acceptance for the use of local staff, Rohingya volunteers, and audio/visual materials in their day-to-day
communication with Rohingya community members. Respondents (19% out of n = 64) shared that training in language and communication practices was vital to doing their jobs well. Training can be expanded to include modes of communication, including a prioritization of in-person communication for the most critical needs.

Many humanitarians feel that sharing information in Chittagonian is sufficient, but Rohingya community members still feel differently

Many humanitarian respondents felt that several years into the crisis, Rohingya community members were better placed to understand Chittagonian and even Bangla in some cases. However, Rohingya community members felt differently.

“We are only fluent in Rohingya. Although we understand the importance of learning the local language and have been living here for six years, our circumstances have made it difficult for us to learn the local language. Additionally, we are not motivated to learn other languages as our ultimate goal is to return to our home country as soon as possible.”

– Male FGD participant, Camp 3

This issue of motivation is critical – while many responders felt that Rohingya were learning Chittagonian terminology and even some Bangla, Rohingya community members emphasized that their situation was temporary.

Seventy four percent (out of n = 64) of humanitarian responders reported that their organizations use Chittagonian-speaking staff to manage day-to-day communication with Rohingya community members. A further 72% reported that their organizations used Rohingya-speaking volunteers in their work.

Rohingya community members from all eight FGDs shared that they strongly prefer the use of Rohingya language, especially when communicating about private or sensitive matters like reproductive health care. This was discussed the most in relation to the health sector, where specific Rohingya terminology is different from Chittagonian terminology. Poor communication can frustrate a person who is already feeling ill when they visit a clinic and need to spend a lot of time there.

“When we share about our problems with newly joined medical practitioners, they say they don’t understand things such as: fet horani (stomachache), gaalamani (diarrhoea), boiyar (acidity), besuit (paralysed), tecchul (conjunctivitis), utani (scabies). We have an easy time with communication when there are Rohingya volunteers in the health sector.
Because it’s difficult for an ill person to take a lot of time and talk to non-Rohingya speakers.”
– Female FGD participant, Camp 11

Amongst humanitarian respondents there was a sense that Chittagonian is well understood. Thirty-six percent (out of n = 44) of respondents who speak to Rohingya community members regularly will speak in Chittagonian. Local staff, meaning those from Cox’s Bazar, were cited as the most appropriate people to serve in the humanitarian response. However, our research uncovered different perceptions in this respect.

“Critical terminologies cannot be explained well by the Chittagonian dialect. Sometimes community responds as if they understand what is said by a staff though they didn’t understand the matter well.”
– Survey Respondent, Site Management and Site Development

Poor communication can make the difference between understanding critical information or missing out. In the comprehension testing workshop, male participants shared that they did not understand a lot of the terminology in a nutrition sector video that included a lesson on how to grow seeds and plants. The video was in Chittagonian. Whereas humanitarian respondents felt that local staff speaking Chittagonian were well understood, Rohingya community members still felt that they were not well understood.

“As the volunteers are from Rohingya community, we understand everything they say. They come and give us information about vaccines and communicable diseases. But when Bangladeshi people come to visit, we face problems in understanding their language.”
– Female FGD participant, Camp 11

It can also mean that the most vulnerable, including people with disabilities or the elderly, miss out on vital information. Difficult communication or language differences adds to the challenges that many Rohingya community members face when seeking care or services. If not addressed, this can deter people from seeking those services in the future.

Conversely, the use of Rohingya volunteers on the “frontlines” indicated a good practice.

“Their good practice is they appoint Rohingya volunteers which helps us to communicate at service centers. If it takes a lot of time to make them understand our problems, it becomes burden to us to sit patiently because we can’t stay there for so long in weaker physical condition.”
– Older female FGD participant, Camp 11
This issue of time was mentioned by female participants, who take on housework and childcare responsibilities. This leaves little time for other responsibilities and makes it difficult for them to leave home.

**Good language and communication practice is culturally appropriate and depends on empathy and respect**

Using the right language or terminology does not go far enough to ensure good language and communication practice. The best forms of language and communication promote respect and good etiquette in everyday interactions. Rohingya community members discussed the issue of “rudeness” in bad examples of practice. They criticized those interactions with humanitarians when a rude tone of voice or language was used.

“All the people are not the same. Some staff in the Nutrition Sector respect us, treat us well and speak politely. Some treat and behave very rudely. For example: when I went to the Site Management Manager of [NGO] who sits in the Camp-in-Charge (CiC) office, I witnessed that she behaved very rudely with a man who went there with a family card issue. Actually, he went there to get her signature since he was refereed there by another facility. She did not sign and behaved rudely.”
– Male FGD participant, Camp 1E

When asked specifically about good practices in the response, Rohingya participants shared that good practice meant they could walk away from an interaction feeling respected. This might include a staff member who listened, who displayed empathy, or who made extra efforts to help a participant.

“All staff are really very good and help us to understand the language. For example, one staff member asked if we were okay. One time we were waiting and our kids were crying. The staff helped us to be more comfortable and even gave us space for breastfeeding.”
– Female FGD participant, Camp 1E

These examples display the power and importance of kind and empathetic interactions. The Health Sector Strategic Plan (2023-2024) similarly cites the importance of using “friendly language and tone.” This coheres with Rohingya perspectives.

While key informants shared the importance of hiring local staff from Cox’s Bazar who spoke Chittagonian, several key informants described the potential for tensions between local staff and Rohingya community members. This is partly due to ongoing tensions between the host
community and Rohingya refugees. One key informant described how host community members see the kinds of benefits given to Rohingya community members and may feel badly about this.

“When you [a host community members] see this kind of disparity, you know, how people are being treated in the same place, just because you’re Bangladeshi, and just because you’re a refugee, it can create some dissatisfaction. And that might have an impact. I’m not saying it, for sure, I’m just saying what I think that it might have an impact on the you know, behavior and communication skills, they may not be very respectful.”
– Key Informant, WASH sector

Some of these tensions were also described by Rohingya participants. For example, one participant from Camp 24 described how they face problems in the CIC office where children are not registered when they are younger than five years old. He described that the NGO staff do not “trust us” and that “They say we give birth to so many children for the relief and also we are increasing the population in Bangladesh. They say if we take a child when we already have a child below five, they won't enlist them in the data card. That’s why we take some precautions for birth control.”

Our comprehension testing workshops revealed the importance of culturally appropriate materials that help to maintain respect. In one poster, from the nutrition sector, women are not wearing any kind of scarf or hijab, and Rohingya participants shared that this was not considered respectful in their community. In a WASH sector video, the grandmother was wearing a sari and blouse with short sleeves, whereas she should have been dressed in full sleeves which was described as more culturally appropriate.

Inclusion of people living with disabilities in the response is not going far enough

People living with disabilities face unique challenges to sharing and receiving good information. Rohingya participants described the importance of supportive family members or neighbors. Without this support, people living with disabilities would not easily be able to access services or describe challenges that they regularly face. This leaves them even more vulnerable.

“Accessing information is even more challenging for people with disabilities. For example, as someone who is physically impaired and unable to walk, I often struggle to obtain the information I need.”
– Male FGD participant, Camp 3
In the WASH sector, female FGD participants (Camp 3) discussed the challenges that those with visual, hearing or speech impairments face.

“Among people in this community who have visual, hearing or speech impairments, it is not easy for them to communicate with the WASH sector staff. We do not have any platform to go for asking help in the camp and we do not have enough information about where we can find any help for the issues we face regularly.”
– Female participant living with disabilities, Camp 3

This challenge was similar in other sectors, such as nutrition and health. Participants described how it would be very difficult for people living with disabilities, especially hearing or visual issues, to access services at the nutrition centers. In the health sector, long wait times at clinics can especially impact those living with disabilities.

“People with special needs have to wait in the line from morning until evening no matter how difficult it is. Also people who can’t talk suffer the most if they don’t take their family members with them. So we feel like there must be some staff who can communicate with these type of people.”
– Female participant, Camp 11

These challenges were also perceived as important by survey respondents and key informants. Two survey respondents spoke about the need for specialized training and support to understand terminology related to disability. One key informant, working in the nutrition sector, shared that they do pay special attention to the most vulnerable, including undernourished children, pregnant and lactating mothers, and also people living with disabilities. However, given the lack of awareness of these measures, additional efforts may be needed to close the information gap between what is available and what is known to be available to support those living with disabilities.

**Data collection for monitoring, evaluation, accountability and learning sets a good example of how to address language difference**

One promising area of good language and communication practice is in data collection for monitoring, evaluation, accountability and learning (MEAL). One MEAL advisor key informant, working in the nutrition sector, shared the extra measures they take to translate tools into Rohingya, pilot test them, and address any confusion prior to collecting data. Enumerators are selected based on their language knowledge and knowledge of local context.
The importance of in-person data collection was emphasized as well. One key informant from the nutrition sector discussed the importance of collecting data in person to capture information from the most vulnerable and to ensure that people understand each other.

One survey respondent working on data analysis across sectors described how good practices were embedded in their data collection efforts.

“One of the most successful things we did was working intensely and very closely with a small group of data collectors (four) on the purpose, meaning, translation, and implementation of a qualitative assessment which included a kind of PRA approach. This was time consuming, and it was only for a very small sample but we thought the quality of the information was good.”

These findings indicate the importance of taking time prior to starting data collection, to ensure that high quality data are collected.

Complaints and feedback mechanisms are available, but not widely used and many prefer to provide feedback to local community leaders

Rohingya participants described several challenges to providing feedback to different sectors. Firstly, “complaining” is perceived to be rude in Rohingya culture and many may not want to complain or provide feedback as it may “cause a bad scene” (Male FGD participant, Camp 1E). This also relates to feeling like outsiders in the country.

“We do not want to complain about such incidents in the hospital because everyone would blame us since we are immigrants in this country. We do not want to create a scene just for a few medicines. It is embarrassing for us.”

– Male FGD participant, Camp 11

Secondly, language and communication challenges hindered the effectiveness of existing complaints and feedback mechanisms. One participant explained that people do not provide feedback in a suggestion box, because many cannot read or write. While hotlines exist, many do not have access to mobile phones. Participants in four of the FGDs described not knowing how to provide feedback.

“We don’t know such a place where we can give feedback, probably there’s no place for feedback or maybe we don’t know.”

– Female FGD Participant, Camp 11
Thirdly, past experiences with complaints and feedback mechanisms discouraged participants from providing feedback again. Participants felt that feedback loops were not being closed and because of this, it did not make sense to provide feedback again.

“We also do not try to complain or provide feedback anywhere or to anyone because they are not taken seriously.”
- Male FGD participant, Camp 1E

This was also a problem that local community leaders (majhis) seemed to be facing. In cases where they do provide feedback, participants prefer to go through a majhi or Rohingya volunteer, indicating again their preference for in-person communication with a trusted person.

“We do not provide any feedback or complain anywhere. If we have any issues, we inform our Majhis and they deal with issues. Majhi has informed us that they do not provide any feedback or complain anymore, because those are not responded. Before we could ask questions or provide feedback.”
- Male FGD participant, Camp 24

Rohingya participants also discussed current challenges related to family planning and registration of new babies. The issue of family planning was raised in two FGDs, where concerns were raised over side effects that women experienced. Concerningly, male participants in Camp 24 perceived that the lack of action on their feedback had lasting implications on families in the camp.

“Before we could ask questions or provide feedback. Now it is not possible at all and staff do not respond even if we give [feedback]. For example: we used to register our newborn babies without any legal complications. But it has been more than one year that the current CIC has imposed a condition on it. To register the newborn babies, every woman has to get contraceptive implant that lasts up to five years. If they do not take it, the newborn babies will not be registered on the family card. Now there are lots of unregistered new babies whose parents expressed unwillingness to get implanted. After the imposition of this condition, there are so many cases of abortions. Parents are willingly committing random abortion after knowing that they have conceived babies or when the fetus is 4/6/7 months old.”

These perceptions amongst community members warrant further exploration to understand the context of the issue, which seems to include a wider disagreement between the CIC and community members.
We heard from a targeted sample of 50 Rohingya community members and 60 humanitarians

This study was led by a team of international and Rohingya-speaking researchers in February-April 2023. It included Rohingya participants from Camps 1E, 3, 11, and 24. The study utilized the following qualitative research methods:

- Focus group discussions (n = 8) specifically targeting Rohingya participants who had used services from the focus sectors (health, nutrition, WASH, and protection) and 2 comprehension testing workshops (health, nutrition sectors).
- An online survey (n = 64) deployed in December 2022-January 2023 with humanitarian responders across sectors in the response.
- Key informant interview (n = 6) with key informants representing the nutrition, food security, WASH, and health sectors.

All data were translated and transcribed in English by members of the research team. Analysis and writing took place from March-April 2023.
Language and communication practices in the nutrition sector

This short brief focuses on language and communication practices in the nutrition sector. It draws on data specific to the nutrition sector, from focus group discussions with Rohingya community members and key informant interviews and survey respondents with nutrition sector staff. This can be read together with past TWB work for the nutrition sector.

Most Rohingya participants focused on their experiences at the nutrition center (Fushthi haana or Shuzi haana in Rohingya). Rohingya community members would prefer to be consulted before changes are made to the nutrition packets to ensure that food can be eaten.

“We are basically provided blended food by the nutrition sector referred as Shuzi haana by the Rohingya community since it almost looks like semolina in a yellow packet. A few months back the color of that food changed and it tasted very bad. Even the poultry did not eat it. We were provided this for three months. After that, when women constantly complained about this service, they did that with the yellow packet. So, the nutrition sector changed something in their service, but they did not consult with us or inform us.”

– Male FGD participant, Camp 1E

When community members provide feedback, they describe negative experiences in terms of staff responses. One female FGD participant from Camp 1E explained that: “If we tell them anything about what we feel about their services at that time we have to hear a lot of negative terms by the staff of the service center.”

Good practice meant that staff shared information in a timely manner using multiple channels of communication, such as both loudspeakers and community awareness sessions.

“In terms of WFP food distribution, on a monthly basis WFP volunteers come to distribute tokens to the certain target beneficiaries. They also inform the people of the time for collecting/purchasing their foods, how much credit is credited in their food cards and how much they can purchase each of the food items. They share this information through miking. They also have an awareness session with the community on the monthly basis where they inform us of the procedure of purchasing foods in the food shop. We could understand this information since they spoke in our language - Rohingya. When we go to the food shop, we can also communicate well because there are volunteers from host community and Rohingya community.”

– Male FGD participant, Camp 1E
Key recommendations for the nutrition sector include:

- Focus on verbal forms of communication through multiple channels, from loudspeakers in the community, to community awareness sessions for two-way communication. Local leaders (*majhis*) can also be engaged to provide information about program changes.

- Consider community consultations prior to program or nutrition changes, to ensure that foods are culturally appropriate. If this is not possible, consider ways of engaging community members to discuss why certain changes were made and what can be done in the future. Be open, honest, and transparent about challenges.

- Find ways to raise awareness of existing complaints and feedback mechanisms, as many are not aware that these exist.

- Train staff in best language and communication practices, such as how to communicate with respect and empathy. Bad language should not be tolerated in interactions with community members.

- Continue to provide and use glossaries for the nutrition sector, so that correct and culturally relevant terminology can be used in everyday interactions.
Language and communication practices in the WASH Sector

This short brief focuses on language and communication practices in the WASH sector. It draws on data specific to the WASH sector, from focus group discussions with Rohingya community members and key informant interviews and survey respondents with WASH sector staff. This can be read together with past TWB work for the WASH sector.

Many Rohingya participants discussed the specific challenges that women, the elderly, and people living with disabilities face in accessing WASH infrastructures. One Rohingya participant described an example where a neighbor’s son had to carry his elderly mother to the toilet. This was not considered to be culturally appropriate, as the woman was not able to maintain her privacy.

These challenges can be frustrating for those who share feedback but then do not hear back from humanitarian responders again.

“We explain to the people of an NGO about some of our problems of older women who are suffering to go to the toilet and anywhere else because of their physical issues at that time [the NGO] provided the older woman of our family with a bed for sleep at the shelter. Another day they came to see her and ask how she was doing and then they did not follow up again.”
– Female FGD participant, Camp 3

Culturally appropriate infrastructure that maintains privacy and dignity is imperative. This is also gendered, and one key informant from the WASH sector described the challenges that staff face when there are not enough female staff to speak with female community members.

“I can be very good at what I do, but if I’m not able to communicate in the way that they understand and that they can relate to, it’s not going to be very efficient. So, sometimes you know, because of funding because, you know, not a lot of women are applying for different positions and sometimes you know, organizations may have some limitations and they may have male staff taking care of hygiene promotion. So, this can be a bit problematic, then again, taking that into consideration, you know, funding and also identifying the right person can be complicated.”

Key recommendations for the WASH sector include to:

● Ensure that WASH infrastructures are culturally appropriate and enable community members to maintain their dignity and privacy.
• Community volunteers from the WASH sector are well-liked, but often may not close a feedback loop. Consider training volunteers on ways of providing updates after feedback is received.
• Improve honest and open communication, including why certain problems are not being addressed in a timely manner. Community members may not know why a problem is being addressed, but transparent communication can help to address this.
• Consider conducting more culturally-appropriate hygiene promotion sessions, including the use of single gender sessions with female volunteers for female participants and male volunteers for male participants.
Language and communication practices in the protection sector

This short brief focuses on language and communication practices in the protection sector. It draws on data specific to the protection sector, from focus group discussions with Rohingya community members and key informant interviews and survey respondents with protection sector staff.

Rohingya community members strongly preferred in-person communication when discussing information in the protection sector. This provided them with opportunities to ask questions, but also enabled deeper and richer discussions about complex topics.

“In WFS, they provide us some awareness sessions where they talk about child marriage, trafficking, dowry, infant death and all. From these discussions, we can learn a lot of things like if we marry the girls off at an early age, it can be dangerous for a girl to give birth to her children at an early age. Also a malnourished mother will give birth to a malnourished child which can die after birth or can be disabled. Also they tell us how dowry can grow crimes in our social life.”
– Female participant, Camp 24

Survey respondents from the protection and child protection sectors (n = 19) described many different challenges related to language and communication. Specifically, low literacy amongst Rohingya community members and language difference contributed to misunderstandings. While community members would prefer in-person and verbal communication, one survey respondent shared that sometimes community members do not want to attend gatherings or community meetings. Another respondent shared that staff at their organization did not know Rohingya language and faced major difficulties in conducting community sessions.

Despite these challenges, Rohingya community members valued receiving good information about how to access services and report cases of domestic violence.

“They come to our houses to inform us about their services. They have volunteers who belong to our community, they come and provide information about services. Like volunteers from ‘Shanti haana’ (WFS) come and tell when we face any domestic violence, we can go there and put a complaint against the perpetrator, we can go to CIC for data card entry for our children, we can learn tailoring from WFS and earn money for being independent.”
– Female participant, Camp 24

Male participants did not engage much with protection sector services, but preferred to speak about other sectors. Survey respondents shared that engaging with men was a challenge.
Key recommendations for the protection sector include to:

- Hire, engage with, and train Rohingya speaking volunteers to deliver information and community sessions in Rohingya language.
- Prioritize in-person communication when possible, especially for complex or sensitive topics. Consult with available glossaries to understand which terminology is preferred in Rohingya language for these topics.
- Consider novel ways of engaging with community members to improve attendance at community meetings. This might include engaging with men and holding sessions for men around protection issues. It might also include improved engagement with local leaders.
Language and communication practices in the health sector

This short brief focuses on language and communication practices in the health sector. It draws on data specific to the health sector, from focus group discussions with Rohingya community members and key informant interviews and survey respondents with health sector staff. This can be read together with past TWB work for the health sector.

Rohingya community members shared the importance of speaking in Rohingya when communicating their health needs, including through Rohingya speaking volunteers at health facilities. Participants felt particularly frustrated by communication gaps in the health sector, compared to other sectors. This is because when a person goes to the clinic, they are either sick or taking care of someone who is sick. Miscommunication, feeling disrespected, or receiving inadequate or inappropriate services can compound this challenging situation. Further, many Rohingya words are different for health issues and this can lead to misdiagnosis and/or inappropriate treatment. The use of Rohingya volunteers to help with communication in the health facility was cited as good practice, but these volunteers were not always available.

“Although they hire Rohingya volunteers, these volunteers are sent to work in the camp and are not kept in the hospital. As a result, we have difficulty communicating with Bangladeshi staff and doctors. Bangladeshi practitioners do not understand the subtle nuances between Rohingya and Chittagonian. For example, when we say that we have diarrhea, the doctor may prescribe medicine for a simple stomach ache instead of for diarrhea.”
– Male FGD participant, Camp 11

When miscommunication happens in the clinic space, Rohingya patients are left feeling frustrated. Participants shared that staff become “rude” with them, when they cannot fully explain their problem. Improved language and communication practice can help to resolve this issue, but hospital and health facility staff from all backgrounds should display empathy and respect in their everyday interactions.

“Some days ago, I went there for medicine. When I kept my data card on the table, the staff threw my card away and scolded me for not giving it in his hand.”
– Female FGD participant, Camp 11

Rohingya participants shared serious concerns specifically about the use of family planning, including what they perceived to be widespread reports of side effects from implants.

“Even after implant/depo, they don’t come to know what we are going through. Most of the women are facing side effects of implants, they are becoming weak, some are
having anemia as a side effect. It would be better if they come and consult about these things.”
– Female FGD participant, Camp 11

One key informant from the health sector shared good learning for language and communication practices. They shared that it is vital to consider both the language and the medium or channel of communication. While Rohingya volunteers are an important human resource for the response, it is important to also look at formalizing translator roles to fill the language and communication gaps in the sector.

Key recommendations for the health sector:

● Train all health facility staff (including cleaners, security guards, and other support staff) to maintain empathy and respect in interactions with Rohingya community members.
● Employ the use of Rohingya volunteers or trained interpreters at health facilities and hospitals, including female volunteers or interpreters for female patients.
● Ensure staff are trained and equipped with glossaries to enable their use of specific Rohingya language terminology.
● Build on good practices from risk communication and community engagement for epidemic response. Use these good practices for everyday public health community engagement in the response. For example, ensure messages are translated into Rohingya and use preferred channels of communication, typically verbal over written.

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