Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

Evaluation commissioned by: UNDP Bangladesh

Evaluation conducted by: The Nielsen Company (Bangladesh) Limited

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The National Urban Poverty Reduction Programme (NUPRP) is a five-year multi-dimensional poverty reduction programme with numerous interventions covering four million urban poor living in a large number of cities/towns across Bangladesh. The ongoing novel corona virus disease 2019 (COVID-19) outbreak, emerged in Wuhan, China on 31 December 2019, has claimed more than 803,200 lives in 188 countries as of 22nd August 2020 and posed a huge threat to global public health. Considering the impact of COVID 19 pandemic, NUPRP (National Urban Poverty Reduction Programme) implemented by UNDP Bangladesh in partnership with the Local Government Division (LGD), Ministry of Local Government, Rural Development & Cooperatives (MLGRD&C), Government of Bangladesh and supported by the DFID served as a key platform to respond to COVID 19 for the vulnerable urban slum dwellers. The third-party monitoring was carried out to evaluate the emergency response by NUPRP in terms of relevance, effectiveness, efficiency and sustainability.

We are greatly indebted to UNDP, NUPRP, DFID, and the Local Government Division (LGD) of the Ministry of Local Government, Rural Development & Cooperatives (MLGRD&C) for entrusting us with the responsibility to undertake Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme. With the continuous and prompt support of the NUPRP team, we were able to successfully complete the study.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

The ongoing novel corona virus disease 2019 (COVID-19) outbreak, emerged in Wuhan, China on 31 December 2019, has claimed more than 803,200 lives in 188 countries as of 22nd August, 2020 and posed a huge threat to global public health. In Bangladesh, the presence of COVID-19 cases was first detected officially in three people on 8 March, 2020. As of 22 August 2020, the Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh has confirmed total 3,822 deaths from the COVID-19 with a total of 287,959 people infected. During COVID 19 pandemic, the lockdown imposed by Bangladesh government from 26th March 2020-31st May 2020, has obstructed the livelihoods of 85% of the country's working population currently employed in the informal sector[1]. Lack of proper employment benefits and compensation structure for these workforce members, especially the slum dwellers make them the most vulnerable group during this national economic shock. The majority of these workers belong to the low income and lower middle income brackets and most of them make just enough to cover their living expenses while residing in the urban peripheries. This has severe impact on the nutritional food intake of these poor people making them more vulnerable.

Considering the impact of COVID 19 pandemic; NUPRP (National Urban Poverty Reduction Programme) implemented by UNDP Bangladesh in partnership with the Local Government Division (LGD), Ministry of Local Government, Rural Development & Cooperatives (MLGRD&C), Government of Bangladesh and supported by the DFID served as a key platform to respond to COVID 19 for the vulnerable urban slum dwellers. The third-party monitoring was carried out to evaluate the emergency response by NUPRP in terms of relevance, effectiveness, efficiency and sustainability.

Mixed methodology was applied for evaluation using stratified random sampling technique. Both the quantitative and qualitative approach was adopted for the evaluation. One to one surveys were conducted with the vulnerable affected people in urban settlements whereas qualitative data was collected through In-depth interviews, case studies, Key Informant Interviews with the relevant stakeholders such as project management team, Local government officials, town managers, CDC members, health officials, coordination function members, and beneficiaries. A total of 4,100 beneficiaries and 440 non-registered community members were surveyed and 162 Key Informant Interviews (KII), 158 in-depth interviews and 40 case studies were conducted with different stakeholders. Due to lockdown during COVID 19, travel to field was restricted. Post lockdown (May 30, 2020), the number of COVID 19 infected people and the number of deaths were increasing every day. Considering the increasing number of COVID 19 infected people and deaths, Nielsen global policy also restricted face to face data collection in order to avoid transmission of COVID 19 among the respondents as well as the enumerators. Hence, it was not possible to conduct face to face interview during that time. Data collection was done over telephone.

Relevance: Considering the situation of the poor people living in urban slums, NUPRP has done 'rapid risk assessment & resource mapping' for the planning of intervention for the vulnerable people and to identify how NUPRP can support City corporation/Paurashovas (Municipality) during the outbreak. The programme also developed overall Rapid COVID -19 Situation Report for different

[1]Impact of Coronavirus on Livelihoods: Low- and Lower Middle-Income Population of Urban Dhaka, Light Castle, https://www.lightcastlebd.com/insights/2020/04/30/impact-of-coronavirus-on-livelihoods-low-and-lower-middle-income-population-of-urban-dhaka

Cities/Towns and the report was shared with the local government stakeholders. These activities have helped UNDP and government stakeholders to identify the needs of the cities during COVID 19. Based on the assessment, NUPRP has undertaken communication and outreach activities, established Hand washing facilities and distributed hygienic package, food Assistance & cash transfer for Urban Poor. The NUPRP team has also maintained liaise with the local health institutes and service providing agencies to ensure delivery of health services for the COVID 19 patients.

NUPRP has ensured that the most vulnerable people receive the emergency response. They have considered MPI (Multidimensional Poverty Index) to select the beneficiaries and verified all the beneficiaries before providing the emergency support. All the vulnerable groups including female headed households; people with disability, elderly people, transgender, minor and children were given priority to provide the emergency response.

Efficiency: The project operations team closely worked with the Project Management as well as UNDP senior management to take certain decisions in relations to procurement of certain goods and services considering the sensitivity and shortage of time. For this, UNDP has shortened the procurement processing time during COVID 19 from 21 days to 7 days. The procurement team has faced tremendous challenges in procurement and distribution of different goods during the lockdown period. The majority offices except few essential services were closed during that time. The team also ensured the timely delivery of the major emergency response items to the field offices. To ensure prompt response, the team adopted alternative approaches to ensure timely delivery of goods to the field offices. The team has managed the cost as per plan and has been able to save some funds. The team utilized various opportunities of networking for procuring certain goods in a cost effective way and distributed those to the communities very efficiently and within a very short period. Although the majority of the items were procured and distributed within standard procurement time, different stakeholders i.e. government stakeholders and town managers felt that the response time for emergency programmes should be faster than the standard procurement time considering the crisis situation. The UNDP senior management and programme team also emphasized on the capacity building of the operations team to work in a more efficient way.

Effectiveness: UNDP NUPRP has worked at city/municipal level to support local governments to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tensions. Under this, four major activities were initiated by NUPRP team; those were Strengthening Coordination Function, efficient Operation & management, Sensitization and Capacity Building of Health Officials, and Data, Research & Third-Party Monitoring. In addition, the team also worked at community level in order to ensure the access to basic human rights by urban poor during the COVID crisis. Communication & outreach, Establishing Hand washing Facilities and Hygienic package, and Food Assistance & Cash Transfer for Urban Poor were the three major activities at the community level.

The NUPRP team strategically engaged with local government stakeholders to response and coordinate. By May 2020, all the 20 cities/towns where NUPRP is working took the preventive measures within urban settlements in terms of awareness raising activities, relief distribution, tracking the COVID 19 cases and imposing immediate lockdown where the COVID 19 cases were identified, establishment of hand washing corners, distribution of personal protection equipment and so on. The town managers in all cities/towns shared the list of Primary Group (PG) members with local government and different development organizations for selecting most vulnerable

households of the low-income settlements for food assistance during COVID 19 outbreak. 70% of the government stakeholders reported that they are using the NUPRP database. Using the list of NUPRP, the local government also distributed relief among poor vulnerable people in order to avoid any duplication. It has increased the efficiency as the list has helped them to reach more people for relief distribution. Some coordination problems were identified between the NUPRP team and government stakeholders because of the poor coordination of NUPRP with the Ward Level Relief Taskforce. There was disagreement between Ward Level taskforce & NUPRP team in terms of selection of beneficiaries for relief distribution. In many places, there was a high demand from the Ward Councillors /Taskforce members for expanding the food assistance beyond the NPRP intervention areas. It was not possible for the town teams to provide any support to the people who were not listed in the beneficiary list. As a result, some of the government officials were dissatisfied with the emergency response of UNDP NUPRP team. In addition, due to lockdown and fear of COVID 19 transmission, it was not possible to conduct regular meetings with government stakeholders in some cities.

In order to ensure poor people getting access to primary health care services and to build capacity of the health professionals and workers, UNDP NUPRP planned to provide online training and Personal Protection Equipment. Due to global procurement of the PPE, there was substantial delay in distributing the PPE to health professionals and workers. A total of 605 PPE was procured and majority of items were handed over to the health officials and health workers between the months of June and July. The remaining items were distributed by the month of August 2020. In addition, the NUPRP team also disseminated online resources and training of COVID-19 of DGHS, GOB link to 385 health officials and workers. Having personal protective equipment along with online training on proper use of those materials helped the health professionals and workers to overcome their fear to work at the front line to some extent.

NUPRP team adapted two types of monitoring mechanism; internal – for verification of the beneficiary selection and for daily reporting & external - Third Party Monitoring for independent evaluation of the emergency response. UNDP NUPRP had the list of beneficiaries prepared in 2018 which helped the team to select the right beneficiary and to response quickly. However, there were issues like some beneficiaries did not have any mobile number, some numbers were closed; some beneficiaries changed their mobile number, digit missing in phone number etc. Therefore the NUPRP team undertook 100% pre verification in 19 cities before relief assistance in order to ensure that the right person is getting the emergency response. During lockdown, it was very challenging to implement the verification process and daily monitoring in the field due to isolation, restricted movement and fear of COVID 19 transmission. Still multiple verification exercises were carried out for different initiatives through mobile and physical verification. This exercise also helped to track the number of HH who have migrated. Town wise trackers were implemented immediately to track the activities across 20 Cities as the coverage was huge and the activities were being implemented in a phased manner. This helped to inform the weekly reporting which was shared with the programme team members and government stakeholders to track the progress against the major indicators.

The operations and management team of NUPRP faced tremendous challenges to procure goods during COVID 19 pandemic. Due to unavailability of transportation during lockdown period, the procurement and delivery of goods were a major challenge. Most of the suppliers and manufacturers couldn’t open their office/factory during that time. Ready stock was also very limited.

In terms of printing communication materials, vendors were not in a position to print because of scarcity of printing materials, limited transportation and workforce due to lockdown. In terms of hygienic package, 1,300 Raincoat, 1,300 Gumboot, 5,200 Hand Sanitizer, 65,000 Hand Gloves and 35,000 mask for the project staff. To support communication and outreach, the operation and management team procured 14,352 festoons, 3178 booklets, 74,360 posters and 148,720 stickers.
At community level, UNDP NUPRP has facilitated mass awareness campaign to spread key messages for COVID 19 prevention in 20 cities through producing & distributing IEC/BCC Materials (poster, festoon, booklet, sticker), loudspeaker announcement in slum areas as well as through local cable TV operator and local media, sharing SMS to Primary Group Members & slum inhabitants, advocacy with media forum (press release on daily newspapers) and media broadcast (ETV) and post sharing in social media. A total of 22 articles were also published by print and digital media. Multimodal communication initiatives of the programme have increased awareness level of slum residents in 20 cities/towns and help them to take precautionary measures to prevent COVID-19. All the respondents (100%) reported increase in their level of awareness on COVID 19 which was 72% before the NUPRP emergency response started.

To encourage healthy WASH habits & practices during COVID 19, UNDP NUPRP team provided 2.6 million soaps and established 3,256 hand washing corners at different important locations of the urban slums. As the result of awareness raising activities, soap distribution and hand washing corner establishment, all the households (100%) are practicing hand washing and also installed 2,341 tippy-taps with their own resources.

In order to support the livelihood of the NUPRP beneficiaries during COVID 19, the team has provided onetime cash transfer/food basket 77,560 HHs. Due to fund shortage it was not possible to provide livelihood support to all the NUPRP beneficiaries. Around 21 percent of the beneficiaries received livelihood support and among those 4% households were from High MPI, 19% households were from medium MPI and 77% households were from low MPI. 89% of the beneficiaries expressed their satisfaction on access to services and information provided by LG/NUPRP. With respect to MPI, it is 92% from high MPI and medium MPI. The team faced several challenges to provide food basket and cash assistance. Many Primary Group Households did not have the mobile phone, Rocket Account or did not provide the accurate mobile number which made the cash transfer difficult. On the other hand, the transportation services were closed during lockdown. As a result, the NUPRP team could provide food basket only in Dhaka North and Dhaka South City Corporation. The distribution of food basket to selected beneficiaries also created animosity among the community members.

Based on the findings discussed above, the following recommendations are made considering the future activities of NUPRP

Preparedness for second wave of COVID 19:

- There is prediction that the second wave of COVID 19 will start very soon in different countries. Based on the experience of COVID 19 emergency response and lessons learnt, UNDP should be better prepared and more efficient in terms of fund arrangements, coordination with government and other development agencies, capacity building of the relevant stakeholders and providing WASH and food/cash to the affected population. UNDP should revisit its' system and make necessary changes in the process of procurement & operations to response faster in any future emergency. There might be a chance of not

getting grants as much as the first wave of COVID 19. UNDP NUPRP should also explore the potential sources of grant so that the programme can response with adequate resources.

AT COMMUNITY AND CDC LEVEL:

- In current context, the major challenge would be to support the livelihoods of the poor people living in urban settlements. UNDP NUPRP is carrying out the socio economic assessment in order to assess to impact of COVID 19 on their livelihoods. It is also imperative to carry out rapid labour market assessment to have in depth understanding about the impact of COVID 19 on labour market. Based on the findings, UNDP NUPRP can go with partnership with NGOs i.e. BRAC, Grameen Bank, ASA, BURO to provide micro loan at easier terms. This would help the beneficiaries of NUPRP to restore their livelihood options.
- Though CDC members have formed the savings fund and have received training on this, there was no mention on how they have utilized the savings during COVID 19 pandemic. UNDP NUPRP needs to build a mechanism so that the savings and credit groups can deal with a crisis like COVID-19.
- The COVID 19 affected the dietary practice and nutritional food intake of the NUPRP beneficiaries. The situation of people of disability, elderly people, and single female headed household was found to be worse. In addition, pregnant women, lactating mother and mother of children under 5 years also need special attention. Providing them nutritional food packages and continuing nutritional counselling on how they can ensure balanced diet for the family members with low cost during COVID 19 pandemic would bring better result.
- FAO is implementing urban agriculture targeting urban poor people. UNDP NUPRP can collaborate with FAO for technical assistance and can promote urban agriculture among beneficiaries so that they can cultivate vegetables and fruits and can fulfil the nutritional requirements of them as well as their family members.
- The CDC members prepare the Community Action Plan every year and track the progress periodically against the action plans. This plan also includes the disaster preparedness. More focus should be given on disaster preparedness & coping mechanism in future so that the poor vulnerable people can be better equipped for any future disaster management.
- Considering the risk of working during the emergency situation, NUPRP should introduce the provision insurance and risk incentives for frontline staff and CDC leaders. It would provide them the sense of security while working in the emergency situation.
- The government stakeholders felt that the CDC leaders are very good at execution but more focus should be given to build the leadership among them. More training can be provided on leadership, negotiation, empowerment, financial management so that they can be better equipped for any future disaster.

AT GOVERNMENT LEVEL:

- Coordination among different stakeholders i.e. government stakeholders and development partners working in COVID response was a vital factor to ensure the success of the emergency response. This pandemic has blurred the boundaries between sectors. The interdependencies are more pronounced than ever. UNDP NUPRP should continue the Multi-sectoral, multi-partner coordination mechanism so that all the government stakeholders and development partners can work in a uniform way for the development of the poor urban people.

- Some reports were found on the lack of coordination between NUPRP team and Ward Level Task Force. The NUPRP team should look into the issue and should work more closely with the Ward Level Task Force in future.
- UNDP NUPRP can request the government stakeholders to ensure the representation of the CDC leaders in all Ward Level Task Force & Ward Level Relief Committees. This would enable the CDC leaders to raise the voice of poor people and to influence the government stakeholders to take actions based on the needs of poor people.
- NUPRP should continue working closely with the government health professionals and workers to build capacity of them. More online training resources can be provided on COVID 19. This would enable them to work more efficiently and would ensure the access of poor people to general health care services.
- In addition, NUPRP can build capacity of the government health professionals and workers to launch the telemedicine service for the urban poor people. This would help the poor people to receive medical consultations without paying visit to general health facilities. However, it should be noted that majority of the poor people do not have access to mobile phone and internet connection. Capacity development of the CDC leaders to establish and manage the call centres at low cost in their community would enable them to get quick services. This would also reduce the risk of COVID 19 transmission as both the doctors and patients do not need to have face to face meeting.

OPERATIONS:

- Different UN organizations have Long term agreements (LTA) with vendors for the supply of different goods/services. The operations team should develop a MIS in collaboration with the operations team of other UN organizations so that all can use the MIS during crisis situation.
- The operations team should have contingency plan and should focus on decentralization of vendors in order to respond faster for future emergency response.
- The operations team can collaborate with Mobile Financial Service providers to open one mobile wallet for all the NUPRP beneficiaries/family members (in case the beneficiary does not have mobile phone). This would help the team to transfer cash instantly for any future programme. It would also resolve the problem of NID (National Identity Card) number verification.
- Different initiatives should be taken to increase the capacity of operations team. Different forms of training, learning sharing across different programmes/countries/UN organizations on emergency response, apprenticeship or job placement in the emergency response countries would increase the capacity of the operations team.

MONITORING:

- The NUPRP had the database of beneficiaries which helped the team to target the people for emergency response as well as to respond faster. Periodic verification is required to ensure that all the critical information is updated so that UNDP NUPRP can take informed decision in any future crisis situation.
- Based on the learning from COVID 19 emergency response, the NUPRP has already made it mandatory to collect the photographs and NID (National Identity Card) of all the newly registered beneficiaries. Collecting the photographs and NID will enable NUPRP to make the cash transfer faster in any future emergency.

- Adapting mobile based data collection and providing capacity building training to the CDC leaders and frontline workers would help to collect periodic data on critical indicators.
- It is imperative to develop a mechanism amongst UN agencies to share data about urban poor. It will enable to UN agencies who are working with urban poor to response faster. UNDP can push for this within the UN System.

WASH:

- In terms of WASH, NUPRP should look beyond COVID-19 crisis to ensure handwashing habit is sustained and is not limited to the fears of corona. It should continue to advocate the NUPRP beneficiaries that handwashing with soap at critical times has a lifetime health benefit. It is one of the most cost-effective preventive health interventions.
- The monsoon flood of the year 2020 has an overall impact on the Northern, North-Eastern and South-Eastern region of Bangladesh. The Monsoon floods coupled with prolonged inundation and the COVID-19 pandemic has an exacerbating effect on the flood affected people. Therefore, making 2020 monsoon flood more complex than ever; as there is an important practice of social distancing and handwashing which is quite impossible to maintain as flood affected people are displaced and are evacuating to shelters where it is congested and WASH facilities are also compromised. Due to acute shortage of food, pure drinking water and poor sanitation system, there is a possibility of communicable disease outbreak when flood water will start receding; there is potential threat that COVID-19 can spread very fast among the people staying in the flood shelters[2]. Considering the situation, UNDP NUPRP should closely monitor the situation of WASH in their flood affected working areas and should ensure the

    - ✓ Provision of safe drinking water through repair/rehabilitation of damaged water points, tube wells, hand washing corners established by NUPRP during COVID 19.
    - ✓ Provision of adequate sanitation facilities through repair/construction of damaged latrines/new temporary latrines and soap distribution for the most vulnerable people, including those with disability, female headed households and elderly people.

COMMUNICATION & OUTREACH:

- Reinforcing capacity of CDC leaders and engage them to promote key behaviours related to hygiene, handwashing with soap at critical times, use of hygienic/basic latrines, use handwashing stations with soap; water safety, stop gender based violence, child marriage during COVID 19.
- UNDP NUPRP should continue engaging the religious leaders, school teachers and other community influential to disseminate the important messages on COVID 19, gender based violence, child marriage, school dropout & child labour in order to create better result.
- Considering the literacy level of the urban slum dwellers, UNDP NUPRP should focus on pictorial communication materials & interactive communication mode in future communication campaign.

[2] Monsoon Floods 2020 Coordinated Preliminary Impact and Needs Assessment, accessed from https://reliefweb.int/sites/reliefweb.int/files/resources/nawg_monsoon_flood_preliminary_impact_and_kin_20200725_final_draft.pdf

FOCUS ON CROSS CUTTING ISSUES:

- There are several reports that the COVID 19 has impact on the increase of gender based violence. NUPRP should continue the awareness raising initiatives to stop domestic violence, child marriage & child labour issues and to encourage parents to continue the study of their children.
- Bangladesh government has established OCCs (one stop crisis centre) in each district. One-Stop Crisis Centres help women and children who have fallen victim to violence by offering integrated services starting from medical support to helping file cases against the perpetrators. NUPRP can collaborate with OCCs to support women and children if there is report of GBV.
- UNDP NUPRP can initiate psychosocial services/counselling for the individuals/families who lost family members or lost income generating opportunities.

LIST OF ACRONYMS

AV	Audio Visual
BCC	Behaviour Change Communication
CAPI	Computer Assisted Personal Interview
CC	City Corporation
CDC	Community Development Committee
CO	Community Organization
COVID-19	Corona virus Disease 2019
DFID	Department for International Development
DGHS	Directorate General of Health Services
DMCC	District Multi-sectoral Coordination Committee
DNCC	Dhaka North City Corporation
DRRC	District Rapid Response Committee
DSCC	Dhaka South City Corporation
IEC	Information, Education Communication
IEDCR	Epidemiology, Disease Control and Research
FGD	Focus Group Discussion
GoB	Government of Bangladesh
HH	Household
IDI	In Depth Interview
KII	Key Informant Interview
LGD	Local Government Division
MC	Municipality Corporation
M&E	Monitoring and Evaluation
MIS	Management Information System
MPI	Multidimensional Poverty Index
MLGRD&C	Ministry of Local Government, Rural Development & Cooperatives
NUPRP	National Urban Poverty Reduction Programme
PG	Primary Group Members
PHQ	Primary Head Quarter
PPE	Personal Protection Equipment
SDG	Sustainable Development Goals
SOD	Standing Orders on Disaster
SMS	Short Message Service
ToR	Terms of Reference
ULG	Urban Local Government
UNDP	The United Nations Development Programme
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

RESULT FRAMEWORK					
DFID supported n COVID-19 Response National Urban Poverty Reduction Programme (NUPRP)					
Indicator 1		**Baseline**	**March**	**April**	**May**
Number of COVID-19 cases nationwide	*Planned: Number of Cases (Cumulative)*	N/A			
	Achieved: Number of Cases (Cumulative)	N/A	51 (March 31, 2020)	7616 (April 30, 2020)	17454 (May 31, 2020)
Indicator 2		**Baseline**	**March**	**April**	**May**
Number of Towns/Cities that have preventative measures in place within urban poor settlements.	*Planned: Number of Cities/Towns (Cumulative)*	0	15	19	20
	Achieved: Number of Cities/Towns (Cumulative)	0	16	19	20
DFID (£m)		**Govt. (£m)**	**DFID (£m)**	**Total (£m)**	**DFID (%)**
Indicator 1.1		**Baseline**	**March**	**April**	**May**
Proportion of affected population expressing satisfaction on access to services and information provided by LG/NUPRP	*Planned: % of Households (Cumulative)*	0	20	60	100
	Achieved: % of Households (Cumulative)	0	N/A	N/A	89
Indicator 1.2		**Baseline**	**March**	**April**	**May**
Proportion of Local Governments using the NUPRP database for relief activities for urban poor	*Planned: % of Cities/Towns (Cumulative)*	0	20	60	100
	Achieved:% of Cities/Towns (Cumulative)	0	N/A	N/A	70
Indicator 2.1		**Baseline**	**March**	**April**	**May**
Proportion of people practicing hand washing at the community and household level	*Planned: % of HH (Cumulative)*	N/A	40	70	100
	Achieved: % of HH (Cumulative)	0	N/A	N/A	100
Indicator 2.2		**Baseline**	**March**	**April**	**May**
Proportion of Households with High/Medium/Low MPI have access to food/cash to meet basic needs	*Planned: % of HH (Cumulative)*	0	N/A	20	100
	Achieved: % of HH (Cumulative)	0	N/A	N/A	21
DFID (£m)			**Govt (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 1.1		**Baseline**	**March**	**April**	**May**
Proportion of Cities/Towns with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	*Planned: Number of Cities/Towns (Cumulative)*	0	15	18	18
	Achieved: Number of Cities/Towns (Cumulative)	0	14	18	18
Indicator 1.2		**Baseline**	**March**	**April**	**May**
Level of engagement by the NUPRP Town teams at the	*Planned: Level of Engagement*	N/A	40	70	100

DFID supported n COVID-19 Response National Urban Poverty Reduction Programme (NUPRP)					
City/Ward level Taskforce Meeting to coordinate COVID response	*(Cumulative)*				
	Achieved: Level of Engagement (Cumulative)	N/A	N/A	N/A	High 50%, Medium 22%, Low 27%
DFID (£m)			**Govt (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 2.1		**Baseline**	**March**	**April**	**May**
Number of health personnel and workers who received complete set of PPE	*Planned: Number of health personnel (Cumulative)*	0	0	0	430
	Achieved: Number of health personnel (Cumulative)	**0**	0	0	0 (By May, 2020) 605 (by August, 2020)
Indicator 2.2		**Baseline**	**March**	**April**	**May**
Number of Cities health officials and workers who have undergone the online training of COVID 19 of DGHS, GOB	*Planned: Number of health personnel (Cumulative)*	0	0	50	200
	Achieved: Number of health personnel (Cumulative)	0	0	105	385
DFID (£m)			**Govt. (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 3.1		**Baseline**	**March**	**April**	**May**
Number for Cities/Towns who undertook 100% pre verification for relief assistance	*Planned: % of verification(Cumulative)*	0	N/A	19	19
	Achieved: % of verification(Cumulative)	0	N/A	19	19
Indicator 3.2		**Baseline**	**March**	**April**	**May**
Number of Cities/Towns reporting on M&E Trackers for Weekly Reporting	*Planned: Number of Cities/Towns (Cumulative)*	0	19	19	19
	Achieved: Number of Cities/Towns (Cumulative)	0	19	19	20
DFID (£m)			**Govt (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 4.1		**Baseline**	**March**	**April**	**May**
Number of Hygienic Package procured (Raincoat; Gumboot; Hand Sanitizer; Hand Gloves; Mask)	*Planned: Number of Hygienic Package(Cumulative)*	0	0	Raincoat-1,129; Gumboot-1,129; Hand Sanitizer-4,516; Hand Gloves-56,450 and Mask-33,870	Raincoat-1,300; Gumboot-1,300; Hand Sanitizer-5,200; Hand Gloves-65,000 and Mask-35,000
	Achieved: Number of Hygienic Package(Cumulative)	0	0	Raincoat-1,069; Gumboot-1,069; Hand Sanitizer-3,991; Hand Gloves-56,450 and Mask-29,524	Raincoat-1,129; Gumboot-1,129; Hand Sanitizer-4,715; Hand Gloves-56,450 and Mask-42,265

DFID supported n COVID-19 Response National Urban Poverty Reduction Programme (NUPRP)					
Indicator 4.2		**Baseline**	**March**	**April**	**May**
Number of communication materials procured (Poster, Festoon, Sticker and Booklet)	*Planned: Number of communication materials (Cumulative)*	0	0	37,000 Festoons; 5,000 Booklets; 130,000 posters; 160,000 Stickers	37,000 Festoons; 5,000 Booklets; 130,000 posters; 160,000 Stickers
	Achieved: Number of communication materials (Cumulative)	0	0	3 Festoons; 206 Booklets; 56,600 posters; 31,000 Stickers	14,352 Festoons; 3,178 Booklets; 74,360 posters; 148,720 Stickers
Indicator 5.1		**Baseline**	**March**	**April**	**May**
Proportion of people reported increase in their level of awareness on COVID 19.	*Planned: % of people (Cumulative)*	72	72	80	100
	Achieved: % of People (Cumulative)	72	72	80	100
Indicator 5.2		**Baseline**	**March**	**April**	**May**
Number of Articles published by the print & digital media	*Planned: Number of Media Articles (Cumulative)*	0	N/A	10	15
	Achieved: Number of Media Articles (Cumulative)	0	N/A	10	22
DFID (£m)			**Govt (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 6.1		**Baseline**	**March**	**April**	**May**
Number of Town staff using Personal Protection Equipment (PPE) gear to undertake field operations	*Planned: Number of Towns (Cumulative)*	0	0	1,034	1,034
	Achieved: Number of Towns (Cumulative)	0	0	1,009	1,034
Indicator 6.2		**Baseline**	**March**	**April**	**May**
Number of Hand washing Corners that are accessible to people at the Household/CDC area	*Planned: Number of HW Corners (Cumulative)*	0	0	2,317	2,367
	Achieved: Number of HW Corners (Cumulative)	0	0	2,886	3,256
Indicator 6.3		**Baseline**	**March**	**April**	**May**
Number of people who have access to soaps for hand washing from NUPRP	*Planned: Number of People (Cumulative)*	0	N/A	2.2m	2.2m
	Achieved: Number of People (Cumulative)	0	N/A	2.2m	2.6m
DFID (£m)			**Govt (£m)**	**DFID (£m)**	**Total (£m)**
Indicator 7.1		**Baseline**	**March**	**April**	**May**

DFID supported n COVID-19 Response National Urban Poverty Reduction Programme (NUPRP)					
Number of households who are most vulnerable to COVID-19 have received livelihood support, e.g. cash transfers, food basket, etc.	*Planned: Number of households (Cumulative)*	0	N/A	7,900	69,686
	Achieved: Number of households (Cumulative)	0	N/A	7,900	77,560 (Food Basket 7,900, Cash Transfer 69,660

CHAPTER ONE: INTRODUCTION

1.1 PRELUDE

The ongoing novel corona virus disease 2019 (COVID-19) outbreak, emerged in Wuhan, China on 31 December 2019, has claimed more than 803,200 lives in 188 countries as of 22nd August, 2020 and posed a huge threat to global public health.

Brief Timeline of COVID-19

31 December 2019

China reported a cluster of cases of pneumonia in Wuhan, Hubei Province

11 January 2020

China announces first death

30 January 2020

WHO declares the outbreak a global health emergency

11 February 2020

WHO names the virus COVID-19

8 March 2020

In Bangladesh the presence of COVID-19 case was first detected officially

11 March 2020

WHO declares COVID-19 outbreak a pandemic

22 August 2020

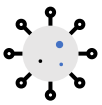
A total of 23,117,813cases are identified &803,200 people are died

Global Situation

Total confirmed cases
23,117,813

Total deaths
803,200

Total recovered
15,709,677



Source: https://www.who.int/news-room/detail/08-04-2020-who-timeline---covid-19/
https://www.worldometers.info/coronavirus/

Top 3 affected countries

By confirmed cases	USA 5,796,727	Brazil 3,536,488	India 2,973,368
By death	USA 179,200	Brazil 113,454	Mexico 59,610

In Bangladesh, the presence of COVID-19 cases was first detected officially in three people on 8 March, 2020. As of 22 August 2020, the Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh has confirmed total 3,822 deaths from the COVID-19 with a total of 287,959 people infected[3].

Total Deaths: **3,822**

Total Recovered: **165,738**

Total Quarantine: **473,741**

Release from quarantine**:** **420,269**

Source: JHU CCSE (https://data.humdata.org/dataset/novel-coronavirus-2019-ncov-cases), DGHS, DHIS2(http://103.247.238.81/webportal/pages/covid19.php)

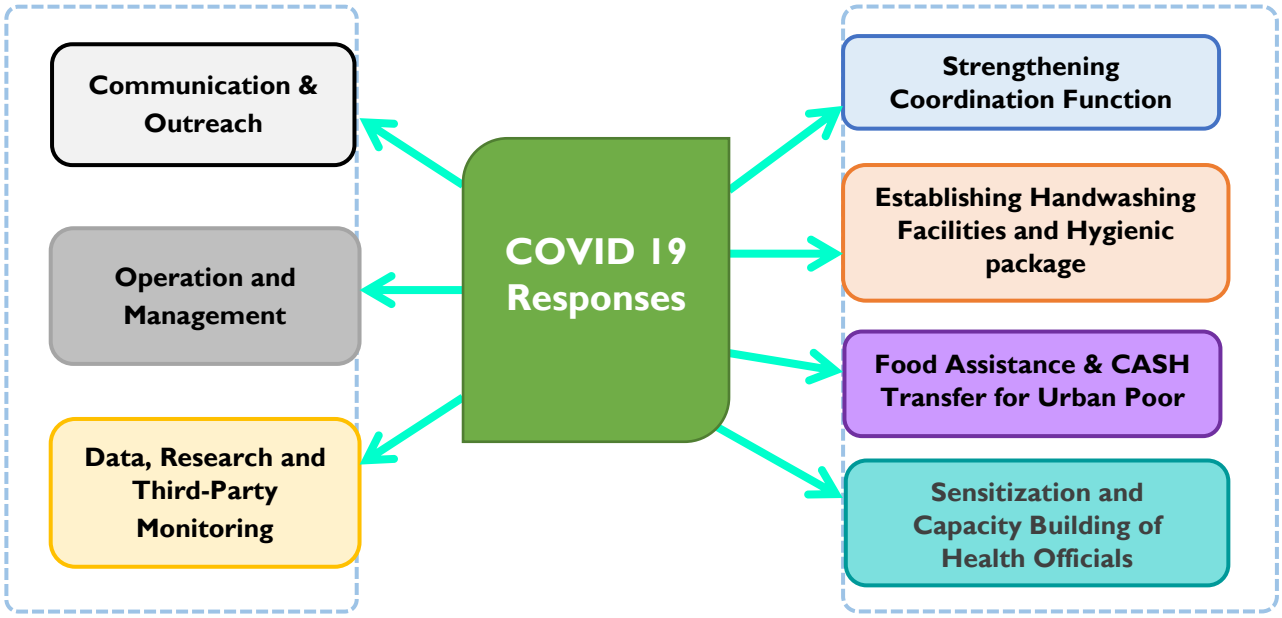
In the urban areas, extreme poor people suffer severely from lack of access to basic health and nutrition care services. High prevalence of chronic malnutrition coupled with inadequate access to health services makes the urban poor in the slums more vulnerable to various health problems. Currently, in Bangladesh there is no formal integrated state healthcare delivery system in the urban areas. Millions of people are living in the urban low-income communities in overcrowded conditions with inadequate sanitation and WASH (water, sanitation and hygiene) facilities. As these low income communities lack proper sanitation, when the common people are being advised to wash their hands repeatedly with soap and water to prevent COVID-19, they do not have adequate access to sources in reality to comply those advisories. Moreover, they are often left out of disaster and epidemic preparedness planning during crisis situation. If the corona virus spreads to the low-income community, the transmission will rapidly spread, resulting in severe uncontrollable outbreak. It also needs to be noted that the progress against the Sustainable Development Goals (SDG) in Bangladesh is going to be also impacted by this pandemic.

NUPRP (National Urban Poverty Reduction Programme) implemented by UNDP Bangladesh in partnership with the Local Government Division (LGD), Ministry of Local Government, Rural Development & Cooperatives (MLGRD&C), Government of Bangladesh and supported by the DFID served as a key platform to respond to COVID 19 for the vulnerable urban slum dwellers.

NUPRP is closely working in partnership with 20 City Corporations/Paurashavas with around 2.16 million slum dwellers grouped under around 2,300 Community Development Committee (CDC). Around 1,200 community staffs work at the forefront of NUPRP's implementation on the ground through community mobilization process.

[3]https://corona.gov.bd/

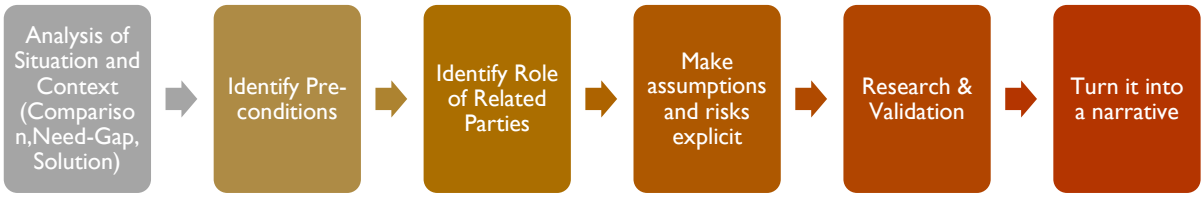
NUPRP's COVID 19 responses included the following:



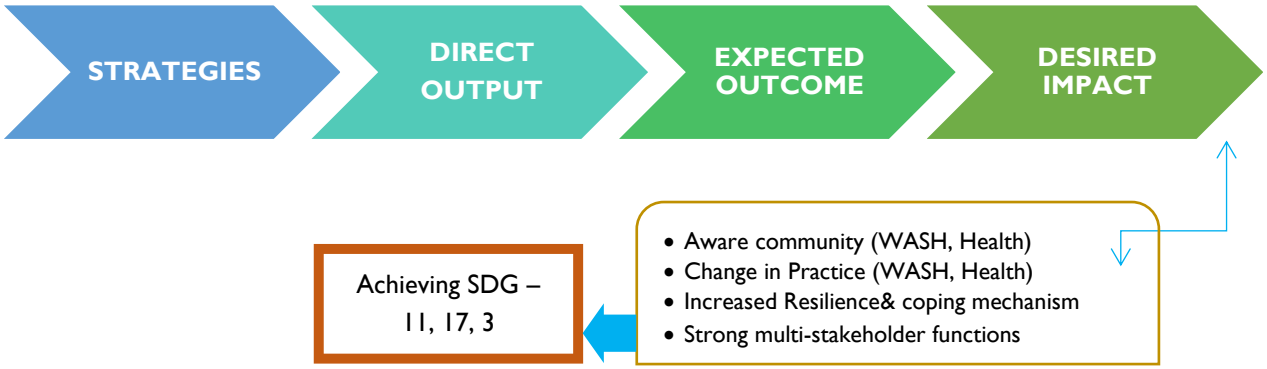
The study was initiated by UNDP to assess the NUPRP's emergency COVID 19 responses in terms of relevance, effectiveness, efficiency, sustainability and to document good practices & lesson learned.

1.2 UNDP EMERGENCY RESPONSE & THEORY OF CHANGE

Theory of change defines how people believe that change could be made to happen and outlines the main elements for that change. Understanding the process includes the following steps –



NUPRP works for the comprehensive development of urban slum communities along with the local Government & MLGRD&C. Life & livelihood of slum dwellers have been affected by COVID 19 pandemic and subsequent lock-down measures declared by the GoB. As part of the national preparedness & response, NUPRP project has done 'rapid risk assessment & resource mapping' for planning intervention, to support City corporation/Paurashovas (Municipality), identify space for isolation of the infected people and potential partner and donors to work on the outbreak. Overall Rapid COVID -19 Situation Report from the Cities/Towns was developed and shared. Risk matrix was updated & shared with stakeholders. These activities have helped UNDP and government stakeholders to identify the needs of the cities during COVID 19. NUPRP has also identified how multiple stakeholders could take part in emergency response and has designed plan of actions accordingly. The emergency response activities undertaken by the NUPRP team focused on ensuring 3 sustainable development goals those are SDG-11 (Sustainable cities & communities), SDG-17 (Partnership For goals) and SDG-3 (Good health & wellbeing).



Outcome 1: City/Municipal level - Local Governments are supported to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tensions

To achieve outcome-1, four major activities were initiated by NUPRP team; those were Strengthening Coordination Function, efficient Operation & management, Sensitization and Capacity Building of Health Officials, and Data, Research & Third-Party Monitoring. According to the Standing Orders on Disaster (SOD), UNDP has supported the existing coordination mechanism at the City-corporation/ Municipality town level to function effectively under the leadership of the Mayor. NUPRP facilitated to activate relevant standing committees as well as developed and maintained linkage with the GOB District Multi-sectoral Coordination Committee (DMCC) & District Rapid Response Committee (DRRC). Under the leadership of the related Standing Committee, they formed task force teams at CC (City Corporation) and MC (Municipality Corporation) level to carry out different activities related to combat COVID-19. A total of 20 City Task Force and 439 Ward Task Force were formed in order to ensure strong coordination mechanism in place to respond to COVID-19 crisis.

NUPRP has the list of Primary Group Registered Households with MPI Score (Multidimensional Poverty Index). This list has helped UNDP to response to COVID 19 situation in a timely manner. The list of the selected NUPRP beneficiaries was also shared with the District Taskforces. The district taskforce identified the people who already received grants (food basket/cash transfer) so that duplication can be avoided and include more people in their list who have not received grants yet. This coordination helped to minimize duplication and to maximize coverage of the relief distribution. In order to distribute government food assistance to the people, cities formed the Ward-level Relief Committees as per instruction by the government. In these relief committees CDC/ Cluster/ Federation Leaders were included in all the towns and cities.

UNDP has sensitized existing health Infrastructure and built the capacity of Health Officials and volunteers in 19 cities. Institutional mapping was conducted by NUPRP and found out probable areas of collaboration to provide capacity building support (orientation and training) to the urban health service providers. 385 health professionals and workers received the online training and 605 health professionals received Personal Protection Equipment (PPE). These have helped the health professionals & workers to improve their knowledge on COVID 19 and to overcome their fear to work at the front line to some extent during COVID 19 pandemic.

During the crisis, timely data collection and sharing accurate data with field staffs and different stakeholders is crucial to understand the real ground situation. NUPRP has created strong MIS that

helps the NUPRP team and government stakeholders to identify trends and to take informed decisions. The data was collected through Mobile App and the NUPRP team shared the report with government stakeholders on weekly basis so that any discrepancy from the actual plan can be identified and can take timely decision.

To fast track the system to respond to COVID-19 response, the operations team of NUPRP has taken several steps to procure several goods in a timely manner. This includes procurement of soap under Hygienic package, Cash Grant Transfer/Food Basket, printing of behavioural change communication materials. The team also procured Raincoat, Gumboot, Hand Sanitizer, Hand Gloves and Mask to NUPRP Town Offices for safety measures and protection for front line staff so that they can protect themselves from the transmission during emergency response. Also significant number of hygiene kits has been distributed to project personnel and LG officials.

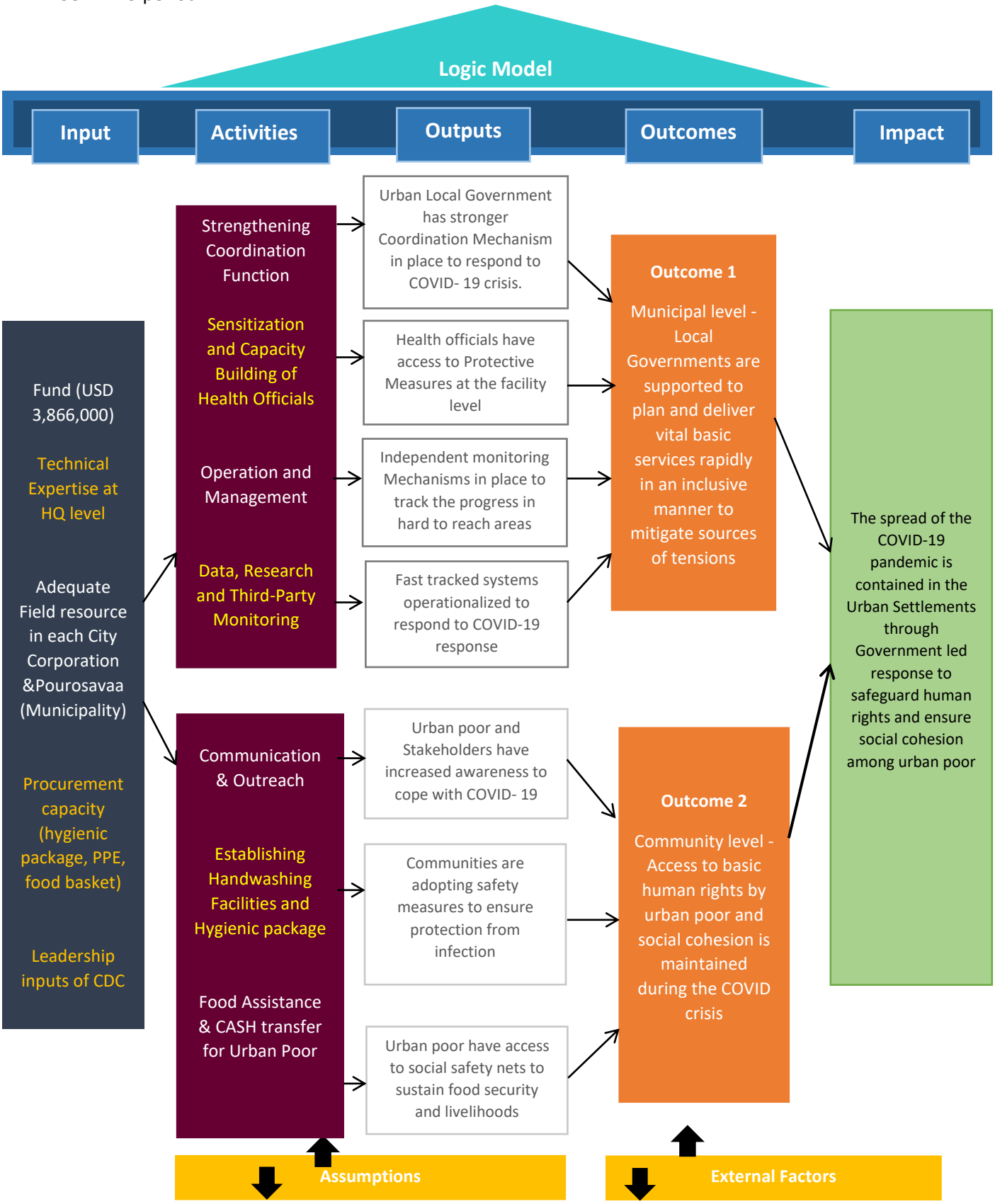
Outcome 2: Community level - Access to basic human rights by urban poor and social cohesion is maintained during the COVID crisis

Communication & outreach, Establishing Hand washing Facilities and Hygienic package, and Food Assistance & CASH Transfer for Urban Poor were the three major activities to achieve outcome-2.
Primary requisite of the COVID 19 pandemic was mass awareness raising among people. UNDP through NUPRP has facilitated mass awareness campaign to spread key messages for COVID 19 prevention in 20 cities through producing & distributing IEC/BCC Materials (poster, festoon, booklet, sticker), loudspeaker announcement in slum areas as well as through local cable TV operator and local media, sharing SMS to Primary Group Members & slum inhabitants, advocacy with media forum (press release on daily newspapers) and media broadcast (ETV) and post sharing in social media. Multimodal communication initiatives of the programme have increased awareness level of slum residents in 20 cities/towns and help them to take precautionary measures to prevent COVID 19.

The NUPRP team has also maintained liaise with the local health institutes and service providing agencies to ensure delivery of health services for the COVID 19 patients. The programme engaged multiple stakeholders and strengthened coordination function which accelerated decision making to implement emergency response activities. The emergency responses included mass awareness raising on COVID 19, prevention techniques, WASH & hygiene among urban poor, soap distribution, hand washing corner installation and Tippy tap usage reached about 5.2 Lac HH.
UNDP & NUPRP has installed hand washing corner at the community level to encourage hand-washing behaviour. There was active participation of Ward Councillors and community people to select the locations and maintenance of the hand washing corners. This has brought behavioural changes to the community to develop healthy WASH habits & practices. Basic hygienic product (soap) was distributed across households (5.2 Lac HH) of slum communities supported by NUPRP in 19 cities.

NUPRP has also initiated‘ Solidarity package (food basket of 2,500 BDT & onetime CASH transfer 1,500 BDT)’ for HH affected from COVID 19’ with objective to send essential livelihoods support fill the gap during quarantine period; those were distributed from the 3rd week of April in 19 cities

among slum inhabitants . Livelihood support ensures security for certain days to cope up during COVID 19 period.



1.3 OBJECTIVE OF THE STUDY

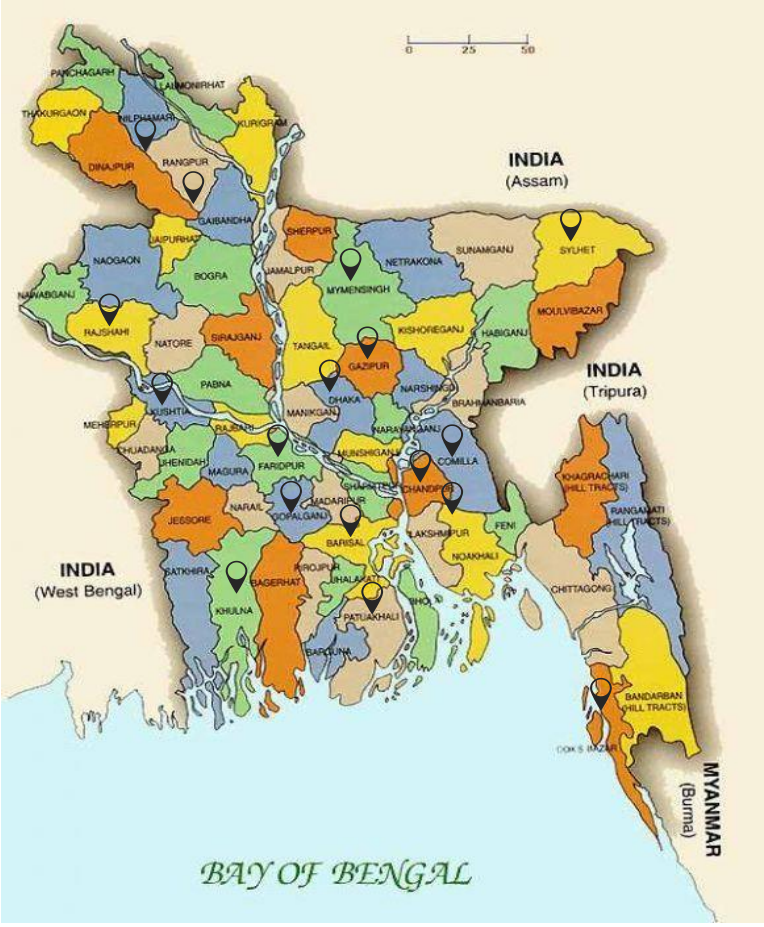
The objective of the study was to make a systematic independent assessment of the NUPRP emergency response. Specific objectives of the study included:

- To evaluate the programme in terms of effectiveness to meet the demand of the urban community, to strengthen the capacity of city authority to response to the pandemic, create awareness of the urban poor about the COVID-19.
- To assess whether the response actions i.e. behavioural change communication, WASH, hygiene, protective measure intervention, coordination and governance intervention and food support were useful for the poor community and city authority.
- To evaluate the efficiency of delivery of the intervention.
- To understand the potential sustainability of the emergency response and the key lessons learnt

1.4 STUDY AREA

The study was conducted over 20 city corporations & towns where NUPRP provided emergency responses as Chandpur, Chattogram, Cox's Bazar, Cumilla, Dhaka North, Dhaka South, Faridpur, Gazipur, Gopalganj, Khulna, Kushtia, Mymensingh, Narayanganj, Noakhali, Patuakhali, Rajshahi, Rangpur, Saidpur, Barishal and Sylhet.

Figure 1: Study Locations



1.5 TARGET POPULATION

The primary target group of the study was the beneficiaries of NUPRP. The beneficiaries can be bifurcated into two groups as follows:

a) Beneficiaries who received behavioural change communication, hygienic packages and onetime cash transfer/food basket (termed as three interventions)
b) Beneficiaries who received awareness message and hygienic packages (termed as two interventions)
c) Nonregistered community members

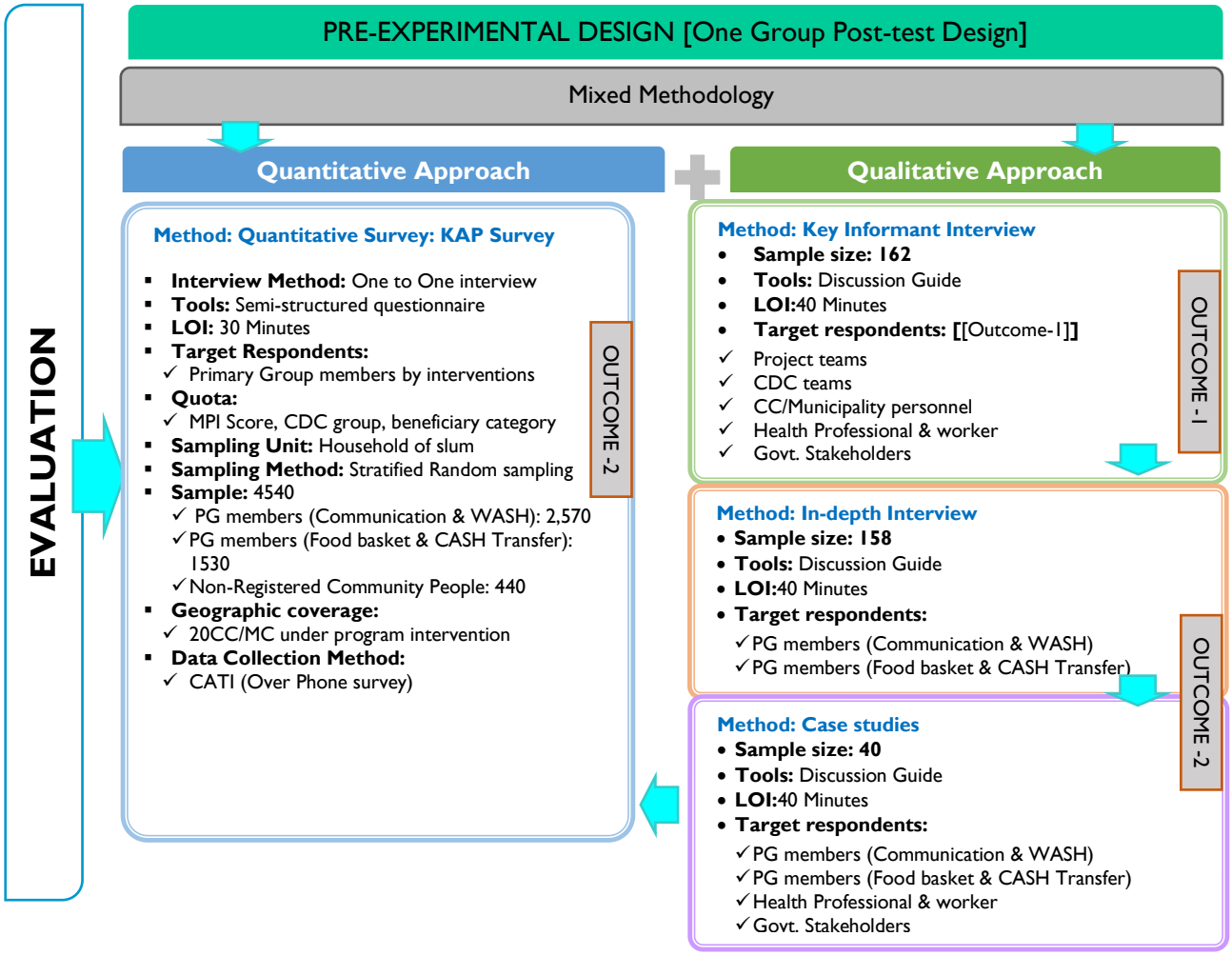
In addition, information was collected from the different stakeholders i.e. local government representatives (City Mayor, city task force, Ward Taskforce), health officials, town managers, NUPRP representatives, other development organizations and Community Development Committee (CDC) members.

CHAPTER TWO: EVALUATION DESIGN AND DATA COLLECTION

2.1 EVALUATION APPROACH

Due to emergency situation, the programme intervention has been implemented as per rapid activity plan. It was not possible for NUPRP to collect any pre-test/baseline data and there was no defined treatment & control group created prior to intervention; hence it was not possible to adopt experimental design. Therefore, considering the objectives of the evaluation, **Pre-Experimental Design** was employed. Pre-experimental designs are the simplest type of design because they do not include an adequate control group. Pre-experimental designs are usually conducted as a first step towards establishing the evidence for or against an intervention which is rigorous in establishing a causal link between program activities and outcomes. The most common pre-experimental design is the '***One group pre-test/post-test design***' which is applicable for emergency response program. Information for this design was collected immediately after participants receive the treatment (intervention). Since formal **pre-test** (baseline survey data) was not conducted prior to COVID-19 outbreak among beneficiaries this evaluation followed only **post-intervention design** as it involved collecting information only on program participants. To minimize the weaknesses of the methodology, the evaluation captured information both on the previous situation (March, 2020: before NUPRP emergency response) and the situation during COVID-19 pandemic (May, 2020). This has allowed the researchers to understand the comparison of same groups between different time periods. In addition, a small number of samples (around 10%) were captured from non-registered community members in order to draw comparisons between two groups.

Mixed methodology was applied for evaluation using stratified random sampling technique. Both the quantitative and qualitative approach was adopted for evaluation. **One to one survey** with the vulnerable affected people in urban settlements was conducted **over phone** through *semi-structured questionnaire* which was designed via digital programming platform. The quantitative component consisted of a multi-indicator KAP survey on the basis of a representative sample of beneficiary sampling frame by different interventions. At a glance the design was as follows -

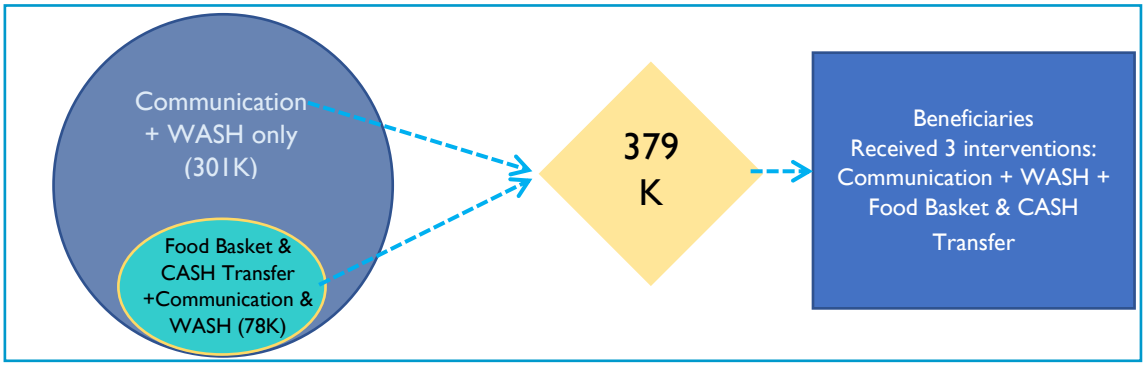


Qualitative data was collected through **In-depth interviews**, **case studies**, **Key Informant Interviews** with the relevant stakeholders such as project management team, Local government officials, town managers, CDC members, health officials, coordination functions members, beneficiaries and so forth to understand how the entire emergency response activities were implemented with synchronization, what were the risks/ challenges, mitigation strategy, learning, coping mechanism & resilience among beneficiaries, and way forward. In addition, **in-depth interviews& case studies** were conducted with the same respondent groups to have more in-depth information and to triangulate the findings received from survey.

2.1.1. QUANTITATIVE SAMPLING AND SAMPLE SIZE DETERMINATION[4]

NUPRP shared a list of about 3,78,560 beneficiaries along with their contact number, name of community groups and MPI (Multidimensional Poverty Index) scores who received three major interventions – Communication materials, WASH interventions , Food basket or onetime CASH. This list was considered as sampling frame. Among the list of 379K beneficiaries, 301K beneficiaries received intervention for communication & WASH.

[4] Detailed methodology is provided in Annexure 2



Stratified sampling technique was used for the survey. Two different interventions –(i) communication, WASH and communication, (ii) WASH, Food-Cash were considered as 2 strata. The city level samples were distributed proportionately based on the MPI score – low, medium, high.

Respondents were contacted from the sampling frame/list using systematic random sampling technique for each group over phone.

Sample size was determined separately by two separate intervention group to avoid selection bias –

i. Beneficiaries who received both communication & WASH interventions
ii. Beneficiaries who received all interventions: communication & WASH, Food Basket & CASH Transfer

i. Beneficiaries who received both communication & WASH interventions:

The sample size has been calculated following the standard statistical formula with 95% level of confidence and 3% margin of error with an assumption that about 20% beneficiaries have some knowledge on COVID 19, received from different media sources. Overall, beneficiary size is 301,000 who received communication & WASH intervention.

Considering non-response rate at 40% and design effect 2, the sample size was calculated to be **2553**. This was further distributed by different cities, by MPI-score, doing some adjustment to ensure adequate minimum sample representation by different quota. Finally, the sample size was considered as **2570** respondents.

ii. Beneficiaries who received all 3 interventions: communication & WASH, Food Basket & CASH Transfer

The sample size was calculated for the beneficiaries who received all 3 interventions (Communication & WASH, Food Basket & Cash Transfer) using following standard statistical formula with 95% level of confidence and 5% margin of error. Overall, a total of 77,560 beneficiaries received full coverage of communication, WASH, food & cash intervention.

Hence, required sample size is 382. Afterwards, three adjustment factors were used i.e. Non-response, design effect & finite population correction to derive the final sample size. Considering non-response rate adjustment factor at 40% and design effect 2, the sample size was calculated to be 1,274. Considering representation, the sample size was considered as **1,530**. Overall, samples were distributed by different cities, by MPI-score, doing some adjustment to ensure adequate minimum sample representation by different quota.

2.1.2. MODE OF DATA COLLECTION

Considering the situation of COVID 19, the survey was conducted **over telephone using mobile numbers from the NUPRP MIS**. Questionnaire **programming** was done in Nielsen ***authorized digital platform***. Interviewers conducted the survey over phone, recorded the information in tab.

2.1.3 QUALITATIVE APPROACH

Qualitative study approach included three techniques for data collection – Key Informant Interviews (KII), In-depth interviews, & Case studies. A total of 162 Key Informant Interviews (KII), 158 in-depth interviews and 40 case studies were conducted with different stakeholders.

2.2 ENUMERATORS TRAINING FOR DATA COLLECTION

A 4-day long training was arranged for the data collection teams and it took place from 27th May to 30th May, 2020. Due to COVID 19, the training was conducted online with 70 enumerators. The key evaluation team members were mainly involved in conducting the training. A training schedule was prepared to cover all the issues related to survey tools as well as other aspects of data collection. Each of the modules was discussed in detail, Conceptual clarifications of the tool were made and all the queries and questions from the field teams were addressed. Further, there were problem solving sessions through doing small exercises where each team member participated in small tests on the issues. The purpose of doing this exercise was to assess whether all the Field Investigators (FIs), Supervisors and Quality Control officers (QC) had common understanding on the similar issues. Also, the mock tests were done after completing each module of the questionnaire.

2.3 DATA COLLECTION

A total of 40 enumerators were selected after the training session. The field team members were divided into eight (8) teams. Each team comprised of five (5) FIs, and one (1) FS. A separate quality control team was also deployed to check the quality of data collection. The field work started on 31st May, 2020 and ended on 12th July, 2020. The qualitative data collection started from 7th July, 2020 and ended on 23rd July, 2020 and a total of 12 qualitative data collectors were engaged in data collection.

2.4 QUALITY CONTROL MECHANISM

Nielsen Bangladesh has always been quality conscious, and as a guiding principle 'Quality Control at all levels' is the basic policy of the company. Therefore, the continuous supervision and monitoring was carried out at all stages of the data collection to ensure the quality of the collected data, i.e.

during data collection and data cleaning. Since the data collection was carried over the phone, separate quality control mechanism was adopted which included telephone back check, listening the audio recording of the interview and daily data dump check. Daily feedback was provided to the data collectors based on the results from telephone back check, audio recording listening and daily data dump checking.

The data management team for the present study mainly looked after the data processing including coding, office editing of the data, and developing a complete database. The core evaluation team provided inputs at various stages of data processing.

2.5 DATA PROCESSING

Since the data was collected through the CAPI[5], data entry was not required. The coders did the coding of the open-ended responses. Following that, analysis was done using SPSS windows program (version 24).

The analysis team analysed the data under the guidance of the expert panel. Descriptive statistics were used as appropriate (frequency, mean, standard deviation, etc.) to describe the socioeconomic characteristics of the respondents.

2.5 ETHICAL CONSIDERATION

It was Nielsen's ethical obligation to maintain the confidentiality of the information collected for the proposed study. In this regard, all the selected respondents who provided information was given full assurance of confidentially that the information gathered will be used exclusively for evaluation purposes and will be aggregated to make estimates. It was assured that information of any individual unit would not be disclosed. Both the respondents and the answers were coded blind. We respected the respondents by assuring that s/he can quit any time during the interview. The interview was taken place only if the respondent agrees.

2.7 CHALLENGES DURING DATA COLLECTION & LIMITATION

Due to lockdown during COVID 19, travel to field was restricted. It was not possible to conduct face to face interview during that time. Post lockdown (May 30, 2020), the number of COVID 19 infected people and the number of deaths were increasing every day. The situation remained same till the month of July, 2020. Considering the increasing number of COVID 19 infected people and deaths, Nielsen global policy also restricted face to face data collection in order to avoid transmission of COVID 19 among the respondents as well as the enumerators. Hence, it was discussed with UNDP and both parties agreed to limit the methodology to remote data collection through mobile.

As the data was collected over telephone; it was really challenging for the data collectors to collect the data on time as the non-response rate was much higher compared to face to face data collection. Since the beneficiaries are from poor community, many of them were not comfortable to

[5]Computer Assisted Personal Interview

provide interview over the phone. During COVID 19 emergency, the respondents were not interested to continue the interview for a longer time. Some of the respondents terminated the interview after 10-15 minutes of the interview. Connectivity was another major challenge as the enumerators had to reach a single respondent multiple times to complete the interview.

Another major challenge was the articulation level of the respondents. As the education level of the beneficiaries is poor, the data collectors had to explain the questions multiple times to make them understand thoroughly before answering.

One of the major limitations of the study was to absence of any control group. Due to emergency situation, it was not possible to establish any control group. Though the study tried to capture some information from the non-registered community members, it was not possible to develop a comprehensive sampling frame for this segment to select the respondents randomly. The town managers of NUPRP collected and shared the contact details of the non-registered community people which might lead to selection bias. Again, it was not possible to match the characteristics of beneficiaries and the non-registered community members due to absence of adequate number of respondents of the non-registered community members. Another limitation of the study was this segment might be exposed to some interventions of the programme which leaves the possibility of contamination or spill over.

Due to unavailability of pre/baseline data, information on the situation before emergency response was captured as claimed responses during this study which leaves the possibility of response bias.

CHAPTER THREE: DEMOGRAPHIC PROFILE

3.1 HOUSEHOLD SIZE

Table 4 presents the percentage distribution of households by the size of surveyed households. Average household size in intervention and non-registered community people are 4.5, and 4.6 respectively, which coincides with the national urban estimate of around 4.00 (HIES, 2016).

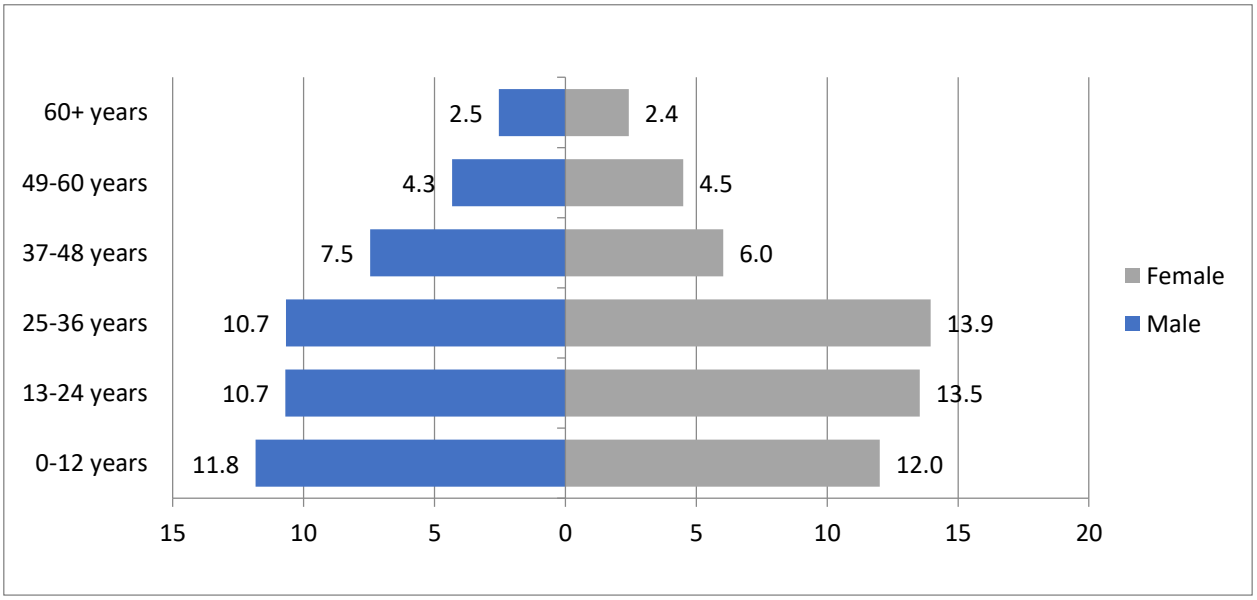
Table 1: Percentage distribution of households by household size

Number of household members	Intervention			Non-registered community member
	Two Interventions	3 interventions	Total	
1-4 members	59.4	54.5	57.6	57.0
5-8 members	38.3	42.9	40.0	39.8
8+ members	2.3	2.6	2.4	3.2
n	2570	1,530	4,100	440
Avg. HH Size	4.5	4.6	4.5	4.6

3.2 AGE AND GENDER OF HOUSEHOLD MEMBERS

A total of 18,462 household members were enlisted and among them, 8,780 were male &9,682 were female. The sex (male-female) ratio of the surveyed population was 48:52 similar to the Population and Housing Census 2011 (BBS, 2011). Similar ratio was observed for the respondents of non-registered community people (Annexure 1: Table 3).

Figure 2: Percentage Distribution of Age & Gender distribution of household members (Intervention)



3.3 AGE, GENDER & RELIGION OF THE RESPONDENTS

All the respondents from intervention and non-registered community people group are female and average age of the respondents is 35 years for intervention and 32 years for non-registered community people. About 92% of the respondents are Muslim & 7% of the respondents are Hindu (Annexure 1: Table 1). Majority of the respondents are married (intervention 87% &non-registered community people 82%) and 8% of the respondents from intervention and 6% of the respondents from non-registered community people are widows (Annexure 1: Table 2).

Table 2: Percentage distribution of Age of the Respondents

Age distribution (in years)	Intervention			Non-registered community member
	2 Interventions	3 interventions	Total	
18-24	14.4	12.4	13.7	20.9
25-34	38.7	36.4	37.8	43.0
35-44	27.7	27.1	27.5	23.4
45-54	12.7	14.0	13.2	9.1
55-64	5.0	7.2	5.8	2.7
65+	1.5	2.9	2.0	0.9
n	2,570	1,530	4100	440
Average Age	34.6	36.0	35.1	32.1

3.4 EDUCATION OF THE RESPONDENTS

Almost half of the respondents in both intervention and non-registered community people (intervention 46.7% and non-registered community people 46.4%) have studied till class 5 to 9. About one fifth of the respondents from intervention areas (20.6%) are illiterate.

Table 3: Percentage distribution of Education Level of the Respondents

Education Level	Intervention			Non-registered community member
	2 Interventions	3 interventions	Total	
Illiterate	18.6	24.0	20.6	11.6
Literate with no formal education	5.8	7.1	6.3	4.1
Class 1 to 4	10.3	11.1	10.6	8.6
Class 5 to 9	47.0	46.1	46.7	46.4
S.S.C/ Dakhil / H.S.C/Alim	14.2	9.6	12.5	20.9
Have some college/ university education but not graduate	4.0	2.0	3.2	8.4
n	2,570	1,530	4,100	440

3.5 OCCUPATION OF THE RESPONDENTS

About two third of the respondents in both intervention and non-registered community people (intervention 66.5% and non-registered community people 64.5%) are housewives. 17% of the respondents in intervention group and 12.0% in the non-registered community people are unemployed.

Table 4: Percentage distribution of Occupation of the Respondents

Occupation	Intervention			Non-registered community member
	2 Interventions	3 interventions	Total	
Housewife	67.7	64.6	66.5	64.5
Unemployed	15.9	17.8	16.6	12.0
Domestic worker	3.0	4.2	3.4	2.3
Tailor/Seamstress	2.1	2.3	2.2	4.6
Garment worker	1.4	1.2	1.4	1.4
Grocery Store	1.1	0.9	1.0	0.0
Tea stall (including betel leaf and cigarette)	0.6	0.4	0.5	0.7
Others	8.2	8.6	8.4	14.4
n	2570	1530	4100	440

CHAPTER FOUR: EVALUATION OF NUPRP EMERGENCY RESPONSE

The evaluation of UNDP NUPRP emergency response has been carried out using the OECD -DAC Evaluation Framework. Based on the emergency response, the evaluation criteria were limited to four: relevance, efficiency, effectiveness and sustainability – to assess the COVID response. In terms of relevance, the study has assessed whether the emergency response design of NUPRP have considered the need of all the vulnerable people including women, children, elderly people, minority groups, transgender, people with disability etc. The study has also evaluated how well the resources were being used and whether the emergency response has achieved its objectives. Finally, the study has also assessed whether the benefits will last to ensure sustainability of the desired result of the intervention.

4.1 RELEVANCE

During COVID 19 pandemic, the lockdown imposed by Bangladesh Government from 26th March 2020-31st May 2020 has obstructed the livelihoods of 85% of the country's working population currently employed in the informal sector[6]. Lack of proper employment benefits and compensation structure for these workforce members, especially the slum dwellers make them the most vulnerable group during this national economic shock. The majority of these workers belong to the low income and lower middle income brackets and most of them make just enough to cover their living expenses while residing in the urban peripheries. Hence, a loss in employment or income would directly impact the livelihoods of these poor people living in urban settlements.

The survey data reveals that during COVID 19, the unemployment rate has increased by 15.5% in the intervention group and around 10% among non-registered community members whereas the monthly household income has decreased by 36% in the intervention group and 50% among non-registered community members. This has also impact on the livelihood of the poor people living in urban settlements. Many people have moved to villages due to unavailability of the suitable livelihood options in urban settlements. As per NUPRP weekly monitoring tracker, 1,564 households in Mymensingh, Noakhali, Patuakhali, Rajshahi and Sylhet have migrated to villages due to COVID 19 situation.

Table 5: Percentage distribution of Impact of COVID 19 on Livelihood

	Intervention		Non-registered community member	
	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19
Unemployement	1.1%	↑ 16.6%	2.3%	↑ 12.0%
Monthly Household Income (BDT) Mean value	9,419.1	↓ 3,355.9	12,570.5	↓ 6,293.2
n	4,100		440	

[6]Impact of Coronavirus on Livelihoods: Low- and Lower Middle-Income Population of Urban Dhaka, Light Castle, https://www.lightcastlebd.com/insights/2020/04/30/impact-of-coronavirus-on-livelihoods-low-and-lower-middle-income-population-of-urban-dhaka

Considering the situation of the poor people living in urban slums, NUPRP has done 'rapid risk assessment & resource mapping' for the planning of intervention for the vulnerable people and to identify how NUPRP can support City Corporations/Paurashovas (Municipalities during the outbreak. The programme also developed overall Rapid COVID -19 Situation Report for different Cities/Towns and the report was shared with the local government stakeholders. These activities have helped UNDP and government stakeholders to identify the needs of the cities during COVID 19. NUPRP has also identified how multiple stakeholders could take part in emergency response and has designed plan of actions accordingly.

Based on the assessment and emerging priorities within the COVID -19 contexts, NUPRP has undertaken communication and outreach activities, established Hand washing Facilities and distributed Hygienic package, Food Assistance & CASH Transfer for Urban Poor.

In order to create awareness among urban slum dwellers on COVID 19 so that they can take protective measures and can practice hand washing, NUPRP facilitated mass awareness campaign to spread key messages for COVID 19 prevention in 20 cities through producing & distributing IEC/BCC Materials (poster, festoon, booklet, sticker), loudspeaker announcement in slum areas as well as through local cable TV operator and local media, sharing SMS to Primary Group Members & slum inhabitants, advocacy with media forum (press release on daily newspapers) and media broadcast (ETV) and post sharing in social media.

NUPRP has installed hand washing corner at the community level to encourage hand-washing behaviour. Basic hygienic product (soap) was distributed across households (5.2 Lac Households) of slum communities supported by NUPRP in 19 cities. This has brought behavioural changes to the community to develop healthy WASH habits & practices.

NUPRP has also initiated' Solidarity package (food basket of 2,500 BDT & onetime CASH transfer 1,500 BDT)' for Households affected from COVID 19' with objective to send essential livelihoods support to fill the gap during quarantine period. These were distributed from the 3rd week of April in 19 cities among slum inhabitants. Livelihood support ensures food security for certain days to cope up during COVID-19 period.

NUPRP has ensured that the most vulnerable people receive the emergency response. They have considered MPI (Multidimensional Poverty Index) to select the beneficiaries and verified all the beneficiaries before providing the emergency support. The MPI scoring process is scientific and there is less room for any error. This scoring process assisted the NUPRP to select the right beneficiaries. Considering the reduction in household income and increase in unemployment rate among the beneficiaries mentioned above reassures that UNDP's use of MPI scores has paid off.

I'd like to appreciate the initiatives taken by NUPRP for providing assistance during this emergency situation. This wasn't a part of the regular project guideline but the programme responded to this emergency situation. No matter what the amount of assistance was given, their actions are commendable. The NUPRP team deserves appreciation for reaching out to most marginalized communities including women, children, people with disability, transgender and so on.

Mayor, Chattogram

However, it should be noted that COVID 19 had impacted the poor as well as the non-poor people. COVID 19 was a unique phenomenon and no one had faced such situation ever before. So the demand for food or cash support was huge. Not only the poor but also the non-poor including the CDC leaders were looking for food and cash support because majority of the people became unemployed during the lock down period. Though MPI is very rigorous and scientific process in general scenario but when it comes to a pandemic or COVID 19 like situation this dataset which only covers the classical set of poor might not be sufficient.

Children & disable friendly hand washing corner

In addition to considering MPI, all the vulnerable groups including female headed households; people with disability, elderly people, transgender, minor and children were also given priority to provide the emergency response. The list of the selected NUPRP beneficiaries was shared with the District Taskforce. The District Taskforce also identified the people who have already received grants (food basket/cash transfer) so that duplication could be avoided and include additional people in their list who have not received grants yet. This coordination helped to minimize duplication and maximize coverage of the relief distribution.

All the beneficiaries, CDC members, town mangers, health professional and government stakeholders appreciated the emergency response taken by the UNDP NUPRP team. They rated the emergency response as very timely initiative taken by the NUPRP team as the urban slum dwellers were the most vulnerable people during the lockdown imposed by the government due to COVID 19.

They stated that it was necessary to make the urban slum dwellers aware on the COVID 19 and how to take preventive measures as the awareness level of urban slum dwellers is comparatively low compared to other people.

The respondents also found the interventions relevant and need based; especially establishment of hand washing corners, tippy-tap, and distribution of soaps among the beneficiaries as the access to and availability of water is usually low in the slums. They stated that this initiative would encourage the slum people to wash their hands regularly to protect themselves from COVID 19.

The respondents who have received one time food assistance or cash transfer highly appreciated the initiative taken by the NUPRP. They stated that majority of the slum dwellers are day labourers and they became unemployed during the lockdown period. The one time cash or food assistance was very helpful for them to cope with the initial shock of food crisis.

Case Story

Life of a Hijra (transgender) in Bangladesh is shackled with stigma, discrimination and humiliation. Shimul Akter is bearing this life for 52 years. She currently lives in Narayanganj Municipality in a house as shabby as her life is. Ejected by her family, she now lives with 12 of her transgender peers and lives on by singing or dancing on the street. The life defined by struggle became a nightmarish experience when the COVID-19 broke out. Narayanganj became one of the worst-hit districts in Bangladesh in terms of COVID-19 infections and deaths. Shimul was afraid to go outside and seek financial help from people.

It was in April 2020, when the NUPRP team in Narayanganj Municipality started its COVID-19 awareness-raising campaign and established hand washing corners in different places of the community. She learned a lot about the virus from the poster and sticker respectively glued on the wall and the front door of her residence by the NUPRP team. She learned about hand washing and how to do it properly. She has also received 5 bars of soaps from the NUPRP emergency response. Because of the communication and outreach activities & soap distribution of NUPRP, Shimul is now aware of symptoms of COVID 19, how to protect herself from the COVID 19 transmission and so on. She regularly wears mask and also practices hand washing on different occasions at the hand washing corners established by NUPRP. Shimul thanked the NUPRP for not forgetting the transgender people like her and included them in the emergency response.

Being a transgender, I always been discriminated from getting access to necessary services. But thanks to UNDP NUPRP that they did not forget us and included the transgender people like me in their emergency support.

- ***Shimul Akter, Narayanganj Municipality***

The NUPRP team provided online training link on COVID-19 of DGHS, GOB, and WHO and a total of 385 health professionals and workers completed the training. A total of 605 Personal Protection Equipment was also provided to the health professionals and health workers. Almost all the health professionals (98%) participated in the study appreciated the initiative taken by UNDP NUPRP. They stated that during this pandemic, this online training was necessary for the capacity building of the health professionals. They further added that during this crisis period, it was not possible to do face to face training. The online training link provided them the opportunity to learn different new things that helped them to provide health services more efficiently.

4.2 EFFICIENCY

The project operations team and UNDP Procurement team closely worked with the Project Management as well as UNDP senior management to decisive and swift decision including fast tracking procurement processes of certain goods and services considering the sensitivity and shortage of time. The procurement team has faced tremendous challenges in procurement and

distribution of different goods during the lockdown period. The majority offices except few essential services were closed during that time. However, considering the emergency response and constraints of the extended nationwide lockdown, the team swiftly responded by procuring and transporting the relief support within a short period of time. For example: UNDP took special procurement arrangement considering immediate responses to COVID-19 pandemic to ensure timely delivery of anti-septic soap to beneficiary households. UNDP approved waiver of competitive procurement process and granted permission to procure soap through Direct Contracting method. Normally a competitive procurement process requires 32 days whereas the Direct Contracting procurement method took 16 days that helped UNDP to ensure timely delivery of soap to the House Holds of the respective field offices. Below the table shows expect few items, majority of the goods were procured well before the standard procurement time.

Table 6: Procurement time of different Items

SL	Item	Name of Vendor	Qty.	Standard Procurement Time (Working Days)	Actual Procurement Time (Working Days)
1	Soap	ACI Limited	1,570,095	32	24
2	Soap	Unilever Bangladesh Ltd.	1,025,352	32	16
3	Soap	ACI Limited	42,175	32	5
4	Cash Grants	Dutch-Bangla Bank Ltd.	69,686	32	22
5	Food basket	Unimart Limited	7,900	32	16
6	Hand Sanitizer	Bengal Herbal Garden Ltd.	5,200	10	4
7	Mask	Jahan Enterprise	39,000	32	23
8	Mask	Yena Enterprise	35,000	10	4
9	Hand Gloves	Khan Enterprise	35,000	10	3
10	Gum Boot	Kamal Trading	1,300	10	4
11	Long Over Coat	Foresee	1,300	10	11
12	Festoon	Milon Printing Press	300	10	3
13	Festoon	Desh Media	9,677	32	18
14	Poster	Milon Printing Press	40,000	10	21

15	Poster	I Bazar Printing Press	20,000	32	23
16	Sticker		100,000		
17	Hand Rub	Khan Enterprise	2,200	10	28
18	NCITs & Towel	Blue Canvas	1,700	32	8

The team also ensured the timely delivery of the major emergency response items to the field offices. For this, UNDP has shortened the procurement processing time during COVID- 19 from 21 days to 7 days. During lockdown, it was challenging to deliver goods to different locations due to unavailability of transportation. To ensure prompt response, the team adopted alternative approaches and delegated Hand washing point installation responsibility to CDC members to avoid delay. The CDC members with the help of financial support from NUPRP locally procured the goods to establish hand washing corners so that people can practice hand washing during the crisis situation.

UNDP follows the international standard procurement policy. But our procurement policy is very flexible considering the different situation. For example, During COVID 19, UNDP has shortened the procurement processing time from 21 days to 7 days. So we can procure goods on urgent basis. For example the food packages procurement just took 24 hours to be approved by regional office for the emergency situation.

Yona Samo
International Operations Manager, UNDP

Table 7: Delivery time of different Items

Sl	Items	Standard Delivery Time	Actual Delivery Time
1	Soap	5	5
2	Cash Grant	36	30
3	Food Basket	23	5
4	PPE for frontline workers	19	9
5	Communication Outreach (Poster, festoon, sticker)	30	19

Though the cash transfer was made within standard delivery time, but it took one month which needs to be re-examined. The situation of COVID 19 was completely a new experience. The team was not fully prepared for this. The team first communicated with Bank Asia to disburse the cash on the locations of the beneficiaries. The bank took almost 15 days to assess the risk associated with cash transfer and to submit their proposal. They charged 10% overhead cost which was around BDT 10 million to distribute cash using their own resource. To save this large amount of money, the operations team then contacted with Dutch Bangla Bank to transfer money to the mobile wallet of

the selected beneficiaries. Again, there were challenges that the phone numbers of the beneficiaries were updated and majority of them did not have mobile wallet account. As a result, The UNDP NUPRP team had to do the pre-verification of the beneficiaries to ensure transparency and accountability which took some time.

Based on the learning from COVID 19 emergency response, the NUPRP has already made it mandatory to collect the photographs and NID (National Identity Card) of all the newly registered beneficiaries. Collecting the photographs and NID will enable NUPRP to make the cash transfer faster in any future emergency. Although the majority of the items were procured and distributed within standard procurement time, different stakeholders i.e. government stakeholders and town managers during qualitative sessions requested UNDP to look into procurement processes further especially for the emergency response. They feel that the response time for emergency programmes should be faster considering the crisis situation and UNDP can develop separate procurement policy for emergency responses so that the procurement and distribution of goods can be done in a faster manner. Otherwise it would not create much impact if the affected vulnerable do not get emergency response in time.
It should also be noted that UNDP NUPRP decided to go for global procurement for the distribution of PPE for the health professionals and workers to ensure the quality of the PPE. However, due to shortage of suppliers and global procurement procedures during COVID 19 pandemic, it took a lot of time to procure and once procured; they were distributed among the health professionals and workers during the month of June and July (details are provided in the later section).

UNDP NUPRP has managed the cost as per plan and has been able to save some funds. The team utilized various opportunities of networking for procuring certain goods in a cost effective way and distributed those to the communities very efficiently and within a very short period. For example: UNDP sourced different renowned soap manufacturers in Bangladesh, such as -Unilever and ACI and bargained with them to procure soap with special discounted rate. Regular price of ACI Savlon soap-125gm was BDT 52, Savlon soap-100gm was BDT 45 & Savlon Soap-75gm was BDT 38 whereas discounted purchased price Savlon soap-125gm was BDT 41, Savlon soap-100gm was BDT 37 & Savlon soap-75gm was BDT 30 (Including VAT). Total savings of UNDP from procuring soap from ACI was USD 155,878. In addition, the supplier delivered soap to the respective delivery locations/towns free of cost.

Table 8: Cost Efficiency

#	Description	Budget & Fund Received from DFID	Budget & Fund Received from UNDP	Expenditure March -July 2020	Fund balance based on available resources
		GBP(£)	US($)	US($)	US($)
		A	B	C	D=(B-C)
A	**Programme Activity Cost**				
1	Communication and Outreach	176,554	220,693	96,589	124,104
2	Establishing Hand washing Facilities and Hygienic pack	1,168,829	1,461,036	1,256,205	204,831
3	Food support/Cash Transfer	1,200,783	1,500,979	1,476,238	24,741

4	Strengthening Coordination Function	16,000	20,000	-	20,000
5	Sensitization and Capacity Building of Health Officials and volunteers (20 cities)	48,000	60,000	72,260	(12,260)
6	Data, research and third-party monitoring	104,000	130,000	126,622	3,378
	Total Programme Activity Cost (A)	**2,714,166**	**3,392,708**	**3,027,914**	**364,794**
B	**Programme Support Cost**				
1	Operations and Management cost	63,612	79,514	77,993	1,521
2	General Management Support fee	222,222	277,778	248,429	29,349
	Total of Programme Support Cost (B)	**285,834**	**357,292**	**326,422**	**30,870**
GRAND TOTAL (A+B)		**3,000,000**	**3,750,000**	**3,354,336**	**395,664**

4.3 PROGRESS ACHIEVED & EFFECTIVENESS

In Bangladesh, the presence of COVID-19 cases was first detected officially in three people on 8 March7, 2020. At the end of month May 2020, number of COVID 19 cases was 17,454. As of 21 August 2020, the Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh has confirmed total 3,822 deaths from the COVID-19 with a total of 287,959 people infected.

Table 9: Number of COVID 19 Cases Nationwide

		Baseline	March	April	May
Number of COVID-19 cases nationwide	Planned: Number of Cases (Cumulative)	N/A			
	Achieved: Number of Cases (Cumulative)	N/A	51 (March 31, 2020)	7616 (April 30, 2020)	17454 (May 31, 2020)

The NUPRP team has worked closely with the city/town authorities since March 2020. They have conducted regular meetings, shared the situation assessment report &emergency plan, took advice of the government officials and engaged them in the emergency response activities and monitoring. By May 2020, all the 20 cities/towns where NUPRP is working took the preventive measures within urban settlements in terms of awareness raising activities, relief distribution, tracking the COVID 19 cases and imposing immediate lockdown where the COVID 19 cases were identified, establishment of hand washing corners, distribution of personal protection equipment and so on.

We have taken every preventive measure in place within urban poor settlements. We have done awareness raising activities, established hand washing facilities, provided relief, sprayed disinfectant on the roads, took strict measures to discourage social gathering, imposed lockdown in specific areas where COVID 19 cases were identified and so many.

Mayor Kushtia

Table 10: Number of Towns/Cities that have preventative measures in place within urban poor settlements

		Baseline	March	April	May
Number of Towns/Cities that have preventative measures in place within urban poor settlements	Planned: Number of Cities/Towns (Cumulative)	N/A	15	19	20
	Achieved: Number of Cities/Towns (Cumulative)	N/A	16	19	20

[7]WHO Bangladesh COVID 19 Situation Report, https://www.who.int/docs/default-source/searo/bangladesh/covid-19-who-bangladesh-situation-reports/who-ban-covid-19-sitrep-10.pdf?sfvrsn=c0aac0b8_4

Outcome 1: Municipal level - Local Governments are supported to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tensions

A) Proportion of Local Governments using the NUPRP database for relief activities for urban poor

> *The list of Primary Group members shared by NUPRP team is authentic and it has helped us a lot to identify the poor vulnerable people for relief distribution.*
>
> *Chief Planning Officer and Member*
> *Khulna City Corporation*

NUPRP Town Managers/key staffs closely worked with the City Task Force Committee on COVID 19 to support them on overall response and contribute to the coordination of the interventions. NUPRP has been maintain an online Management Information System which serves as a data bank and collect real time data to measure progress against the project interventions. During the COVID Response, NUPRP was able to capitalize on the existing databank to target the relief operations to the most vulnerable households and build the evidence base. The database had the list of beneficiary's name; mobile numbers, address, age, gender, Multidimensional Poverty Index (MPI) score etc. from across all 19 Cities/Towns. Because of the database, NUPRP team was able to respond faster. If the database was not available, then it would have taken longer time to respond to the emergency and it would not have been possible for NUPRP to monitor, track and do the targeting.

The NUPRP team strategically engaged with the local government stakeholders to respond and coordinate. The Town Managers in all cities/towns shared the list of Primary Group (PG) members with the local government and different development organizations for selecting most vulnerable households of the low-income settlements for food assistance during COVID 19 outbreak. 70% of the government stakeholders reported that they are using the NUPRP database. Using the list of NUPRP, the local government also distributed relief among poor vulnerable people in order to avoid any duplication. It has increased the efficiency as the list has helped them to reach more people for relief distribution. For example, the honourable Mayor of Khulna City Corporation used the database to distribute food package to additional 2,015 households of 31 Wards of Khulna City Corporation. The food package contains nutritional items for children which includes 1 kg Suji (Semolina), 1 kg sugar and ½ kg milk powder. The Patuakhali Municipality used Primary Group (PG) list of NUPRP for distributing food support to households suffering from food shortage in urban poor settlements due to COVID-19 pandemic. The Patuakhali Municipal authority also provided food support to 1,962 Primary Group members who were not covered in cash support from UNDP. In addition, the Municipal Authority provided support to another 9,000 poor families from Open Market Sell (OMS) and Vulnerable Group Feeding (VGF) prorgamme. The Noakhali Municipality distributed 11,500 food baskets from their own budget using the list of NUPRP. The food basket contained 1 kg rice, 1 kg lentils, 2 kg potatoes, 1 kg onion and 1-liter soybean oil.

Community Leaders also used the list for selecting beneficiaries to give emergency support from different sources like Ward Councillors Office, Local Clubs and philanthropic persons. In Chattogram, 32,785 households received food support from local elites by the mobilization of CDC and cluster leaders.

In some cities, the municipal authority also shared the list of Primary Group members with other government agencies i.e. LGED, and DC office for any kind of assistance during the lockdown period. The Local Government authority included the Primary Group list in their beneficiary list of safety-net programme.

The government stakeholders who reported not using the NUPRP database explained that NUPRP is working in limited areas with small number of poor people. They said they have the database of population for each Ward prepared by Bangladesh Bureau of Statistics and they provide assistance based on that database. They also requested UNDP NUPRP to increase the number of beneficiaries as well as working areas.

> *We have a statistical report prepared by Bangladesh Bureau of Statistics on the population size in each ward. We provide assistance keeping that ratio in mind.*
>
> *Mayor*
> *Cumilla*

B) Proportion of affected population expressing satisfaction on access to services and information provided by LG/NUPRP

Ninety one percent (91%) of the beneficiaries stated the emergency response undertaken by LG/NUPRP was useful (Annexure 1: Table 6) and 89% of the beneficiaries expressed their satisfaction[8] on access to services and information provided by LG/NUPRP. With respect to MPI, it is 92% from high MPI and medium MPI. They stated that during lockdown period it was very challenging for them to arrange the food for the family members as they did not have any work during lockdown period. The beneficiaries added that the one-time cash transfer/food distribution was a blessing for them as they could arrange food for their family members for 15 days with this relief. They also appreciated the initiative of awareness campaign, soap distribution, establishment of hand washing corner by UNDP NUPRP team. They stated that these initiatives helped them to understand the severity of COVID 19 and to practice hand washing regularly and to use protection gears in order to protect them from COVID 19 transmission.

Table 11: Proportion of affected population expressing satisfaction on access to services and information provided by LG/NUPRP

	Intervention		MPI			
	2 Interventions	3 interventions	High	Medium	Low	Total
Very dissatisfied	0.5	1.1	0.8	0.8	0.7	0.8
Dissatisfied	3.4	1.2	1.5	2.0	3.2	2.6
Neither dissatisfied nor satisfied	10.4	3.4	4.6	5.5	9.8	7.8
Satisfied	63.1	49.0	54.0	55.5	60.0	57.8
Very satisfied	22.5	45.3	39.1	36.3	26.3	31.0
n	2570	1530	261	1612	2227	4100

[8] The beneficiaries were asked to rate the level of satisfaction on 1 to 5 point rating scale where 1 denotes very dissatisfied and 5 denotes very satisfied.

Case Story

Dipali Robi Das was studying at standard IV when she got married. Now she is 25 years and has 3 children – her eldest is a son, 13 years old and disabled; next is a daughter aged 10 years and studies in class four; and the youngest is 7 years old, and studies in class I.

Her husband, the sole bread-earner in the family, has a small tea-stall. But due to the COVID-19 outbreak and subsequent nationwide lockdown, her husband could not run the tea stall. With no income and zero savings, her husband was struggling to feed this large family of 7 members. Before COVID-19, Dipali's family could eat 3 times a day. But now, they can only afford 2 meals a day.

In this difficult time, the NUPRP team launched the COVID-19 emergency response program to help vulnerable people like Dipali. She became the Primary Group member in Wari of Dhaka South City Corporation 8 months ago. She received the food basket comprising rice, wheat, potato, pulse, sugar, onion, salt, Soybean oil, chili powder, turmeric powder, powder milk, and eggs from the NUPRP team. The food basket became a life saver for Dipali's family; it saved them from facing hunger. She is very grateful to the UNDP NUPRP team to receive the food basket aid for her family during this crisis time.

However, some disappointments were also reported by the beneficiaries. Due to fund shortage, it was not possible for UNDP to provide one time Cash Assistance/Food Basket to all the beneficiaries. As a result, few beneficiaries who received awareness message and so apex pressed dissatisfaction. According to them, all the community members irrespective of their socio economic status suffered during lockdown. When they heard about NUPRP emergency response, they expected to receive cash/food from the programme. This led to disappointment for them. On the other hand, around two percent beneficiaries who received cash/food basket were also found to be dissatisfied for two reasons. Some of them found the amount of food/money was not adequate to survive during lock down period. In addition, some beneficiaries were also dissatisfied due to delay in cash transfer as they expected to receive the cash when they needed it most.

UNDP NUPRP completed pre-verification before providing cash/food support. During lockdown, it was really challenging for the frontline workers to complete the pre-verification process. Several challenges were faced during this procedure. One of the major challenges faced during pre-verification was the database prepared in 2018. During pre-verification stage, it was found that some numbers were closed; some beneficiaries changed their mobile number, digits missing in phone number etc. Some beneficiaries also did not have any mobile phone. Therefore, the NUPRP team had to collect phone number of their family members to transfer the cash. Another major challenge was majority of the beneficiaries did not have the Rocket Accounts which made the cash transfer difficult. The team members of NUPRP had to open Rocket Accounts for the beneficiaries to transfer cash support. As a result, it took some time to complete the entire process before transferring the cash which led to disappointment for some beneficiaries.

C) Urban Local Government has stronger Coordination Mechanism in place to respond to COVID- 19 crisis

During COVID 19, a total of 20 City Corporation / Paurashava Taskforce were formed on COVID-19 by the local government to manage the COVID-19 emergency response plan and activities. In addition, a total of 439 Ward Level Relief Taskforce were formed by the local government to support the Ward level relief activities. Though it was planned to form 534 Ward Level Relief taskforce but was not possible to form the planned number of Ward Level Relief Task Force due to lack of cooperation & fear of COVID 19 transmission from some Ward Commissioners.

Standing Committee on Disaster Management of the local government was activated to respond to the COVID-19 emergency. Out of 20 Cities/towns where UNDP NUPRP works, 12 Standing Committees on Disaster Management were fully activated, 3 were semi activated and 3 (Dhaka South, Gazipur, Mymensingh) were not activated. In Gopalganj, there were no Standing Committees on Disaster Management. In addition, City Corporation Disaster Management Committee (CCDMC)/ Paurashava Disaster Management Committee (PDMC) were also activated.

Table 12: Role/Task of different Taskforce/Committee

Taskforce/Committee	Role/Task
City Corporation / Paurashava Taskforce	To manage the COVID-19 emergency response plan and activities
Ward Level Relief Taskforce	To manage & distribute government relief at Ward Level
Standing Committee on Disaster Management	To create awareness for prevention and mitigation of climate vulnerabilities and disasters through organizing campaigns and training for different groups, institutions and staff of City Corporation.
City Corporation Disaster Management Committee (CCDMC)/ Paurashava Disaster Management Committee (PDMC)	a) Hold a hazard, vulnerability and risk analysis at City Corporation level and prepare contingency plan for earthquake and other natural and human-induced disasters e.g. for fire, flood etc. Ensure that all lifeline support agencies e.g. WASA, DESA, gas companies, T&T have their own agency contingency plan for earthquake, fire and subsequent mass causality management) b) Identify community at risk based on age, sex, physical fitness, social status, profession and economic condition. c) Prepare short, medium and long-term vulnerability reduction and capacity building action plan for the high-risk people with the active participation of the community at risk

NUPRP Town Managers/key staffs worked closely with the Ministries/Urban Local Governments, NUPRP team and different development partners. The National Ministry provided leadership and the Urban Local Government was responsive to the priorities and needs of the poor during COVID 19. Municipal Corporations are committed to implement actions at cities/town levels to ensure

It was possible because of the combined work. Our municipality, UNDP & district administration helped each other to provide all the emergency responses to the vulnerable people. Without combined effort, it would not be possible to achieve the desired result.

Mayor
Cox's Bazar

that urban poor people have access to their basic needs during COVID 19. 18 cities/towns formed multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response. The local government stakeholders mentioned that in order to fast track the emergency response and ensure efficiency. They emphasized on multi-sectoral, multi-partner coordination mechanism so that all parties can work in a coordinated manner and can increase the reach of beneficiaries during the emergency relief distribution. The UNDP NUPRP team members shared the situation assessment report and overall emergency response plan with the government stakeholders. The suggestions from the government stakeholders were also included in the response plan. The NUPRP team has also shared the beneficiary list with all the City Task Force across 19 cities/towns. The District Taskforce identified the people who have already received grants (food basket/cash transfer) so that duplication can be avoided and include more people in their list who have not received grants. This coordination helped to minimize duplication and maximize coverage of the relief distribution. In many cities, the authority also used the NUPRP database (i.e. Khulna, Kustia, Noakhali, Cox's Bazar) to distribute government relief among Primary Group Members who were not included in The NUPRP emergency response due to fund shortage. In addition, the CDC/Cluster/Federation Leaders were also included in the Ward Level Relief Committees of many cities so that they can help the Primary Group Members to receive relief from government who did not receive relief from NUPRP emergency response.

The NUPRP team also maintained daily tracker of the emergency response activities and updates were shared & discussed with the government stakeholders on weekly basis. Based on the suggestions of the government stakeholders, the team also took necessary actions. As per suggestion from the Faridpur Municipality, the team distributed soap to the sex workers in the brothels so that they can practice hand washing on different occasions to protect themselves from COVID 19 transmission.

Though all the government stakeholders appreciated the emergency response activities carried out by UNDP NUPRP, however mixed responses were found on the coordination activities. The government stakeholders were asked to rate the level of engagement on 3-point rating scale where 1 denotes low, 2 denotes medium and 3 denotes high. Fifty Percent (50%) of the government stakeholders rated the level of engagement high (Chandpur, Chattogram, Cox's Bazar, Gazipur, Gopalganj, Khulna, Kushtia, Noakhali, Patuakhali). Twenty two (22%) percent of the government stakeholders rated the coordination effort medium (Dhaka North, Sylhet, Siadpur, & Narayongonj) and 27% rated poor (Rajshahi, Rangpur, Cumilla, Faridpur & Mymensingh).

Table 13: Proportion of Cities/Towns with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response & level of engagement

		Baseline	March	April	May
Proportion of Cities/Towns with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	Planned: Number of Cities/Towns (Cumulative)	0	15	18	18
	Achieved: Number of Cities/Towns (Cumulative)	0	14	18	18

Level of engagement by the NUPRP Town teams at the City/Ward level Taskforce Meeting to coordinate COVID response	Planned: Number of Cities/Towns (Cumulative)	N/A	40	70	100
	Achieved: Number of Cities/Towns (Cumulative)	N/A	N/A	N/A	High 50%, Medium 22%, Low 27%

Those who rated the level of engagement high considered UNDP NUPRP as partner to provide support to poor vulnerable people during COVID 19 pandemic. They said the intervention has been a timely response e since the people have not faced this type of situation before. They appreciated the efforts of UNDP NUPRP to provide emergency response during the period of lockdown when people were afraid to go outside home because of COVID 19 transmission.

Case Study

When the COVID-19 started spreading in the country, Gazipur was considered as one of the worst hits just after Dhaka city. Gazipur City Corporation is abode to some 3,500, 000 citizens and houses 3,000 industrial establishment, as informed by the chief executive officer of the city. When corona virus hit, the floating population were the first to take the brunt. Besides getting affected these low income group had no job and could hardly afford a whole day's meal.

As part of the government mandate, the Gazipur City Corporation distributed 2,400 metric ton rice and allocated ration cards under a special open market sale or OMS scheme offering subsidized rice at BDT10 per kg to the poor. They provided two ambulances to collect sample for COVID testing in the government hospital.

The city corporation standing committee, chaired by Municipality Secretary held regular meeting with the NUPRP team on COVID Response initiatives. Regular meeting was held to discuss on the subjects i.e., advocacy tools, establishing hand washing stations, soap distribution, cash and food distribution and providing masks, sanitizers & other protective equipment. The beneficiary selection was done through CDC or community development committee in every intervened ward. The committee consisted of CDC members, counsellors, civil society representatives, local politicians & city corporation officials. The CEO of Gazipur City Corporation supervised all the activities carried out by NUPRP.

We work together. They work with us in coordinated way; we also do it from our end. We have city level committee with all our counsellors to address the emergency situation. We hold regular meetings to tackle the problems that appear due to these disasters. NUPRP town team participates in these meetings. It helped to be better coordinated with the works we are doing.

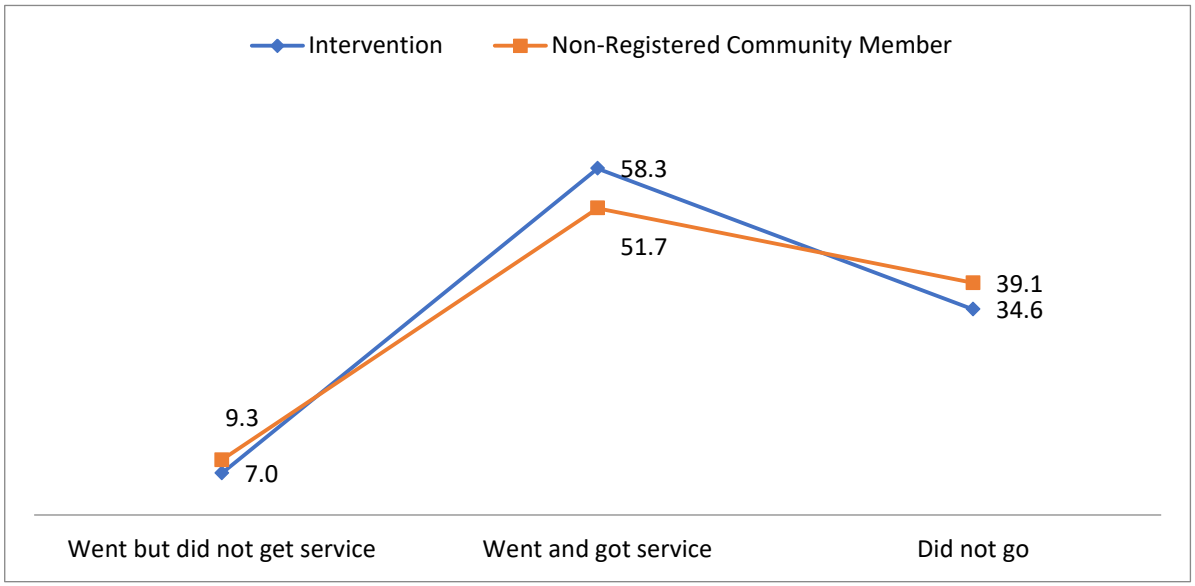
The respondents who rated the level of engagement low highlighted the poor coordination of NUPRP with the Ward Level Relief Taskforce. They also mentioned that due to lockdown and fear of COVID 19 transmission, it was not possible to conduct regular meetings. They urged the team to work more closely with the Ward Level taskforce. However, the town managers who participated in the study stated that the Ward Level Relief Taskforce was responsible for the distribution of government relief. In many places, there was a high demand from the Ward Councillors/Taskforce

members for expanding the food assistance beyond the NUPRP intervention areas. It was not possible for the town teams to provide any support to the people who were not listed in the beneficiary list. As a result, some of the government officials were dissatisfied with the emergency response of UNDP NUPRP team.

D) Health officials have access to Protective Measures at the facility level

During the COVID 19 pandemic, one of the major challenges was the lack of access to primary health care services. About one third of the respondents in both intervention and non-registered community members faced different general health problems (Annexure 1: Table 4) i.e. Flu, cough, fever, diabetes, heart disease, high blood pressure. Among them, almost half of the respondents reported that they visited doctor or hospital/clinic/health facility. It should be noted that a large percentage of the respondents (35% intervention, 39% control) did not visit any doctor or hospital/clinic/health facility. Those who did not visit any health care facility mentioned that they were afraid of being infected by Corona Virus Disease 2019/Covid-19 and they did not have money to consult with a doctor (Annexure 1: Table 5).

Figure 3: Percentage Distribution of People Visited Doctor or Hospital/Clinic/Health facility for General Health Problems during Month of May-June, 2020



During the qualitative sessions, the beneficiaries and the CDC members stated that many people faced challenges to get primary health care services. They also reported that many people were afraid to go to health care facilities because of being infected by Corona Virus Disease. Many respondents also reported that many primary health facilities were closed, or the health service providers were not present due to fear of COVID 19 transmission.

In order to ensure poor people getting access to primary health care services and to build capacity of the health professionals and workers, UNDP NUPRP planned to provide online training and Personal Protection Equipment. It was planned to provide PPE to 430 Health professionals. However, it was not possible to provide any PPE till the month of May, 2020. The NUPRP team decided to go for global procurement for the PPE for the health professionals and workers considering the WHO

specification of PPE in mind. The team started the process of global PPE procurement on time but did not get supply from the vendors due to scarcity of the standard PPE globally. UNDP followed standard procedures of PPE procurement including quality testing. Due to global procurement policy, the vendors took time to follow standard procedures of shipment of PPE including quarantine of PPE items in the warehouse. As a result, the PPE were procured after the emergency completed in May 2020. A total of 605 PPE was procured, and majority of items were handed over to the health officials and health workers between the months of June and July. The remaining items will be distributed by the month of August 2020.



Table 14: Number of health personnel and workers who received complete set of PPE& Online Training

		Baseline	March	April	May
Number of health personnel and workers who received complete set of PPE	Planned: Number of Cities/Towns (Cumulative)	0	0	0	200
	Achieved: Number of Cities/Towns (Cumulative)	0	0	0	385
Number of Cities health officials and workers who have undergone the online training of COVID-19 of DGHS, GOB	Planned: Number of Cities/Towns (Cumulative)	0	0	50	430
	Achieved: Number of Cities/Towns (Cumulative)	0	0	50	0 (up to May 2020) 605 (up to August 2020

In addition, the NUPRP team also disseminated online resources and training of COVID-19 of DGHS, GOB link to 385 health officials and workers against the actual plan of 200.

All the health professionals and workers appreciated the

They (health officials) work in a risky environment. They always work in fear. Getting the protective gear materials creates a sense of confidence among them. I've talked with the beneficiaries & they replied seeing the workers in protective gears also increase the sense of confidence among them. When they get assurance that they won't feel any problem while receiving assistance from us, they visit our centres for assistance.

Chief Health Officer
Dhaka North City Corporation

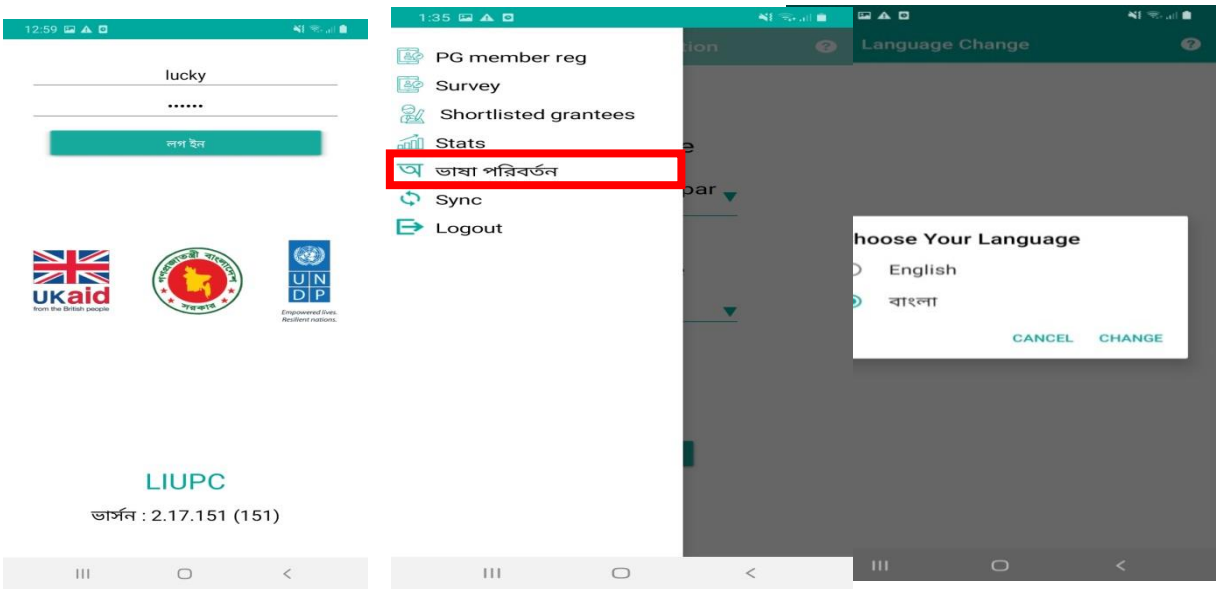
initiatives taken by NUPRP team to provide online training link and PPE. The online training topics, as mentioned by the respondents, included proper use of personal protective gear, COVID-19 symptoms and changing treatment pattern etc. Though some of the health professionals and workers reported that they could not manage time to complete the training due to extreme pressure at workplace during COVID 19; those who completed the training showed more awareness about safety rules and were more comfortable working at the front line. They also requested the NUPRP team to provide more online training links as they feel that the COVID 19 is a new experience and there are lots of updates coming about health issues every day. They stated that online training on the current update would help to prepare them to provide better health services.

Health officials across different locations reported to have received personal protective equipment that includes N-95 mask, surgical masks, infrared thermometer, flexible digital thermometer, hand sanitizers etc. from UNDP NUPRP. Receiving PPE, as mentioned by the health officials, created a sense of confidence among both the health service providers. For health service providers, having personal protective equipment along with online training on proper use of those materials helped overcome their fear to work at the front line to some extent.

E) Independent monitoring Mechanisms in place to track the progress in hard to reach areas

As part of data & research, the NUPRP team developed Rapid COVID -19 Situation Report before initiation of the emergency response and they shared the report with city/town authorities. The team also developed Risk Matrix and shared with relevant stakeholders. NUPRP team adapted two types of monitoring mechanism; internal –for verification of the beneficiary selection and for daily reporting& external- Third Party Monitoring- for independent evaluation of the emergency response.

The team also developed data collection tools using Mobile Application for monitoring the daily activities and shared the tools with town teams for daily/weekly reporting. As mentioned earlier, UNDP NUPRP maintained an exhaustive city wise MIS since 2018 which served as a databank which helped the team to select the right beneficiary and to respond quickly. However, there were issues like some beneficiaries did not have any mobile number, some numbers were closed; some beneficiaries changed their mobile number, errors in phone numbers etc. Therefore, the NUPRP team undertook 100% pre verification in 19 cities before distributing relief assistance in order to ensure that the right person received the emergency response. During lockdown, the transportation services were closed, and movement were also restricted. Hence, it was very challenging to implement the verification process and daily monitoring in the field due to isolation, restricted movement and fear of COVID 19 transmission. Still multiple verification exercises were carried out for different initiatives through a mixed approach using mobile and physical verification. This exercise also helped to track the number of Households who have migrated.



The NUPRP team also carried out post verification of grants to understand the accuracy of grants delivery to the targeted beneficiary and to ensure accountability of grants management. The findings of verification have allowed the project management to improve the quality of delivery. The third-party monitoring was conducted to evaluate the NUPRP emergency response against relevance, effectiveness, efficiency, and sustainability criteria.

The government stakeholders and town managers who participated in the study reported that the beneficiary selection process was done though a fair process. In order to ensure the transparency, the process of primary listing, verification of the primary list of beneficiaries as well as verification of those who are receiving any assistance was done by different sets of groups. They said that the accuracy of the verification is about 90-95 percent.

I've observed strict measurement was taken for the verification for relief assistance in order to ensure transparency. One team made the list of people, another team did the verification. The money was sent through mobile banking system & it was done through head office. Before sending the money another set of people did the verification.

Chief Engineer
Gopalganj

Table 15: Independent monitoring Mechanisms in place to track the progress in hard to reach areas

		Baseline	March	April	May
Number for Cities/Towns who undertook 100% pre verification for relief assistance	Planned: Number of Cities/Towns (Cumulative)	0	N/A	19	19
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	19	19
Number of Cities/Towns reporting on M&E Trackers for Weekly Reporting	Planned: Number of Cities/Towns (Cumulative)	0	19	19	19
	Achieved: Number of Cities/Towns (Cumulative)	0	19	19	20

Town wise trackers were implemented immediately to track the activities across 20 Cities as the coverage was huge and the activities were being implemented in a phased manner. This helped to inform the weekly reporting which was shared with the programme team members and government stakeholders to track the progress against the major indicators.

F) Fast tracked systems operationalized to respond to COVID-19 response

The operations and management team of NUPRP faced tremendous challenges to procure goods during COVID 19 pandemic. Due to unavailability of transportation during lockdown period, the procurement and delivery of goods were a major challenge. Most of the suppliers and manufacturers couldn't open their office/factory during that time. Ready stock was also very limited. In terms of printing communication materials, vendors were not in a position to print because of scarcity of printing materials, limited transportation and workforce due to lockdown.

Capacity of the procurement team also needs to be improved. The team was not acquainted to deal with such emergency response since the COVID 19 is completely a new thing. Capacity building in terms of training, learning sharing between different countries, job placement in emergency response countries would enable them to response more efficiently to future emergency responses.

In terms of hygienic package, 1,300 Raincoat, 1,300 Gumboot, 5,200 Hand Sanitizer, 65,000 Hand Gloves and 35,000 mask for the project staff. To support communication and outreach, the operation and management team procured 14,352 festoons, 3178 booklets, 74,360 posters and 148,720 stickers.

Table 16: Fast tracked systems operationalized to respond to COVID-19 response

		Baseline	March	April	May
Number of Hygienic Package procured (Raincoat; Gumboot; Hand Sanitizer; Hand Gloves; Mask)	Planned: Number of Cities/Towns (Cumulative)	0	0	Raincoat-1,129; Gumboot-1,129; Hand Sanitizer-4,516; Hand Gloves-56,450 and Mask-33,870	Raincoat-1,300; Gumboot-1,300; Hand Sanitizer-5,200; Hand Gloves-65,000 and Mask-35,000
	Achieved: Number of Cities/Towns (Cumulative)	0	0	Raincoat-1,069; Gumboot-1,069; Hand Sanitizer-3,991; Hand Gloves-56,450 and Mask-29,524	Raincoat-1,129; Gumboot-1,129; Hand Sanitizer-4,715; Hand Gloves-56,450 and Mask-42,265
Number of communication materials procured (Poster, Festoon, Sticker and Booklet)	Planned: Number of Cities/Towns (Cumulative)	0	0	37,000 Festoons; 5,000 Booklets; 130,000 posters; 160,000 Stickers	37,000 Festoons; 5,000 Booklets; 130,000 posters; 160,000 Stickers
	Achieved: Number of Cities/Towns (Cumulative)	0	0	3 Festoons; 206 Booklets; 56,600 posters; 31,000 Stickers	14,352 Festoons; 3,178 Booklets; 74,360 posters; 148,720 Stickers

Outcome 2: Community level - Access to basic human rights by urban poor and social cohesion is maintained during the COVID crisis

A) Proportion of people practicing handwashing at the community and household level

Access to improved water and sanitation facilities leads to improved health. WASH (Water, Sanitation and Hygiene) has always been an integral component of UNDP NUPRP programme. Tap water inside dwelling or piped to community/slum yard/plot is the main source of drinking water for around 50% of the beneficiaries and non-registered members. Around 35% (32% beneficiaries & 37% non-registered community members) people also collects drinking water from tube well inside community/slum (Annexure 1: Table 8).

About half of the people (56.8% beneficiaries & 49.5% non-registered community members) use pit latrine with slab. Another 30% people (27.4% beneficiaries & 33.6% non-registered community members) use sanitary latrine (water sealed) (Annexure 1: Table 9). In both cases (intervention and non-registered community members) around 50% people share the toilet with other slum people (Annexure 1: Table 10). About 55% people have water and soap outside the toilet (Annexure 1: Table 11 & 12).

In order to encourage healthy WASH habits & practices during COVID 19, UNDP NUPRP team provided 2.6 million soaps and established 3,256 hand washing corners at different important locations of the urban slums. The community development group members were actively engaged in the process and they selected the important locations for establishing hand washing corners in consultation with the community people. It has helped the NUPRP team to identify the important locations so that the community people have access to those hand washing corners. As the result of awareness raising activities, soap distribution, hand washing corner establishment, the households become aware of importance of handwashing on different occasions to protect themselves from COVID 19 transmission. All the respondents (100%) reported that they are practicing hand washing and they also installed 2,341 tippy-taps with their own resources.

Table 17: Proportion of people practicing hand washing at the community and household level

		Baseline	March	April	May
Proportion of people practicing hand washing at the community and household level	Planned: Number of Cities/Towns (Cumulative)	N/A	40	70	100
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	N/A	100
Number of hand washing Corners that are accessible to people at the Household/CDC area	Planned: Number of Cities/Towns (Cumulative)	0	0	2,317	2,367
	Achieved: Number of Cities/Towns (Cumulative)	0	0	2,886	3,256

Number of people who have access to soaps for hand washing from NUPRP	Planned: Number of Cities/Towns (Cumulative)	0	N/A	2.2m	2.2m
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	2.2m	2.6m

It is also observed that the beneficiaries are practicing hand washing more frequently during COVID 19 pandemic. The beneficiaries and CDC members stated that due to emergency response programme of NUPRP (awareness campaign, soap distribution, establishment of hand washing corners and tippy-tap), the people are now aware of the preventive measures to protect themselves from the COVID 19 transmission and they are now practicing hand washing regularly at household and at community level.

Because of the communication and WASH activities of NUPRP during COVID 19, not only the beneficiaries but also the community members were encouraged to develop hand washing behaviour. It is observed that the hand washing practice with soap on different occasions have increased significantly during COVID 19. Almost all the beneficiaries (95%) who have received soap from NUPRP stated that they will purchase soap for hand washing after the soaps received from NUPRP are over (Annexure 1: Table 14). Around 90% of the beneficiaries and non-registered community members reported that they have access to the hand washing corners established by UNDP NUPRP (Annexure 1: Table 15).

Table 18: Percentage Distribution of Hand Washing Occasions with Soap before and during COVID 19

Hand Washing Occasions with Soap	Intervention		Non-Registered Member	
	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19
Before cooking	57.6	96.3	48.7	95.3
During cooking	51.8	93.3	44.4	94.2
After cooking	68.8	96.8	57.9	96.3
Before eating	71.7	96.5	64.8	96.7
Before feeding the child	74.5	97.6	64.4	95.3

After cleaning the child's feces	90.6	97.9	91.5	98.7
After going to the toilet	93.9	97.9	95.5	98.2
If hands are dirty	82.7	97.4	87.6	97.3
After coming home from outside	71.0	96.8	72.3	96.5
After touching things and packets purchased from the market	68.4	96.6	60.6	96.2
After any sort of contact with animals or cleaning their feces	90.8	98.6	60.6	100.0
After carrying or coming in contact with a person infected with the corona virus	0.0	98.2	0.0	98.4
n	4100		440	

Case Story

Halima, a 55 year old lady living in Chandpur Municipality, makes and sells paper bags to earn a living. It was 2 years back when she joined Rajanigandha, a Primary Group of Chandpur Municipality CDC. Soon her leadership quality and active role in the group earned her the role of President within a year. When the COVID-19 hit her area, she did not sit idle either. With guidance from the NUPRP team, she took an active role in raising awareness about corona virus spread in her area.

As a CDC leader, she was involved in all of UNDP's emergency response initiatives - posters, stickers, and soap distribution; and establishment of hand washing corner to make people aware and prevent the pandemic in her community. Under the emergency response program, CDC leaders like her have been trained about proper hand washing to prevent Corona Virus. Halima then went on to spread her knowledge in the community and also make them develop a healthy habit of hand washing. She thinks this knowledge along with the availability of hand washing corners made people habitual of washing hands properly and frequently and established the programme team and CDC in almost every corner of her community.

The initiative came at a time when many people are losing their jobs. Her husband had a scrap business that had to be shut down because of the COVID-19 pandemic. And she knows it well, when the livelihood is hit hard, it becomes difficult to focus on health and afford even a soap.

> *From CDC, we have distributed 4 soaps to 170 households each out of 240 households. In such a tough time, things like distributing four bars of soap that are worth of 45 BDT each have been a great help for the poor.*
>
> - Halima, CDC President, Chandpur Municipality

She thinks that the program interventions are a success story and feels proud that she was a part of the initiative to help the poor people of her community as a CDC leader during this crisis time. She believes because the program has elements of success, the coverage of this assistance needs to be increased to help more vulnerable people.

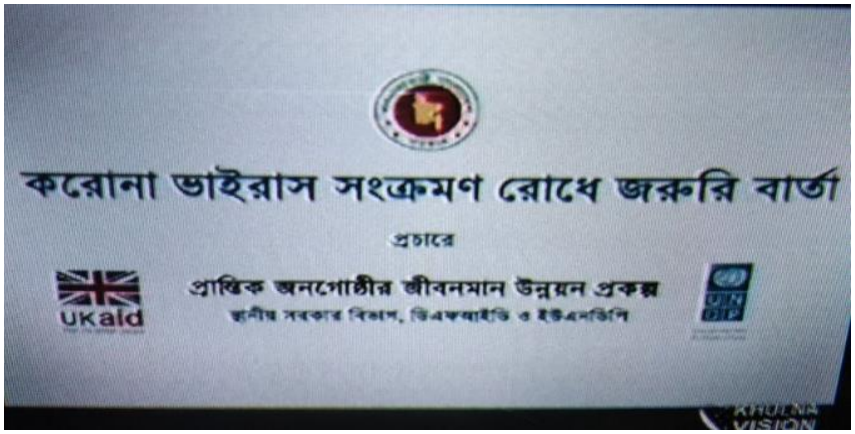
B) Urban poor and Stakeholders have increased awareness to cope with COVID- 19

As people were unaware of the COVID 19, it was imperative to create mass awareness to make the slum people aware to take precautionary measures to prevent COVID 19. UNDP NUPRP facilitated mass awareness campaign to spread key messages for COVID 19 prevention in 20 cities through producing & distributing IEC/BCC Materials (poster, festoon, booklet, sticker), loudspeaker announcement in slum areas as well as through local cable TV operator and local media, sharing SMS to Primary Group Members & slum inhabitants, advocacy with media forum (press release on daily newspapers) and media broadcast (ETV) and post sharing in social media. A total of 22 articles were published by print and digital media.

One of the most significant achievement was the UN Secretary General António Guterres wrote an Op-Ed on UN News global webpage. Since NUPRP was able to effectively reach out to the most vulnerable populations across the urban slums in Bangladesh who were worst affected by the pandemic, this was highly recognized by United Nation Secretary General and by UN Deputy Secretary-General Amina Mohammed as UN News published her interview. NUPRP's communication inputs and photographs of COVID-response were featured in two blog articles by Andrew Hudson, Head of Water and Ocean Governance Programme, UNDP, and Ulrika Modéer, UN Assistant Secretary-General and Director of the Bureau of External Relations and Advocacy, UNDP.

Festoon

Loudspeaker Announcement



Awareness message dissemination through local cable

Multimodal communication of the programme resulted in increasing the awareness level of slum residents in 20 cities/towns and helps them to take precautionary measures to prevent COVID-19. In addition to UNDP, The government of Bangladesh, all the remaining UN agencies and international and local NGOs put high emphasis on creating mass awareness on COVID 19. As a result of combined effort of all, all the respondents (100%) reported increase in their level of awareness on COVID 19 which was 72% before the NUPRP emergency response started.

Table 19: Urban poor and Stakeholders have increased awareness to cope with COVID- 19

		Baseline	March	April	May
Proportion of people reported increase in their level of awareness on COVID 19	Planned: Number of Cities/Towns (Cumulative)	72	72	80	100
	Achieved: Number of Cities/Towns (Cumulative)	72	72	80	100
Number of Articles published by the print & digital media	Planned: Number of Cities/Towns (Cumulative)	0	N/A	10	15
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	10	22

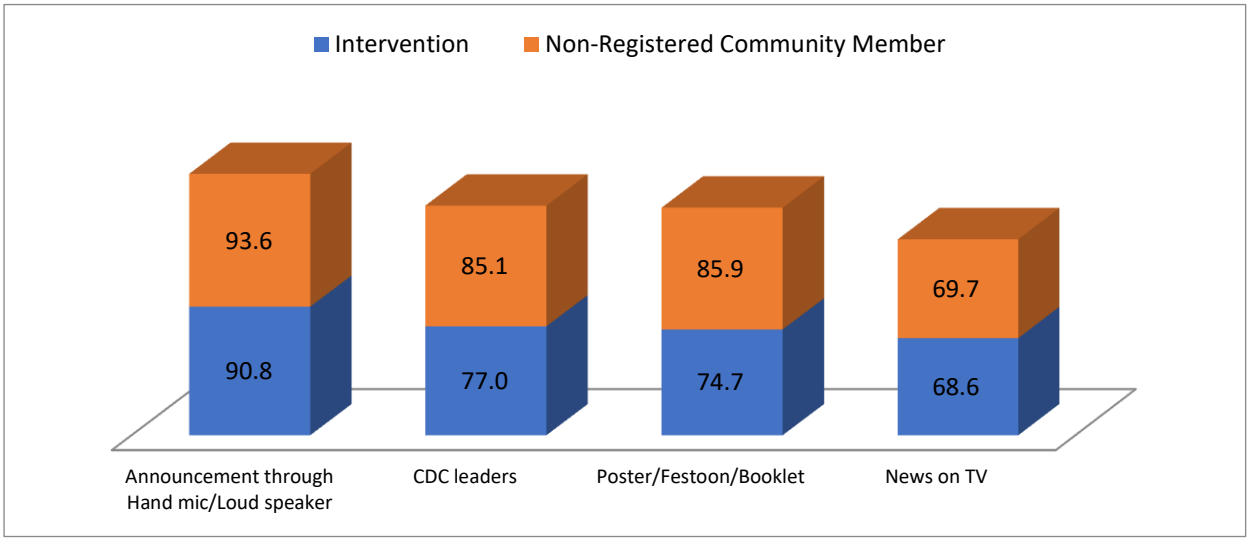
The communication and outreach of UNDP NUPRP was able to create mass awareness among the community people. Around 97% of the beneficiaries and 88% of the community members heard of awareness campaign run by LG/NUPRP. With respect to knowledge, it is found that both the beneficiaries and non-registered community members are aware on what COVID 19 is, how COVID spreads and how to prevent the transmission of COVID 19. This knowledge enables them to take precautionary actions in their everyday life to protect themselves from COVID 19 transmission.

Table 20: Percentage Distribution of Learning from NUPRP Communication Campaign

Learning from NUPRP Communication Campaign	Intervention	Non-Registered Community Member
Wash your hands regularly for 20 seconds, with soap and water	98.4	98.7
Cover your nose and mouth with a disposable tissue or flexed elbow when you cough or sneeze	87.8	79.2
Dispose used tissue in bin immediately & properly wash hands with soap after cough or sneeze	80.9	83.0
Avoid close contact with people who are suffering from flu or cough or fever	76.9	73.0
Avoid spitting in public	72.7	64.8
If you have fever, cough, and difficulty breathing seek medical care early and share previous travel history with your them	65.8	57.3
Do not touch your eyes, nose, or mouth if your hands are not clean or after touching anything	68.0	61.4
Stay home and self-isolate from others in the household if you feel unwell	64.4	52.7
Thoroughly cook meat and eggs	57.0	56.6
If possible avoid or otherwise maintain social distance in crowd, market, and social/religious gatherings	70.7	66.3
Using mask outside home	70.6	69.2
Frequently wash your hands with soap and water after touching animals and animal products	46.4	54.0
Share information on corona virus prevention to a person with disability in your family or in your neighbourhood, if any	45.1	51.7
n	3973	389

Announcement through loudspeaker and community development group leaders & poster/festoon/booklet/sticker are the top three sources of knowledge on COVID 19. There was very little mention about text message, cable TV announcement, and social media posts. During qualitative sessions, the beneficiaries preferred announcement through loudspeakers and involvement of CDC members to spread information on COVID 19. The CDC leaders played a crucial role on spreading knowledge on COVID 19. They visited door to door during lockdown period using protective gears and made people aware of COVID 19. There was less mention about poster/festoon, and booklet during qualitative session. The posters/festoons are verbose, and it is difficult for the urban slum people to comprehend the messages due to their education level.

Figure 4: Percentage Distribution of Source of Information on COVID 19



Case Story

Rina Horijon is a sweeper in Noakhali Pourshobha Colony. She is uneducated, earns very little from cleaning wastes, and belongs to a community that often faces discrimination solely for their inherited occupational identity. She has to work almost every day and has little savings.

Rina's husband, three sons and brother-in-law shares the same profession with her. Despite everyone working, they had a monthly household income of BDT 15,000. The outbreak and spread of COVID-19 predictably hit the family hard. They did not lose their jobs, but they could not sit at home either. Rina and her family members had to get out and clean the street every day with the fear that anytime they will be affected by the virus. They have known about the spread of corona virus from television like many others. But little did they know that they can minimize the possibility of contracting it if they took necessary precautions. This is when the NUPRP team launched its emergency response program to make poor vulnerable people aware about the COVID-19.

The awareness campaign of the CDC team in Ward no 4, Noakhali Municipality incorporated distributing leaflets and stickers, distributing soaps and establishing a hand washing point in a place accessible to all. Rina has been a member of CDC Primary Group called Dab for a year now. She and her family breathed a little when the CDC leader went to her, shared the leaflets and told them how the COVID-19 spreads and how they can prevent it. Adding to it was the hand washing corner. Rina believes it did help them to develop the habit of regular hand washing.

> *We know that corona virus spreads from person to person, but we also know how to protect ourselves against the virus. Now me and my family regularly wash our hands, wear masks outside the home, and maintain social distance. We probably wouldn't have done if CDC hadn't come and let us know.*
>
> *- Rina Harizon, Noakhali Municipality*

The awareness campaign helped her family in two ways – providing information on how they can still work taking necessary precautions and forming a healthy habit of regular hand washing. Being cautious

is the key, she now understands. She is grateful for the work the NUPRP team doing in her community. She feels a lot safer when every morning she and her family step out of home and earn that feeds her 7 family members. In a time like this pandemic, she cannot be more thankful!

C) Communities are adopting safety measures to ensure protection from infection

The NUPRP has ensured PPE for all the frontline workers to ensure their safety from infection and enabled them to continue providing their services for the urban poor most exposed and vulnerable to the pandemic. A total of 1,034 personal protection equipment gears were provided to the frontline workers. This has created a sense of confidence among the frontline workers. The provision of PPE enabled the frontline workers to engage in COVID response at the community and household level without any fear of COVID 19 transmission.

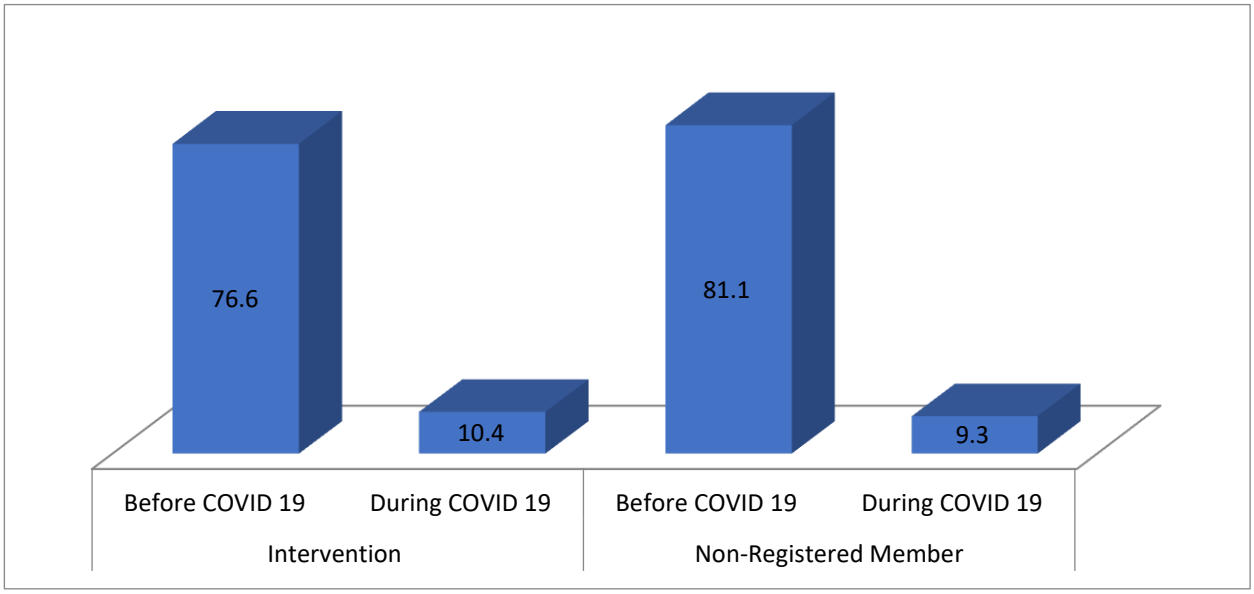
Table 21: Number of Town staff using Personal Protection Equipment (PPE) gear to undertake field operations

		Baseline	March	April	May
Number of Town staff using Personal Protection Equipment (PPE) gear to undertake field operations	Planned: Number of Cities/Towns (Cumulative)	0	0	1,034	1,034
	Achieved: Number of Cities/Towns (Cumulative)	0	0	1,009	1,034

D) Proportion of Households with High/Medium/Low MPI have access to food/cash to meet basic needs

COVID 19 has severely affected the livelihood of the poor people specially the urban slum dwellers. The situation exacerbated when the government imposed nationwide lockdown from 26th March to 31st May, 2020. Majority of the slum dwellers are day labourers and domestic workers. These people became unemployed and struggled to manage the minimum food for their family members. They did not have access to Cash/Food to meet the basic needs.

Figure 5: Percentage Distribution of People Have Access to Cash/Food to Meet the Basic Needs



In order to understand the impact of COVID 19 and subsequent lockdown on dietary diversity of the slum dwellers, a respondent's dietary diversity has been measured analysing last 24 hours food consumption of the households. Respondents were asked for a 24 hour recall to know whether they consumed any of the thirteen sets of food group. The food group include Cereals, Roots and tubers, any coloured vegetable, any leafy vegetable, any fruits, any meats, any egg, any fish, pulses/legumes/nuts, milk product, oil/fat, sugar/honey and miscellaneous. The proportion of beneficiaries and non-registered community members having 5 food groups or more has reduced significantly during COVID 19 (Table 25). The situation of old age people with disability and female headed households is worse compared to other group of people (Annexure 1: Table 16). With respect to food items consumed, the protein (meat, egg, and fish) and milk and milk products intake had reduced significantly (before COVID 19: intervention- meat 33.7%, egg 57.3%, fish 84.7%, milk& milk products 12.3%, Non-registered member- meat 39.8%, egg 71.4%, fish 88.6%, milk& milk products 16.1%, during COVID 19: intervention- meat 11.5%, egg 33.3%, fish 47.9%, milk& milk products 6.5%, Non-registered member- meat 13.9%, egg 43.6%, fish 49.1%, milk& milk products 11.1%, (Annexure 1: Table 15). To deal with the crisis situation, majority of the people had to take in-kind loan from outside HH (intervention: 71%, non-registered community member 82%) and cash loan (intervention: 67%, non-registered community member 65%). Some people also sold their assets (intervention: 9%, non-registered community member 14%) and livestock (intervention: 5%, non-registered community member 8%) to deal with COVID 19 crisis period (Annexure 1: Table 17).

Table 22: Percentage distribution of Impact of COVID 19 on Dietary Diversity

	Intervention		Non-Registered Member	
	Before COVID 19	**During COVID 19**	**Before COVID 19**	**During COVID 19**
5 food group and above	86.2	73.6	89.5	79.5
4 food group	7.9	18.0	4.5	13.4
3 food group	2.8	4.7	1.6	3.2
2 food group	2.2	2.4	4.1	3.6
1 food group	0.9	1.3	0.2	0.2
Household Dietary Diversity Score (HDSS)	8.0	6.8	8.5	7.3
n	4100		440	

Considering the impact of the COVID 19 on the livelihood of the NUPRP beneficiaries, the team decided to provide onetime cash transfer/food basket so that they have access to food/cash to meet basic needs. Due to fund shortage, it was not possible to provide cash assistance/food basket to all the beneficiaries. A total of 77,560 Households received (which is around 21 percent of the total beneficiaries) the cash/food assistances. Among the 77,560 households who received cash/food assistance, 4% households were from High MPI, 19% households were from Medium MPI and 77% households were from Low MPI.

Table 23: Proportion of Households with High/Medium/Low MPI have access to food/cash to meet basic needs

		Baseline	March	April	May
Proportion of Households with High/Medium/Low MPI have access to food/cash to meet basic needs	Planned: Number of Cities/Towns (Cumulative)	0	N/A	20	100
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	N/A	21 (Due to fund shortage, a total of 77,560 HHs receive food/cash assistance out of 378,560 registered HHs. Among them 4% HHs from High MPI, 19% HHs from medium MPI and 77% from low MPI
Numbers of households who are most vulnerable to COVID-19 have received livelihood support, e.g. cash transfers, food basket, etc.	Planned: Number of Cities/Towns (Cumulative)	0	N/A	7,900	69,686
	Achieved: Number of Cities/Towns (Cumulative)	0	N/A	7,900	77,560 (Food Basket 7,900, Cash Transfer 69,660

In terms of cost, the distribution of food basket incurred less operational cost. However, several challenges were associated with cash transfer and food basket distribution. Cash is the most preferred system as providing food doesn't include the freedom of choice. It is a human right based approach and with cash, the beneficiary can spend money on purchasing necessary items along with food items. It was very challenging for NUPRP to transfer cash to the beneficiaries during COVID 19. Many Primary Group Households did not have the mobile phone, Rocket Account or did not provide the accurate mobile number which made the cash transfer difficult. The NUPRP team had to check all the mobile numbers before transferring the money. They also had to open Rocket accounts for the beneficiaries who did not have account before.

On the other hand, distribution of food basket has also certain limitations. Due to lockdown, the transportation services across districts were closed. Therefore, it was not possible for the NUPRP team

to provide food basket to the cities/towns except Dhaka. UNDP also did not have registered vendor in each of the NUPRP working areas for the supply of food basket. Procuring food basket from major cities and then send them to other cities would incur huge transportation cost. In addition, due to fund shortage it was not possible to provide food basket to all the urban slum people. It was really challenging to manage mass gathering & there was backlash in the community, especially from the remaining registered households & non-registered community members who did not receive food basket.

Distribution of food basket or transferring cash is very subjective, depending on the situation and time. In general, cash is preferred but food might also be preferred in some contexts. For example, if it takes 30 days to transfer cash where it takes only 3 days to distribute food basket then the programme should go for providing food basket. Suring emergency situation, it is imperative to ensure that people are getting emergency response in time. UNDP NUPRP should examine all the potential risks before taking decision for any future emergency response.

Table 24: Risk Factors associated with Cash Transfer and Food Basket

Type of assistance	**Unit Cost (BDT)**	**Per Unit Operational Cost**	**Risk Factors**
Cash Grant	1,500	13.5	• Many Primary Group Households did not have the mobile phone, Rocket Account or did not provide the accurate mobile number which made the cash transfer difficult. The NUPRP team had to check all the mobile numbers before transferring the money. They also had to open Rocket accounts for the beneficiaries who did not have account before.
Food Basket	2,262	0	• Due to direct delivery to the distribution spot, it was challenging to manage mass gathering & distribute food basket among them smoothly. • There was backlash in the community, especially from the remaining registered Households who have not received food basket and also from the non-registered community members. • Due to lockdown, the transportation service across districts was closed. Therefore, it was not possible for the NUPRP team to provide food basket to the cities/towns except Dhaka. This option is not viable to during the emergency situation. • UNDP did not have registered vendor in each of the NUPRP working areas for the supply of food basket. Procuring food basket from major cities and then send them to other cities would incur huge transportation cost. • With respect to perishable good, the programme had to ensure quick delivery of the good.

The beneficiaries who have received the livelihood support expressed their sincere gratitude to NUPRP for providing the support in time of acute crisis. They stated that during the crisis period, they did not have any option to earn money and had no way to bear the regular expenditure of the

family members. The further added that this livelihood support was like blessing for them as they could survive around 15 days with this support.

Case Story

Dilu and her husband both lost their earnings to COVID-19. Along with her mother, husband and 3 daughters, she lives in Chattogram Municipality. It was in 2008 when she suffered a stroke and became paralyzed. She has gained limited mobility over time. But she cannot afford the cost of medical treatment that can make her become better than she is now. She joined a Primary Group named Shapla in Ward 37, Maddham Hali Shahar, Ananda Bazar in 2018. Before the COVID-19 outbreak, she had received 10,000 BDT as an entrepreneurship grant from the NUPRP program and started a Pitha shop. But as the COVID-19 spread, the shop had to be closed. Her husband, who is an auto-rickshaw driver, lost his job too once the pandemic hit off. He used to drive a hired auto-rickshaw. Already struggling with an ill health, he was one of the first to be ousted from his job. The corona virus impacted this family severely.

The first thing they had to compromise was their food intake. Their daughters are very young, aged 1.5 years, 4 years, and 9 years. They are growing up and need proper nutritional intake. Lack of affordability to provide good food made Dilu very worried. At that crisis moment, the NUPRP team of Chattogram City Corporation helped her under their emergency response program. She received 5 soaps and BDT 1,500 as cash assistance. As soon as she received the money, the first thing she did was buying nutritious food for her daughters and medicine for her ailing husband.

> ***Before the COVID-19 outbreak, my family used to have meat or fish at least once a week. We lost our ability to buy that when the corona virus came. We lost to a virus. Thanks to UNDP's cash assistance. I was able to buy some good food for my daughters and medicine for my husband.***
>
> - ***Dilu, Person with disability***, Chattogram City Corporation

The cash received has been put to a good use for her family during the pandemic. While interviewing, she expressed great happiness with the support she has received from the UNDP. She thinks it not only was a great help to her family but also to other poor people in her community.

Case Story

Roushan-Ara is a 56 year member of Shiyuli, a Primary Group in Gunraj Buiyan Bari, Chandpur Municipality. She lost her husband 12 years ago. Currently, she lives with her only son, one daughter and her husband, and 2 grandchildren. One of the grandchildren is autistic. Before the COVID-19 outbreak, her son and son-in-law were the main earners in the family. Her son-in-law worked in a grocery shop and earned around BDT 6,000 per month. Her son, who has passed Fazil and is still studying, was working as a teacher in a Madrasa. He earned BDT 2,000 every month. As the COVID-19 outspread, both the grocery shop and the Madrasa closed down and the family lost all sources of income. The pandemic deprives her family of livelihood opportunities that are already hard to come by. They have lost whatever opportunities they have created for themselves. Now they get up every day and worries every morning whether they would have anything on the table. They already eat less than they used to; trade off meat and fish with lentil. Life has become harder than it already was.

Being a member of a Primary Group, she was selected for a cash assistance of BDT 1,500 by the NUPRP team. As she received the money, she went to bazar herself and bought food for the family and clothing for the grandchildren. In a dire time like this pandemic, the money did bring a bundle of joy to this family. Roushan-Ara joined the CDC only 9 months ago and given her financial insolvency, she received BDT 10,000 as business grant. She bought a goat with that money. Although the pandemic has brought her life to a stalemate, she remains hopeful with CDC beside her and is waiting for brighter days.

E) Gender Responsive Safeguarding

The Covid-19 pandemic not only affects the physical health of people but also other aspects of their social life – ultimately resulting in mental health issues and domestic violence. "Manusher Jonno Foundation (MJF)" conducted a tele survey on 53,340 women and children and found 11,323 women and 2,171 children have experienced domestic violence in Bangladesh amid the Covid-19 pandemic[9]. The organisation also found that 462 child marriages occurred in 53 districts in June – up from 170 the month before[10]. Against the backdrop of the economic downturn – that has led to job and income losses both in formal and informal sectors – violence against women and children has increased and early marriage has become a way for families to rid themselves of the responsibility of caring for their girls.

During the qualitative sessions, some CDC leaders mentioned that during lockdown people had to stay at without any work. Loss of job and fear of death of COVID 19 have also impact on the mental health of the people. During this time, people were staying in monotonous, unusual and anxious state at home, experiencing helpless, blaming others to be responsible and slowly progress to mental breakdown[11]. As a result, there were few incidents of domestic violence (physical and verbal

9 Dhaka Tribune, online news published on September 04, 2020. Accessed from https://www.dhakatribune.com/health/coronavirus/2020/06/10/mjf-13-494-women-children-faced-domestic-violence-during-covid-19-lockdown

10 The business standard, online news published on September 04, 2020. Accessed from https://tbsnews.net/coronavirus-chronicle/covid-19-bangladesh/child-marriages-rise-amid-covid-19-economic-crisis-mjf

11 KM Amran Hossain, Susmita Roy, Mohammad Mosayed Ullah, Russell Kabir, SM Yasir Arafat, , COVID-19 and Mental Health Challenges in Bangladesh, April 02, 2020, accessed from

harassment) reported. The CDC leaders also stated that in majority cases, women do not feel comfortable to report domestic violence due to family and social pressure. It was also found that in some cities (Dhaka South City Corporation, Rangpur) the CDC leaders (women) were harassed by the local political leaders, CDC members and community people during the distribution of food/cash assistance.

During the time of COVID 19, UNDP NUPRP disseminated messages and content on COVID impact with gender perspective. It has established gender-based violence and safeguarding reporting mechanism at community and staff level. It has also strengthened community organizations (safe community committees/clusters) to share the information of local referral mechanism with women and girls of the respective community. NUPRP responded immediately by management if any safeguarding case happened. UNDP NUPRP supported the distribution of dignity kit in partnership with UNFPA among women of reproductive health on a pilot basis in Dhaka South City Corporation. These dignity kits consisted of items such as cloths, sanitary napkins, women's underwear, bathing soap, laundry soap, nail clippers, hair oil, combs, rubber sandals, toothpaste and toothbrushes. To ensure protection from COVID-19 and dengue, the kits also included hand sanitizers and mosquito repellents.

4.4 SUSTAINABILITY & GOOD PRACTICES

In order to ensure the sustainability of the results of the emergency response, UNDP NUPRP has strategically engaged both local government and community leaders. Coordination with government stakeholders helped to plan the logistics more efficiently. Using the databank of NUPRP, the local government distributed relief among poor vulnerable people in order to avoid any duplication. It has helped them to reach more people for relief distribution. Though the emergency response of UNDP NUPRP ended in May, 2020, the government officials have continued their work in terms of food relief distribution, awareness raising activities, hand washing corner establishment, PPE distribution among health staffs and frontline workers in different cities.

> It is confirmed that the COVID 19 will stay for a longer period. So it is important to continue the dissemination of the awareness messages among community people otherwise people will not continue the handwashing practice, social distancing and using personal protection equipment.
>
> CDC Member
> Dhaka South

The community development groups also played a very important role during emergency response and different good practices are reported during the data collection. NUPRP has engaged the CDC members from the very beginning of the emergency response in order to empower them so that they own the initiatives of the emergency responses in future. The CDC members were actively engaged in awareness raising activities, selecting locations for establishing hand washing corners, helping community people to make tippy-taps, selecting and distributing relief to vulnerable people and so on. This gives them a sense of ownership and to ensure the long term effect of the emergency response carried out by UNDP NUPRP, the CDC members are now regularly following up

https://www.researchgate.net/publication/342623723_COVID-19_and_Mental_Health_Challenges_in_Bangladesh

with the community people on the preventive measures to keep themselves safe from COVID 19. They stated that though the emergency programme has ended but the crisis of COVID 19 will stay for a longer period. Therefore, this is imperative to continue the dissemination of the messages on COVID 19 on a continuous basis. It will motivate people to wash their hands regularly, to maintain social distance and to use personal protection equipment.

In some cities, the CDC leaders also went to government stakeholders to discuss the situation of the vulnerable people in their community who have not received. They negotiated and convinced the government stakeholders to include the names of the poor who were not covered in the government relief distribution coverage. They also took personal initiatives to raise funds from the wealthy people and distributed food with that fund to the poor people who were extremely vulnerable during COVID 19 pandemic. However, the CDC leaders reported that many of them feel hesitant to discuss and negotiate with the government stakeholders. Capacity building initiatives on negotiation and fund mobilization and increased interface would enable the CDC leaders to hold dialogue with government stakeholders about the problems of their communities and to negotiate for different solutions to resolve those problems.

It is also reported that in many cities i.e. Khulna, Faridpur, the CDC members are making masks at home and distributed/sold those masks for free or at a lower cost so that people can wear masks to protect them from COVID 19.

To ensure sustainability of hand washing corners established by NUPRP team, the CDC members are placing soap and water at the hand washing corners every day and also raising a fund from the community and local authority for the maintenance and repairing of the hand washing corners. They are also motivating the community people to wash their hands with soap at the hand washing corner so that they can develop the habit of hand washing and protect themselves from COVID 19.

4.5 LESSON LEARNT

The COVID-19 pandemic has ushered in changes worldwide that were unimaginable even a few months back. Although the calamity might appear to have been around for a long period, it is still in its ascendancy and many more transformations may be in store for us in the foreseeable future. Different projects of UNDP Bangladesh have carried out emergency response and several lessons were learnt. Some of the lessons learnt are highlighted below:

Coordination with government & Development partners:

- Coordination among different stakeholders i.e. government stakeholders and development partners working in COVID response was a vital factor to ensure the success of the emergency response. Multi-sectoral, multi-partner coordination mechanism can maximize the reach of beneficiaries during the emergency relief distribution. This coordination helps to increase the efficiency and ensure transparency in different activities of emergency response.
- Representation of community development groups in Ward Level Relief Committee is very important to raise voice of poor community members in Ward Level Committees. Strengthening community based organization and capacities of the urban local government can in future help to strengthen their capacity to respond.

Operations:

- For procurement, there should be a contingency plan for procuring goods in small quantity alongside with the bulk procurement for addressing emergency needs.
- Long term agreement (LTA) with selected vendors can eliminate the lengthy procurement process and can ensure prompt response during emergency time.
- Decentralization of the procurement through local vendors at City level can give flexibility to the operations team to respond faster and reduce the cost of transportation.
- Strong coordination between programme and operations team can reduce the time of procurement process which will ensure prompt response during the emergency time.

CDC Members:

- Community development groups can play a catalyst role in the emergency response. Engaging them at the beginning of the programme can help to motivate them to build ownership and to work for the sustainability of the prorgamme intervention results.
- Including CDC leaders to receive food/cash assistance would motivate them work diligently.

Food & Cash Distribution:

- During COVID 19 pandemic, households with low MPI scores have been equally affected and lost their livelihoods. It was important for the NUPRP team to reconsider using the MPI score as yardstick for prioritizing poor during this crisis.
- UNDP has experimented two types of livelihood support- One Time Cash Transfer and Food Basket Distribution. In terms of Cash transfer, it is imperative to have updated database with accurate mobile phone number and Rocket Account as most did not have Rocket Accounts.
- In terms of food basket distribution, transportation was a major challenge to provide food basket across cities during the lockdown period. Distribution of food basket to certain proportion of people also led to tension among the community members as the demand was more than the supply. Hence, distribution of food basket was not feasible option during the COVID 19 epidemic.
- The cash transfer is the faster option to respond to the any emergency situation. It also allows the vulnerable people to spend money on different necessities i.e. food, health care etc.

Communication & Outreach:

- The interactive communication i.e. announcement through loudspeaker and door to door visit by the CDC leaders are the most effective methods to disseminate the awareness message on any issue.
- The urban slum dwellers faced difficulty to understand the print materials as they find the print materials wordy. The pictorial print materials would be easier for the urban slum dwellers to understand the message.

- Collaboration with the religious leaders & schoolteachers to disseminate the important messages on COVID 19, violence against women and children, child marriage, school dropout & child labour could bring better result.
- Sending text message to the urban slum dwellers does not have much impact as they are not comfortable reading messages in their mobile phones.

WASH:

- Providing hygiene materials (soap), establishing hand washing corners at the important locations at community level, assisting community people to install tippy-tap at household level encourage people to practice hand washing at community and household level.

MIS & Monitoring:

- The NUPRP team established the MIS with a databank of beneficiary contacts in 2018. Having an exhaustive city wise databank of beneficiaries enabled UNDP to target the most vulnerable populations and plan and respond to the emergency situation. The two years old database needs to be updated to reduce the verification and avoid delays.
- The Pre & post verification of grants were very important to ensure the right people are getting cash/food and to assess the accuracy of grants delivery and receipt of support. The findings of verification would allow project management to improve the quality of delivery.

Front line workers:

- Bangladesh's frontline responders are highly vulnerable during COVID 19 pandemic. The mortality rate of doctors in Bangladesh was the highest in the world in June. 1,352 nurses, 1,919 people providing medical services, 11,000 police officials, and 3,000 armed force personnel were tested positive for COVID-19[12].
- Ensuring safety and security of front-line staff and community leaders in terms of providing them training on COVID 19, and personal protection equipment was critical to carry out response activities against COVID-19 in densely populated low-income urban settlements.
- To keep up the morale of frontline staff and CDC leader's health, insurance measures and risk incentives are essential.

Knowledge Sharing:

- Knowledge sharing on the challenges and learning's from COVID 19 emergency response across different programmes and different countries would enable the UN team members to formulate strategies for any future emergency response.

[12] COVID 19 Situation Report, BRAC, accessed from https://www.brac.net/covid19/res/sitrep/COVID-19-Sitrep_8-July-2020.pdf

Online Platform:

- During COVID 19 pandemic, a lot of activities were undertaken online i.e. meeting, conference, training. This has reduced the need for face to face interaction and communication became faster. Continuing this practice in future would bring more efficiency in time management.

Cross-cutting issues:

- During any disaster, women and children are the most vulnerable segments. In addition, people with disability, elderly people, and female headed households suffer a lot during any disaster.
- Along with providing livelihood support and WASH materials, it is imperative to consider the cross-cutting issues i.e. violence against women and children, child marriage, internal migration, child labour, school dropout, mental wellbeing of people and so on.

CHAPTER FIVE: CONCLUSION & RECOMMENDATION

In conclusion it can be said that the emergency response carried out by LG/NUPRP was highly successful for supporting the vulnerable people during COVID 19 pandemic. During nationwide lockdown, the situation of the urban poor people became very miserable. Majority of the urban poor people are daily labourers and had no income during that time. This had severely impacted their monthly household income, food intake, health and so on.

Considering the impact of COVID 19 on the livelihoods of poor people, UNDP NUPRP undertook 7 core activities for the emergency response. The NUPRP team strategically engaged with local government stakeholders to respond and coordinate. The town managers in all cities/towns shared the list of Primary Group (PG) members with local government and different development organizations for selecting most vulnerable households of the low-income settlements for food assistance during COVID 19 outbreak. Using the list of NUPRP, the local government also distributed relief among poor vulnerable people in order to avoid any duplication. It has increased the efficiency as the list has helped them to reach more people for relief distribution. Some coordination problems were identified between the NUPRP team and government stakeholders because of the poor coordination of NUPRP with the Ward Level Relief Taskforce. Due to lockdown and fear of COVID 19 transmission, it was not possible to conduct regular meetings. In addition, there was disagreement between Ward Level taskforce& NUPRP team in terms of selection of beneficiaries for relief distribution. In many places, there was a high demand from the Ward Councillors/Taskforce members for expanding the food assistance beyond the NPRP intervention areas. It was not possible for the town teams to provide any support to the people who were not listed in the beneficiary list. As a result, some of the government officials were dissatisfied with the emergency response of UNDP NUPRP team.

With respect to communication and outreach, UNDP NUPRP has facilitated mass awareness campaign to spread key messages for COVID 19 prevention in 20 cities. Multimodal communication initiatives of the programme have increased awareness level of slum residents in 20 cities/towns and help them to take precautionary measures to prevent COVID-19. However, the announcement through loudspeakers and involvement of CDC members to spread information on COVID 19 were found to be more effective compared to other communication initiatives. The respondents find the print materials wordy and are difficult to understand.

To encourage healthy WASH habits & practices during COVID 19, UNDP NUPRP team provided soaps and established hand washing corners at different important locations of the urban slums. As a result of awareness raising activities, soap distribution and hand washing corner establishments, the households are practicing hand washing and also installed 2,341 tippy-taps with their own resources.

In order to support the livelihood of the NUPRP beneficiaries during COVID 19, the team has provided onetime cash transfer/food basket to 77,560 Households. Due to fund shortage, it was not possible to provide livelihood support to all the NUPRP beneficiaries. The team faced several challenges to provide food basket and cash assistance. Many Primary Group Households did not have the mobile phone, Rocket Account or did not provide the accurate mobile number which made the cash transfer difficult. On the other hand, the transportation services were closed during

lockdown. As a result, the NUPRP team could provide food basket only in Dhaka North and Dhaka South City Corporation. The distribution of food basket to selected beneficiaries also created animosity among the community members.

UNDP NUPRP has also provided online training and Personal Protection Equipment to the government health professionals and workers. However, due to global procurement of PPE, it was not possible for the team to procure the PPE during the emergency response (April-May 2020) period. The handover of PPE to health professionals and workers is still going on and it is expected to complete the distribution by August, 2020. Having personal protective equipment along with online training on proper use of those materials helped to overcome the fear of health professionals and workers to work at the front line.

As part of data & research, the NUPRP team adapted two types of monitoring mechanism; internal – for verification of the beneficiary selection and for daily reporting & external- Third Party Monitoring- for independent evaluation of the emergency response. UNDP NUPRP established the MIS with a databank of beneficiary contacts in 2018 which enabled the team to select the most vulnerable beneficiaries and to respond swiftly to the emerging priority needs. However, there were issues like some beneficiaries did not have any mobile number, some numbers were closed; some beneficiaries changed their mobile number, digit missing in phone number etc. Therefore, the NUPRP team undertook 100% pre verification in 19 cities before relief assistance in order to ensure that the right person is getting the emergency response. Still multiple verification exercises were carried out for different initiatives through mobile and physical verification.

The operations and management team of NUPRP faced tremendous challenges to procure goods during COVID 19 pandemic. Due to unavailability of transportation during lockdown period, the procurement and delivery of goods were a major challenge. Capacity of the procurement team also needs to be improved. While the NUPRP team was not fully equipped or prepared to respond to the COVID 19 outbreak, the assessment of the 3 month response demonstrates the high potential and capacity of NUPRP to leverage its resources on the ground to ensure swift and effective response during any crisis.

As the COVID 19 is not going to be ended very soon this will have long term impact on the economy; the following recommendations are made considering the future activities of NUPRP

Preparedness for second wave of COVID 19:

- There is prediction that the second wave of COVID 19 will start very soon in different countries. Based on the experience of COVID 19 emergency response and lessons learnt, UNDP should be better prepared and more efficient in terms of fund arrangements, coordination with government and other development agencies, capacity building of the relevant stakeholders and providing WASH and food/cash to the affected population. UNDP should revisit its' system and make necessary changes in the process of procurement & operations to response faster in any future emergency. There might be a chance of not getting grants as much as the first wave of COVID 19. UNDP NUPRP should also explore the potential sources of grant so that the programme can response with adequate resources.

AT COMMUNITY AND CDC LEVEL:

- In current context, the major challenge would be to support the livelihoods of the poor people living in urban settlements. UNDP NUPRP is carrying out the socio economic assessment in order to assess to impact of COVID 19 on their livelihoods. It is also imperative to carry out rapid labour market assessment to have in depth understanding about the impact of COVID 19 on labour market. Based on the findings, UNDP NUPRP can go with partnership with NGOs i.e. BRAC, Grameen Bank, ASA, BURO to provide micro loan at easier terms. This would help the beneficiaries of NUPRP to restore their livelihood options.
- Though CDC members have formed the savings fund and have received training on this, there was no mention on how they have utilized the savings during COVID 19 pandemic. UNDP NUPRP needs to build a mechanism so that the savings and credit groups can deal with a crisis like COVID-19.
- The COVID 19 affected the dietary practice and nutritional food intake of the NUPRP beneficiaries. The situation of people of disability, elderly people, and single female headed household was found to be worse. In addition, pregnant women, lactating mother and mother of children under 5 years also need special attention. Providing them nutritional food packages and continuing nutritional counselling on how they can ensure balanced diet for the family members with low cost during COVID 19 pandemic would bring better result.
- FAO is implementing urban agriculture targeting urban poor people. UNDP NUPRP can collaborate with FAO for technical assistance and can promote urban agriculture among beneficiaries so that they can cultivate vegetables and fruits and can fulfil the nutritional requirements of them as well as their family members.
- The CDC members prepare the Community Action Plan every year and track the progress periodically against the action plans. This plan also includes the disaster preparedness. More focus should be given on disaster preparedness & coping mechanism in future so that the poor vulnerable people can be better equipped for any future disaster management.
- Considering the risk of working during the emergency situation, NUPRP should introduce the provision insurance and risk incentives for frontline staff and CDC leaders. It would provide them the sense of security while working in the emergency situation.
- The government stakeholders felt that the CDC leaders are very good at execution but more focus should be given to build the leadership among them. More training can be provided on leadership, negotiation, empowerment, financial management so that they can be better equipped for any future disaster.

AT GOVERNMENT LEVEL:

- Coordination among different stakeholders i.e. government stakeholders and development partners working in COVID response was a vital factor to ensure the success of the emergency response. This pandemic has blurred the boundaries between sectors. The interdependencies are more pronounced than ever. UNDP NUPRP should continue the Multi-sectoral, multi-partner coordination mechanism so that all the government stakeholders and development partners can work in a uniform way for the development of the poor urban people.

- Some reports were found on the lack of coordination between NUPRP team and Ward Level Task Force. The NUPRP team should look into the issue and should work more closely with the Ward Level Task Force in future.
- UNDP NUPRP can request the government stakeholders to ensure the representation of the CDC leaders in all Ward Level Task Force & Ward Level Relief Committees. This would enable the CDC leaders to raise the voice of poor people and to influence the government stakeholders to take actions based on the needs of poor people.
- NUPRP should continue working closely with the government health professionals and workers to build capacity of them. More online training resources can be provided on COVID 19. This would enable them to work more efficiently and would ensure the access of poor people to general health care services.
- In addition, NUPRP can build capacity of the government health professionals and workers to launch the telemedicine service for the urban poor people. This would help the poor people to receive medical consultations without paying visit to general health facilities. However, it should be noted that majority of the poor people do not have access to mobile phone and internet connection. Capacity development of the CDC leaders to establish and manage the call centres at low cost in their community would enable them to get quick services. This would also reduce the risk of COVID 19 transmission as both the doctors and patients do not need to have face to face meeting.

OPERATIONS:

- Different UN organizations have Long term agreements (LTA) with vendors for the supply of different goods/services. The operations team should develop a MIS in collaboration with the operations team of other UN organizations so that all can use the MIS during crisis situation.
- The operations team should have contingency plan and should focus on decentralization of vendors in order to respond faster for future emergency response.
- The operations team can collaborate with Mobile Financial Service providers to open one mobile wallet for all the NUPRP beneficiaries/family members (in case the beneficiary does not have mobile phone). This would help the team to transfer cash instantly for any future programme. It would also resolve the problem of NID (National Identity Card) number verification.
- Different initiatives should be taken to increase the capacity of operations team. Different forms of training, learning sharing across different programmes/countries/UN organizations on emergency response, apprenticeship or job placement in the emergency response countries would increase the capacity of the operations team.

Monitoring:

- The NUPRP had the database of beneficiaries which helped the team to target the people for emergency response as well as to respond faster. Periodic verification is required to ensure that all the critical information is updated so that UNDP NUPRP can take informed decision in any future crisis situation.
- Based on the learning from COVID 19 emergency response, the NUPRP has already made it mandatory to collect the photographs and NID (National Identity Card) of all the newly registered

beneficiaries. Collecting the photographs and NID will enable NUPRP to make the cash transfer faster in any future emergency.

- Adapting mobile based data collection and providing capacity building training to the CDC leaders and frontline workers would help to collect periodic data on critical indicators.
- It is imperative to develop a mechanism amongst UN agencies to share data about urban poor. It will enable to UN agencies who are working with urban poor to response faster. UNDP can push for this within the UN System.

WASH:

- In terms of WASH, NUPRP should look beyond COVID-19 crisis to ensure handwashing habit is sustained and is not limited to the fears of corona. It should continue to advocate the NUPRP beneficiaries that handwashing with soap at critical times has a lifetime health benefit. It is one of the most cost-effective preventive health interventions.
- The monsoon flood of the year 2020 has an overall impact on the Northern, North-Eastern and South-Eastern region of Bangladesh. The Monsoon floods coupled with prolonged inundation and the COVID-19 pandemic has an exacerbating effect on the flood affected people. Therefore, making 2020 monsoon flood more complex than ever; as there is an important practice of social distancing and handwashing which is quite impossible to maintain as flood affected people are displaced and are evacuating to shelters where it is congested and WASH facilities are also compromised. Due to acute shortage of food, pure drinking water and poor sanitation system, there is a possibility of communicable disease outbreak when flood water will start receding; there is potential threat that COVID-19 can spread very fast among the people staying in the flood shelters[13]. Considering the situation, UNDP NUPRP should closely monitor the situation of WASH in their flood affected working areas and should ensure the

    - ✓ Provision of safe drinking water through repair/rehabilitation of damaged water points, tube wells, hand washing corners established by NUPRP during COVID 19.
    - ✓ Provision of adequate sanitation facilities through repair/construction of damaged latrines/new temporary latrines and soap distribution for the most vulnerable people, including those with disability, female headed households and elderly people.

Communication & Outreach:

- Reinforcing capacity of CDC leaders and engage them to promote key behaviours related to hygiene, handwashing with soap at critical times, use of hygienic/basic latrines, use handwashing stations with soap; water safety, stop gender based violence, child marriage during COVID 19.
- UNDP NUPRP should continue engaging the religious leaders, school teachers and other community influential to disseminate the important messages on COVID 19, gender based violence, child marriage, school dropout & child labour in order to create better result.

[13] Monsoon Floods 2020 Coordinated Preliminary Impact and Needs Assessment, accessed from https://reliefweb.int/sites/reliefweb.int/files/resources/nawg_monsoon_flood_preliminary_impact_and_kin_20200725_final_draft.pdf

- Considering the literacy level of the urban slum dwellers, UNDP NUPRP should focus on pictorial communication materials & interactive communication mode in future communication campaign.

Focus on Cross Cutting Issues:

- There are several reports that the COVID 19 has impact on the increase of gender based violence. NUPRP should continue the awareness raising initiatives to stop domestic violence, child marriage & child labour issues and to encourage parents to continue the study of their children.
- Bangladesh government has established OCCs (one stop crisis centre) in each district. One-Stop Crisis Centres help women and children who have fallen victim to violence by offering integrated services starting from medical support to helping file cases against the perpetrators. NUPRP can collaborate with OCCs to support women and children if there is report of GBV.
- UNDP NUPRP can initiate psychosocial services/counselling for the individuals/families who lost family members or lost income generating opportunities.

ANNEXURE 1: PERCENTAGE TABLES

Table 1: Percentage Distribution of Religion of Respondents

Religion	Intervention			Non-registered Community Member
	Two Interventions	3 interventions	Total	
Islam	92.0	90.5	91.5	93.4
Hindu	7.6	8.3	7.9	6.6
Buddhist	0.2	0.2	0.2	0.0
Christian	0.2	1.0	0.5	0.0
n	2570	1530	4100	440

Table 2: Percentage Distribution of Marital Status of Respondents

Marital Status	Intervention			Non-registered Community Member
	Two Interventions	3 interventions	Total	
Single	2.2	2.1	2.1	7.7
Married	87.2	85.4	86.5	82.3
Divorced/ Separated	3.0	3.3	3.1	4.3
Widow	7.6	9.2	8.2	5.7
n	2570	1530	4100	440

Table 3: Percentage Distribution of Age & Gender distribution of household members (Non-registered Community Member)

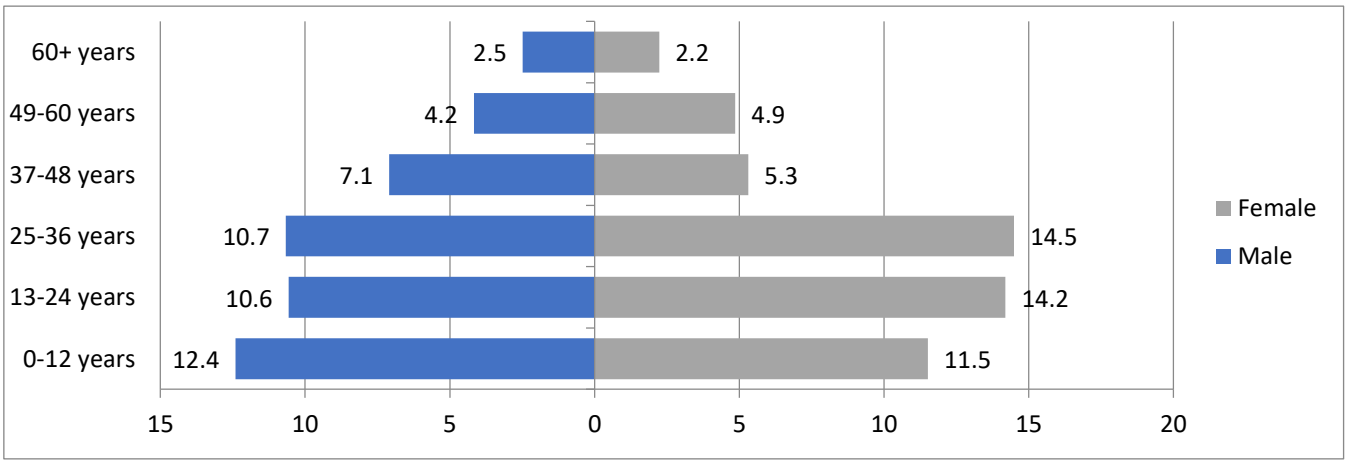


Table 4: Percentage Distribution of People faced general health problem during COVID 19

	Intervention	Non-registered Community Member
Yes	27.0	34.3
No	73.0	65.7
n	4,100	440

Table 5: Percentage Distribution of Reasons for not visiting any Doctor or Hospital/Clinic/Health facility for General Health Problems during COVID 19

	Intervention	Non-registered Community Member
Afraid of being infected by Corona Virus Disease 2019/COVID-19	32.9	40.8
Did not have money	35.0	35.2
The health facility/hospitals are closed	2.9	1.4
There is no doctor	3.1	1.4
Purchase medicine from pharmacy counters without any prescription	25.8	12.7
Others	0.3	8.5
n	383	71.0

Table 6: Percentage Distribution of Respondents think the Emergency Response by NUPRP was Useful

	Two Interventions	3 interventions	Total
Not at all	1.0	0.3	0.7
Little	10.4	5.9	8.7
Useful	38.4	26.9	34.1
Very	29.1	23.3	27.0
Very much	21.2	43.7	29.6
n	2570	1530	4100

Table 7: **Percentage distribution of Impact of COVID 19 on Dietary Diversity**

	Intervention		Non-registered Community Member	
	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19
Cereal	99.8	99.3	100.0	100.0
Milk and milk products	12.3	6.5	16.1	11.1
Oil/fats	79.8	79.4	90.2	89.5
Sugar/Honey	57.8	38.8	62.5	43.6
Roots and Tubers	93.3	92.3	94.5	93.6
Any coloured vegetables	96.7	97.3	97.5	98.6
Any leafy vegetables	87.0	86.0	87.3	83.6
Any fruits	12.9	7.6	9.8	8.9
Any meat	33.7	11.5	39.8	13.9
Any eggs	57.3	33.3	71.4	43.6
Any Fish	84.7	47.9	88.6	49.1
Pulses/legumes/nuts	72.0	69.2	82.3	80.0
Miscellaneous	94.2	92.7	97.3	96.1
n	4100	4100	440	440

Table 8: **Percentage distribution of Main Source of Drinking Water**

	Intervention	Non-Registered Community Member
Tap water piped to community/slum yard/plot	21.3	22.5
Tap water piped into dwelling	27.6	28.2
Tube well / deep tube well inside community/slum	32.0	37.0
Public tap/ tube well / deep tube well outside community/slum	18.5	11.6
Well	0.1	0.7
Pond	0.2	0.0
River / Canal	0.2	0.0
n	4100	440

Table 9: **Percentage distribution of People using different Toilets**

	Intervention	Non-Registered Community Member
Pit latrine with slab	56.8	49.5
Sanitary (water-sealed)	27.4	33.6
Pit latrine without slab/open pit	12.2	14.8
Non-sanitary/hanging / Katcha toilet	3.2	1.8
Open space / No toilet	0.4	0.2
n	4100	440

Table 10: **Percentage distribution of People using Shared Toilet**

	Intervention	Non-Registered Community Member
Used by own household/family	50.5	50.0
Shared by other household/family in the slum/community	49.5	50.0
n	4100	440

Table 11: **Percentage distribution of People Have Water inside the Toilet**

	Intervention	Non-Registered Community Member
Yes, inside the toilet	35.7	38.9
Yes, near the toilet	56.9	51.8
No water near or inside toilet	7.5	9.3
Total	4100	440

Table 12: **Percentage distribution of People Have Soap inside the Toilet**

	Intervention	Non-Registered Community Member
No soap or liquid hand wash or ash	7.5	4.8
Soap or liquid hand wash outside the toilet	59.0	56.8
Don't have soap or liquid hand wash, but ash to wash hands	1.5	1.6
Soap or liquid hand wash inside the toilet	32.0	36.8
n	4100	440

Table 13: Percentage Distribution of Hand Washing Occasions before and during COVID 19

Hand Washing Occasions	Intervention		Non-Registered Member	
	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19
Before cooking	73.5	86.4	77.5	87.5
During cooking	40.8	56.4	36.8	50.9
After cooking	66.1	79.5	62.3	85.0
Before eating	92.2	90.2	94.3	89.5
Before feeding the child	47.4	52.8	42.7	48.2
After cleaning the child's feces	38.9	42.5	29.3	34.5
After going to the toilet	92.0	87.0	91.8	88.2
If hands are dirty	78.3	82.3	78.9	85.5
After coming home from outside	60.7	88.8	56.6	91.1
After touching things and packets purchased from the market	36.2	77.5	24.8	83.6
After any sort of contact with animals or cleaning their feces	26.3	41.0	16.1	29.8
After carrying or coming in contact with a person infected with the corona virus	0.0	17.6	0.0	14.5
n	4100		440	

Table 14: Percentage Distribution of Beneficiaries who will purchase soap for hand washing when the soaps received from NUPRP will be over

	Percentage
Will use Tippy-tap /hand washing corner where soap is available	10.7
Will collect soap	23.1
Will purchase soap	94.7
Will use ash	0.1
Will use bleaching powder	0.0
Don't know/cannot say	0.0
n	4033

Table 15: Percentage Distribution of Dietary Diversity of the people before and during COVID 19

	Intervention		Non-Registered Member	
	Before COVID 19	**During COVID 19**	**Before COVID 19**	**During COVID 19**
Cereal	99.8	99.3	100.0	100.0
Milk and milk products	12.3	6.5	16.1	11.1
Oil/fats	79.8	79.4	90.2	89.5
Sugar/Honey	57.8	38.8	62.5	43.6
Roots and Tubers	93.3	92.3	94.5	93.6
Any coloured vegetables	96.7	97.3	97.5	98.6
Any leafy vegetables	87.0	86.0	87.3	83.6
Any fruits	12.9	7.6	9.8	8.9
Any meat	33.7	11.5	39.8	13.9
Any eggs	57.3	33.3	71.4	43.6
Any Fish	84.7	47.9	88.6	49.1
Pulses/legumes/nuts	72.0	69.2	82.3	80.0
Miscellaneous	94.2	92.7	97.3	96.1
n	4100	4100	440	440

Table 16: Percentage Distribution of Dietary Diversity of the people before and during COVID 19 (Respondent group wise)

	Intervention									
	Mother of under 5 years children /Pregnant women		Women of Reproductive age (15-49 years)		Old Age People		People with disability		Female Headed HH	
	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19	Before COVID 19	During COVID 19
5 food group and above	88.8	78.0	86.9	73.9	79.3	68.9	77.5	72.5	83.9	72.4
4 food group	7.3	15.3	7.5	18.1	11.3	18.9	13.8	18.8	7.7	18.5
3 food group	2.2	3.8	2.5	4.4	5.3	7.6	6.3	7.5	4.4	4.6
2 food group	1.3	2.5	2.1	2.4	3.0	3.0	2.5	1.3	3.3	3.1
1 food group	0.4	0.4	0.9	1.3	1.2	1.6	0	0	0.7	1.5
	1165		3573		434		80		753	

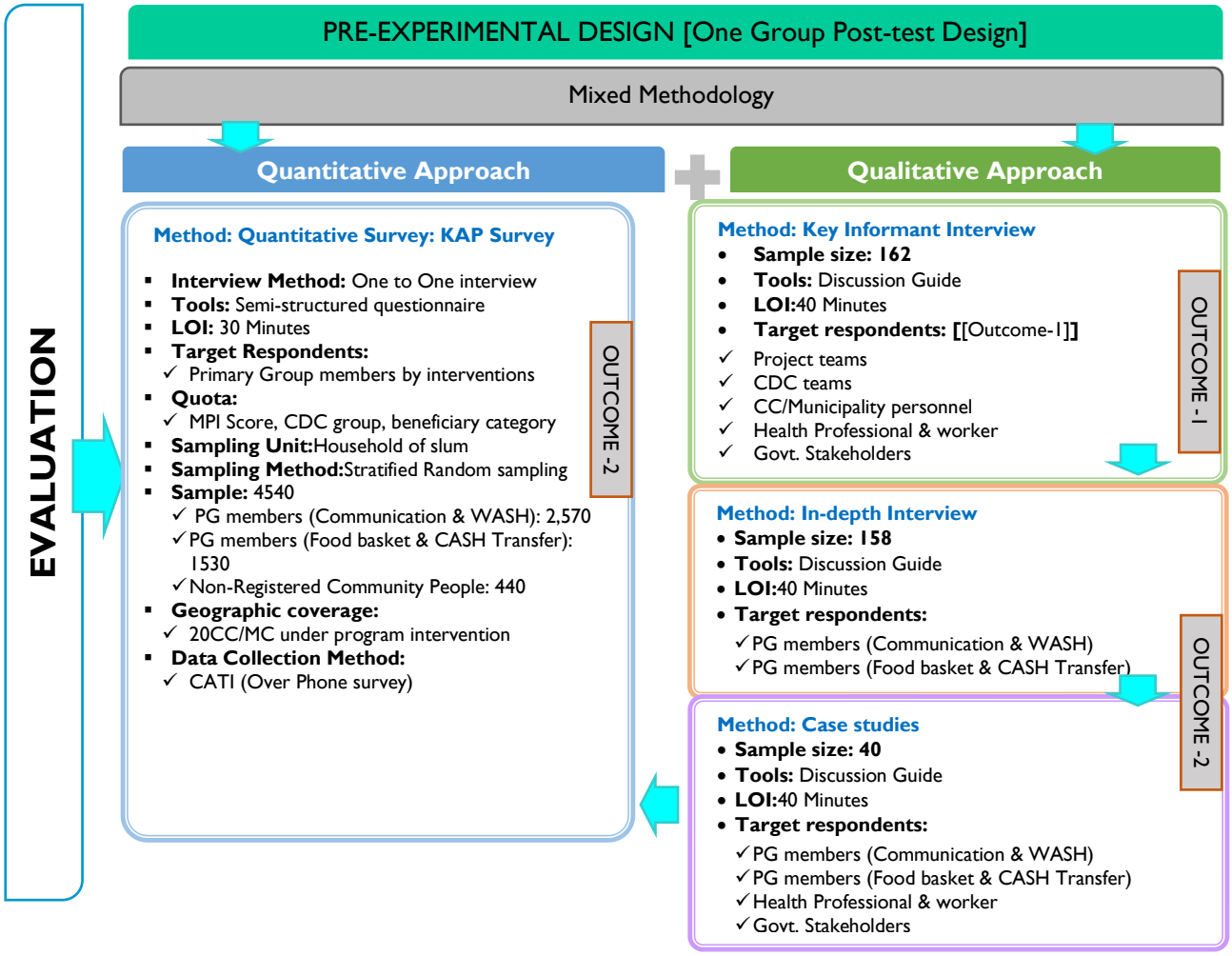
Table 17: Percentage Distribution of people did to deal with COVID 19 Crisis

Crisis Management Strategy	Intervention	Non-Registered Community Member
Take a cash loan from outside HH	66.7	64.5
Take an in-kind loan from outside HH (e.g. Shop/boutique	71.1	81.8
Sell assets (e.g. furniture, jewellery)	9.4	14.3
Sell livestock	5.3	8.2
n	4100	400

ANNEXURE 2: METHODOLOGY

Due to emergency situation, the programme intervention has been implemented as per rapid activity plan. It was not possible for NUPRP to collect any pre-test/baseline data and there was no defined treatment & control group created prior to intervention; hence it was not possible to adopt experimental design. Therefore, considering the objectives of the evaluation, **Pre-Experimental Design** was employed. Pre-experimental designs are the simplest type of design because they do not include an adequate control group. Pre-experimental designs are usually conducted as a first step towards establishing the evidence for or against an intervention which is rigorous in establishing a causal link between program activities and outcomes. The most common pre-experimental design is the '***One group pre-test/post-test design***' which is applicable for emergency response program. Information for this design was collected immediately after participants receive the treatment (intervention). Since formal **pre-test** (baseline survey data) was not conducted prior to COVID-19 outbreak among beneficiaries this evaluation followed only **post-intervention design** as it involved collecting information only on program participants. To minimize the weaknesses of the methodology, the evaluation captured information both on the previous situation (March, 2020: before NUPRP emergency response) and the situation during COVID-19 pandemic (May, 2020). This has allowed the researchers to understand the comparison of same groups between different time periods. In addition, a small number of samples (around 10%) were captured from non-registered community members in order to draw comparisons between two groups.

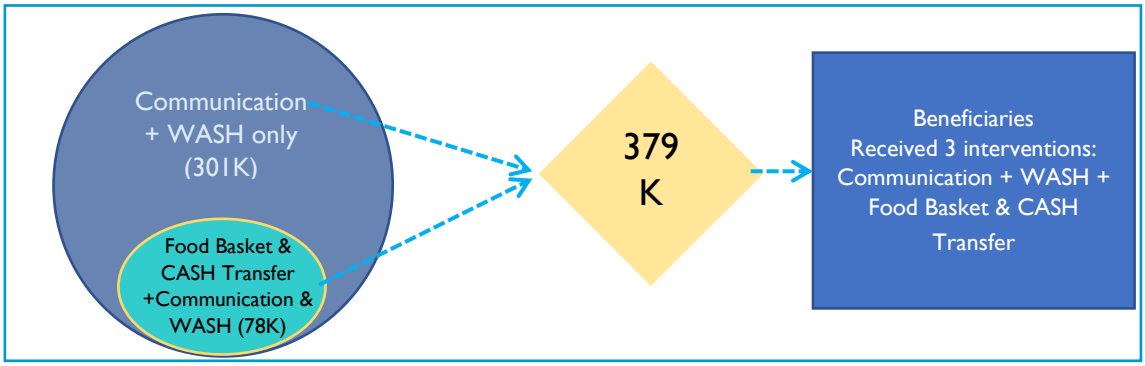
Mixed methodology was applied for evaluation using stratified random sampling technique. Both the quantitative and qualitative approach was adopted for evaluation. **One to one survey** with the vulnerable affected people in urban settlements was conducted **over phone** through *semi-structured questionnaire* which was designed via digital programming platform. The quantitative component consisted of a multi-indicator KAP survey on the basis of a representative sample of beneficiary sampling frame by different interventions. At a glance the design was as follows -



Qualitative data was collected through **In-depth interviews**, **case studies**, **Key Informant Interviews** with the relevant stakeholders such as project management team, Local government officials, town managers, CDC members, health officials, coordination functions members, beneficiaries and so forth to understand how the entire emergency response activities were implemented with synchronization, what were the risks/ challenges, mitigation strategy, learning, coping mechanism & resilience among beneficiaries, and way forward. In addition, **in-depth interviews& case studies** were conducted with the same respondent groups to have more in-depth information and to triangulate the findings received from survey.

2.1.1. QUANTITATIVE SAMPLING AND SAMPLE SIZE DETERMINATION

NUPRP shared a list of about 3,78,560 beneficiaries along with their contact number, name of community groups and MPI (Multidimensional Poverty Index) scores who received three major interventions – Communication materials, WASH interventions , Food basket or onetime CASH. This list was considered as sampling frame. Among the list of 379K beneficiaries, 301K beneficiaries received intervention for communication & WASH.



Stratified sampling technique was used for the survey. Two different interventions – (i) communication, WASH and communication, (ii) WASH, Food-Cash were considered as 2 strata. The city level samples were distributed proportionately based on the MPI score – low, medium, high.

Respondents were contacted from the sampling frame/list using systematic random sampling technique for each group over phone.

Sample size was determined separately by two separate intervention group to avoid selection bias –

iii. Beneficiaries who received both communication & WASH interventions
iv. Beneficiaries who received all interventions: communication & WASH, Food Basket & CASH Transfer

iii. *Beneficiaries who received both communication & WASH interventions*:

The sample size has been calculated following the standard statistical formula with 95% level of confidence and 3% margin of error with an assumption that about 20% beneficiaries have some knowledge on COVID 19, received from different media sources. Overall, beneficiary size is 301,000 who received communication & WASH intervention.

The following formula was used to determine sample which is applicable for finite population (for proportion):

$n = \frac{n_0 * N}{n_0 + (N-1)}$; Where $n_0 = \frac{Z^2 * p\,(1-p)}{e^2} = initial\ sample$

Calculated required sample size is 764. Afterwards, three adjustment factors were used i.e. Non-response, design effect & finite population correction to derive the final sample size.

$$\mathrm{n} = n_0 * k * (d.e) * f$$

Considering non-response rate at 40% and design effect 2, the sample size was calculated to be **2553**. This was further distributed by different cities, by MPI-score, doing some adjustment to ensure adequate minimum sample representation by different quota. Finally, the sample size was considered as **2570** respondents.

Where,
n = required sample size
n_0 = Initial sample size
N = Total number of beneficiary population (301,000)
p = 0.20 assuming 20% of the slum dwellers have some knowledge on COVID 19 received from different media source
q = 1- p = 0.80
e = Permissible Margin of error for 2.8%
z = 1.96 which corresponds to the 95% confidence level
k=Non-response rate = 40% (used adjustment factor)
f=finite population correction =1
[as the ratio of initial sample to total population is 0.2% which is less than level of significance 0.05, hence this adjustment is not required]

Sample distribution

As per sampling frame, 2570 beneficiaries were disaggregated by 19 cities proportionately by size of the beneficiary population, afterwards distributed by MPI-score (low, medium & high) proportionately across all cities. To ensure adequate sample size by different, quota some adjustment were made.

Samples were distributed by the following the ratio of low, medium & high MPI score group- 73: 23: 4. During the interview, quota was applied by gender/sex (female, & transgender) and different beneficiary categories (Mother of under 5 years children /Pregnant women, Women of Reproductive age, Adult male, Old Age People (55+), People with disability, female headed household etc.).

In addition, a quota of non-register community members was investigated based on the availability of non-registered list with the town team. About 10% of the total sample (440) was captured from non-registered community. The contact details of non-registered community members were collected from Town team and interviews were conducted over phone.

The sample distribution was as follows:

Table: Sample distribution for Two Interventions

Division	Cities	CC/MC	Beneficiary Total: COMMUNICATION & WASH	Registered				Non-Registered community member
				High MPI	Medium MPI	Low MPI	Sample Size	Sample Size
Chattogram	Chattogram	CC		15	141	336	492	40
	Cox's Bazar	MC	912	7	5	24	36	20
	Chandpur	MC	10174	7	25	59	91	20
	Cumilla	CC	7141	2	11	50	63	20
	Noakhali	MC	1197	1	10	20	31	20
Dhaka	Dhaka South	CC	12461	7	40	79	126	20
	Dhaka North	CC	38597	7	60	229	296	40
	Gazipur	CC	12316	6	20	94	120	20
	Narayanganj	CC	15638	7	22	94	123	20
	Faridpur	MC	3578	5	5	25	35	20
	Gopalganj	MC	2462	5	5	20	30	20
Mymensingh	Mymensingh	CC	14348	0	0	85	85	20
Khulna	Khulna	CC	57376	16	124	316	456	40
	Kushtia	MC	8384	3	15	40	58	20
Barishal	Patuakhali	MC	6779	2	15	40	57	20
Rajshahi	Rajshahi	CC	15442	7	26	99	132	20
Rangpur	Rangpur	CC	15601	7	26	119	152	20
	Saidpur	MC	4487	3	10	24	37	20
Sylhet	Sylhet	CC	14039	6	40	104	150	20

Grand Total		***301,000***	***113***	***600***	***1,857***	***2,570***	***440***

iv. Beneficiaries who received all 3 interventions: communication & WASH, Food Basket & CASH Transfer

The sample size was calculated for the beneficiaries who received all 3 interventions (Communication & WASH, Food Basket & Cash Transfer) using following standard statistical formula with 95% level of confidence and 5% margin of error. Overall, a total of 77,560 beneficiaries received full coverage of communication, WASH, food & cash intervention.

The following formula was used to determine sample which is applicable for finite population (for proportion):

$n = \frac{n_0 * N}{n_0 + (N-1)}$; Where $n_0 = \frac{Z^2 * p\,(1-p)}{e^2} = initial\ sample$

Hence, required sample size is 382. Afterwards, three adjustment factors were used i.e. Non-response, design effect & finite population correction to derive the final sample size.

$n = n_0 * k * (d.e) * f$

Where,
n = required sample size
N = Total number of beneficiary population who received all 3 interventions (77,560)
p = 0.50
q = 1-p = 0.50
e = Permissible Margin of error for 5%
z = 1.96 which corresponds to the 95% confidence level
de = 2
k=Non-response rate = 40% (used adjustment factor)
f=finite population correction =1 [as the ratio of initial sample to total population is 0.5% which is less than level of significance 0.05, hence this adjustment is not required]

Considering non-response rate adjustment factor at 40% and design effect 2, the sample size was calculated to be 1,274. Considering representation, the sample size was considered as 1,530. Overall, samples were distributed by different cities, by MPI-score, doing some adjustment to ensure adequate minimum sample representation by different quota.

Sample distribution

In total, 1,530 beneficiary samples were disaggregated by 19 cities proportionately by size of the beneficiary population size of each city, subsequently distributed by MPI-score (low, medium & high) proportionately across all cities. Samples size was adjusted to ensure adequate sample size by different quota.

Actual proportion of MPI score groups were – Low (18): Medium (77): High (5). Samples were distributed by the ratio of low, medium & high MPI score group which is 24: 66: 10 to ensure adequate representation of all groups. During interview, quota was applied by gender/sex (female, & transgender) and different beneficiary categories (Mother of under 5 years children /Pregnant women, Women of Reproductive age, Adult male, Old Age People (55+), Female headed household, People with disability etc.).

The sample distribution was as follows:

Table: Sample distribution for Three Interventions

Division	Cities	CC/MC	Beneficiary Total: All 3 interventions	High MPI	Medium MPI	Low MPI	Sample
Chattogram	Chattogram	CC	20148	19	231	70	320
	Cox's Bazar	MC	476	5	15	10	30
	Chandpur	MC	3551	5	55	20	80
	Cumilla	CC	713	5	15	10	30
	Noakhali	MC	460	3	15	3	21
Dhaka	Dhaka South	CC	5000	10	70	20	100
	Dhaka North	CC	2900	7	38	15	60
	Gazipur	CC	1664	5	15	10	30
	Narayanganj	CC	2519	39	16	61	39
	Faridpur	MC	912	5	15	11	31
	Gopalganj	MC	970	15	10	30	15
Mymensingh	Mymensingh	CC	4690	13	68	20	101
Khulna	Khulna	CC	18853	25	220	67	312
	Kushtia	MC	1728	5	15	11	31
Barishal	Patuakhali	MC	1962	7	38	15	60
Rajshahi	Rajshahi	CC	2855	6	39	15	60
Rangpur	Rangpur	CC	3069	5	40	15	60
	Saidpur, Nilphamari	MC	672	5	15	12	32
Sylhet	Sylhet	CC	4418	7	54	20	81
Total			**77,560**	**148**	**1,012**	**370**	**1,530**

QUALITATIVE APPROACH

Qualitative study approach included three techniques for data collection – Key Informant Interviews (KII), In-depth interviews, & Case studies. A total of 162 Key Informant Interviews (KII), 158 in-depth interviews and 40 case studies were conducted with different stakeholders. The sample distribution was as follows:

Table: Sample distribution for Qualitative Approach

Division	Cities	Beneficiaries (2 & 3 Interventions)	CDC Members (Federation, cluster, primary group members)	Local Government stakeholder (City authority focal person/ coordination team member)	Town Manager/ Regional M&E Officer/ Governance & Mobilization Expert/Socio Economic & Nutrition Expert	Health Officer	NUPRP Team Members
Chittagong	Chandpur	8	3	2	1	1	
	Chattogram	10	3	2	1	1	
	Comilla	8	3	2	1		
	Cox's Bazar	8	3	2	1	3	
	Noakhali	8	3	3	1		
Dhaka	Dhaka North	9	3	1	1	3	
	Dhaka South	9	6	1	1	2	
	Faridpur	8	3	2	1	2	
	Gazipur	8	3	2	1	3	
	Gopalganj	8	3	2	1	1	
	Narayanganj	8	3	1	1	1	
Mymensingh	Mymensingh	8	3	2	1	1	
Khulna	Khulna	10	3	1	1	2	
	Kushtia	8	3	2	1	1	
Barishal	Patuakhali	8	3	2	1	2	
	Barishal	0	0	1	1	1	
Rajshahi	Rajshahi	8	3	1	1	1	
Rangpur	Rangpur	8	3	2	1	1	
	Saidpur	8	3	2	1	1	
Sylhet	Sylhet.	8	3	1	1	2	
	Total	158	60	34	20	28	20

ANNEXURE 3: LIST OF STAKEHOLDERS CONSULTED

S.L	Name	Designation	City
1	A J M Nasir Uddin, Mayor, Chattogram City Corporation	Mayor	Chattogram
2	Md. Shamsuddoha, Member Secretary, City Project Board (CPB), LIUPC & CEO, Chattogram City Corporation	Member Secretary	Chattogram
3	Dr. Salim Akhter Chowdhury, Chief Health Officer	Chief Health Officer	Chattogram
4	Kohinur Akter, Chairperson, CDC Town Federation	Chairperson, CDC Town Federation	Chattogram
5	Khursida begum	CDC Cluster leader	Chattogram
6	Shanaz begum	CDC Secretary	Chattogram
7	Mojibur Rahman (Mayor)	Mayor	Cox's Bazar
8	Rashel Chowdhury (Secretary)	Local Government Secretary	Cox's Bazar
9	Ripon Chowdury	Chief Health Officer	Cox's Bazar
10	Rony Das	Health Supervisor	Cox's Bazar
11	Abdur Rahim	Health Supervisor	Cox's Bazar
12	Jobaida	(CDC,) President	Cox's Bazar
13	RipaAkter	(CDC,) Secretary	Cox's Bazar
14	Jesmin	(CDC,) president	Cox's Bazar
15	Nasir Uddin Ahmed	Mayor	Chandpur
16	Farida Elias, Councilor, Chandpur Purashava	Health Officer	Chandpur
17	Abul Kalam Bhuiyan, Member Secretary, LIUPC, Chandpur	Member Secretary	Chandpur
18	Nasma Akter	(CDC Cluster)president	Chandpur
19	Fatema Begum, CDC Cluster Leader	CDC Secretary	Chandpur
20	Nurun Nahar, CDC Leader	CDC president	Chandpur
21	Sk Md. Noorullh, Member Secretary	Member Secretary	Cumilla
22	Mir Sawkat Hossain, CEO	CEO, Local Government	Cumilla
23	DR. Chandana Rani Debnath	Health Officer	Cumilla
24	Shahina Akter, Chairperson, Jamuna Cluster	Chairperson, CDC Cluster	Cumilla
25	Nuranhar Akter pinky	CDC president	Cumilla
26	Farzana Akter Apu, Cashier, Vaterpukurpar CDC	CDC, Cashier	Cumilla
27	Md. SahidUllah Khan	Mayor	Noakhali
28	Shamol Kumar Datta	Secretary of Noakhali Paurashava	Noakhali
29	Tanmir Hossain	SDO	Noakhali
30	SharminAkter	Chairperson CDC	Noakhali
31	Amina Siddiqa	CDC, Cashier	Noakhali
32	RuhenaAkter	CDC, Treasurer	Noakhali

S.L	Name	Designation	City
33	Shah Md. Imdadul Haque	Member Secretary city corporation	DSCC
34	Brgdr. Gen. Sharif Ahmed	Chief Health Officer	DSCC
35	DR.Sanzida Islam	Medical Officer ,Local government	DSCC
36	Mamtaz Begum	President Federation	DSCC
37	Asma begum,	President CDC Cluster	DSCC
38	Aliay begum	Secretary CDC Cluster	DSCC
39	ParulAkter	Secretary CDC Cluster	DSCC
40	Rabeya Begum	CDC president	DSCC
41	Md. Anwar Hossain Bhuiyan, SDO, DNCC	SDO, DNCC	DNCC
42	Dr. Mahmuda	Medical Officer ,Local government	DNCC
43	Brgdr. General Md. Mominur Rahman Mamun, Chief Health Officer, DNCC	Chief Health	DNCC
44	Dr. Naila Pervin	Medical Officer ,Local government	DNCC
45	Selina Begum,	Chairperson, Town Federation, DNCC	DNCC
46	Ashrafi	President CDC Cluster	DNCC
47	Jahida begum	Chasier, CDC	DNCC
48	Md. Aminul Islam - CEO	CEO, Local Government	Gazipur
49	Md. Mostafizur Rahman - Secretary & MS of LIUPC	Deputy Secretary, Local Government	Gazipur
50	Dr.Md. Rahmathullah	Chief Medical officer	Gazipur
51	Dr .Taina	Medical Officer ,Local government	Gazipur
52	Dr. Silvia	Medical Officer ,Local government	Gazipur
53	Shahida Begum	Chairperson, Town Federation,	Gazipur
54	Moinaakter	President CDC Cluster	Gazipur
55	Asma Akter	CDC	Gazipur
56	Md. Shahjahan Miah,	CEO and Member Secretary, Local Government	Faridpur
57	Syed Ahaduzzaman,	SDO	Faridpur
58	Md. Tanzilur Rahman	Focal person for Health	Faridpur
59	Shamsul Alam	Health Officer	Faridpur
60	Shampati Basu	President CDC Cluster	Faridpur
61	Shadona Bissas	President CDC Cluster	Faridpur
62	Nilufer Yesmin	President CDC	Faridpur
63	K M Faridul Miraj (MS)	Member Secretary ,Local Government	Narayangonj
64	Dr. Sheikh Mostofa Ali	Health Officer	Narayangonj

S.L	Name	Designation	City
65	Achiya Khanom Sumi	Chairperson, Town Federation,	Narayangonj
66	Salma Sultana	President CDC Cluster	Narayangonj
67	Khadija Rhaman	CDC president	Narayangonj
68	Md. Harun Ar Rashid	(Administrative Officer Gopalganj Paurashava)	Gopal gonj
69	Abinash Chandra Sarker	Member Secretary -LIUPCP & Executive Engineer, Gopalganj Paurashava	Gopal gonj
70	Kazi Nasiruddin	(Sanitary Inspector, Gopalganj Paurashava)	Gopal gonj
71	Morium Akter	(Chairperson Federation)	Gopal gonj
72	Maksuda Jahan Junu	(Chairperson CDC Cluster)	Gopal gonj
73	Rumu Begum	(Treasurer of Markas CDC)	Gopal gonj
74	Md. EkramulHaqueTitu	Mayor	Mymensingh
75	Rafikul Islam Mia	Member Secretary, Local Government	Mymensingh
76	Dr. H K Debnath	Health Officer	Mymensingh
77	Shamima Chowdhury	(Chairperson Federation)	Mymensingh
78	Hosnera Begum	(Chairperson CDC Cluster)	Mymensingh
79	NasimaAkter	Chasier, CDC	Mymensingh
80	Abir-ul-Jabbar,	Chief Planning Officer and Member-Secretary, CPB, LIUPC, KCC	Khulna
81	Dr. A K M Abdullah, Chief Helth Officer, KCC and Member-Secretary, nCOVID-19 Response Committee, KCC	Chief Health Officer	Khulna
82	Dr.ShaponKumer	Health Officer	Khulna
83	Ms. Rokeya Begum,	President, Federation	Khulna
84	Ms. RokeyaKhalifa,	Chairperson, Kapotakkha CDC Cluster	Khulna
85	Ms. Nadia Yasmin,	Cashier, CDC	Khulna
86	Anwar Ali	Mayor	Kustia
87	Md. Rabiul Islam,	Executive Engineer & MS, TPB, LIUPC, Kushtia Pourashava	Kustia
88	Md. Abdur Rahim,	Sanitary Inspector, Kushtia Pourashava, Kushtia	Kustia
89	Ahmed Ali Montu,	President, Kushtia Town Federation	Kustia
90	Shanjidarahman	CDC Cluster leader	Kustia
91	ShahinoorKhatun,	Cashier, CDC	Kustia
92	Dr. Rabiul Hossain, Conservancy Officer, BCC	Chief Conservancy officer, Barishal	Barishal
93	Mohiudin Ahmed (Mayor)	Mayor	Patuakhali
94	BhabaniSankarSingha (MS)	Member Secretary, Local Government	Patuakhali

S.L	Name	Designation	City
95	Dr. SM Ekramul Islam Nahid	Health Officer	Patuakhali
96	Dr. Sharmin sultana	Health Officer	Patuakhali
97	Nadira begum	Secretary CDC Cluster	Patuakhali
98	Nazmunnahar	Chairperson CDC Cluster	Patuakhali
99	Mousumi	CDC ,president	Patuakhali
100	Noor Islam Tusher- Member Secretary	Member Secretary, Local Government	RCC
101	Dr. FAM Anjuman Ara Begum-CHO	Chief Health Officer	RCC
102	Mrs. AyshaKhatun-Federation	President, Town Federation	RCC
103	Mrs. Arefa Begum-CDC Cluster	Chairperson CDC Cluster	RCC
104	Tanzilla Ahmed -CDC	CDC ,president	RCC
105	MR.Nurunnabi	Panel Mayor	Rangpur
106	Md. RashedulHaque	Member Secretary, Local Government	Rangpur
107	DR.Kamruzzaman IBNE Taz,	Health Officer	Rangpur
108	Jostna Begum,	Federation Cashier	Rangpur
109	Ashia Begum	Chairperson CDC Cluster	Rangpur
110	Sabina Begum	Chasier, CDC	Rangpur
111	ZaiulHaque Zia	Panel Mayor	Saidpur
112	Ayub Ali	Member Secretary, Local Government	Saidpur
113	AKM. Akmal Sarker	Health Officer	Saidpur
114	Sabana	President, Town Federation	Saidpur
115	Mrs. Shahinur Begum	Chairperson CDC Cluster	Saidpur
116	MstShuma	CDC, President	Saidpur
117	Arifulhaque Mayer	Mayor	Sylhet
118	NurAzizur Rahman	CEO Member Secretary, LIUPC and Chief Engineer	Sylhet
119	Dr. Md. Zahidul Islam,	Chief Health Officer	Sylhet
120	Ms. Mina Begum	Chairperson, CDC-Federation	Sylhet
121	Monoawra Begum,	President, Cluster CDC	Sylhet
122	Jorna Rani Talukder	President, Gotatikor CDC	Sylhet

ANNEXURE 4: EVALUATION INSTRUMENTS

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

Household Questionnaire

INTRODUCTION

Hello! I would like to introduce myself. My name is _____.
I have come from a Research Organization named – The Nielsen Company (Bangladesh) Limited situated in Dhaka. We are conducting a DFID supported evaluation for UNDP Bangladesh, entitled '**COVID-19 Response for National Urban Poverty Reduction Programme'**. We want to understand the presentation situation of Covid-19 outbreak and its impact on you as well as on the society as well as to assess the various services and information provided by the program such as awareness campaign, food and cash transfer, soap, hand washing corner etc.

Although you are quite free to give the interview or reject me, still you can contact Nielsen for any further queries about your responses. Please be informed that, all your information will be kept highly confidential and these will not be disclosed anywhere other than this study.

Everything you say is important to us; we are here to get your opinions and thoughts, there is no right or wrong answer to any of the questions. You can also refuse to participate anytime. Thank you in advance for your cooperation. Do you want to know anything else about this study? Can we start the discussion now?

DEMOGRAPHIC & SOCIOECONOMIC PROFILE

Q1a. Please select in which group of beneficiaries the respondent belongs to in emergency Covid-19 response of the LG/NUPRP-UNDP program: DON'T READ THE OPTIONS [SA]

	Code
Beneficiary of communication, wash facility/hygiene package, but did not get food basket & cash transfer intervention	1
Beneficiary of communication, wash facility/hygiene package, food basket & cash transfer intervention	2

Q1b.	MPI Group	High	1
		Medium	2
		Low	3

Q2.	Name of the respondent	
Q3.	Age (in years)	

Q4. Sex

	Code
Male	1
Female	2
Transgender	3

Q5. How are you involved in the Community Development Committee (CDC) activities? **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [MA]

	Code
Primary Group	1
CDC	2
CDC Cluster	3
Federation	4

Q6. In which level/post are you involved in the Community Development Committee (CDC) activities? **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [SA]

	Code
Primary Group- General Member - Registered	01
Primary Group- General Member - Non-registered	02
Primary Group – President/Leader	03
Primary Group – Secretary	04
CDC Chairperson	05
CDC Vice-chairperson	06
CDC Secretary	07
CDC Joint Secretary	08

CDC Cashier	09
CDC Cluster President	10
CDC Cluster General Member	11
Federation General Committee Members	12
Federation Executive Committee Members	13
Federation Advisory Committee Members	14
Others (specify)	

Q7. Name of the Division

	Code
Dhaka	1
Mymensingh	2
Chattagram	3
Rajshahi	4
Rangpur	5
Khulna	6
Barishal	7
Sylhet	8

Q8. Cities

	Code
Chandpur	1
Chattogram	2
Cox's Bazar	3
Cumilla	4
Dhaka North	5
Dhaka South	6
Faridpur	7
Gazipur	8
Gopalganj	9
Khulna	10
Kushtia	11
Mymensingh	12
Narayanganj	13
Noakhali	14
Patuakhali	15
Rajshahi	16
Rangpur	17
Saidpur	18
Sylhet	19
Barisal	20

Q9.	Ward Number	
Q10.	Name of the CDC	
Q11.	Name of the Primary Group	
Q12.	Unique identification number of PG membership	

Q13.	Detail Address	
Q14.	Mobile Number	

Q15. What religion are you? [SA] **DON'T READ THE OPTIONS**

	Code
Islam	1
Hinduism	2
Buddhism	3
Christianity	4
Non-believer	5
Other religion (please specify…):	

Q16. What is your ethnicity? [SA] DON'T READ THE OPTIONS

	Code
Bangalee	1
Indigenous	2
Bihari	3
Rohingya	4
Dalit	5
Harijan	6
Others (specify)	
Refused to answer	9

Q17. Marital Status [SA] DON'T READ THE OPTIONS]

	Code
Single	1
Married	2
Divorced/ Separated	3
Widowed/ Widower	4
Refused to answer	5

Q18. How many people are there in your household including yourself? That is, how many people eat and sleep here (including live-in maids)? Please exclude visitors and boarders.

Q19. Please tell their relationship with you, age, sex and disability. [Write from elder to younger members]

Name	Relation	Hosehold Head (Yes/No)	Age	Sex	Disability Status (Physical/Mental) (Yes/No)

Q24. Group of respondent [MA] **DON'T READ THE OPTIONS**

	Code
Mother of under 5 years children /Pregnant women	1
Women of Reproductive age (15-49 years)	2
Married men having wife in reproductive age	3
Old Age People (55+) both male and female	4
People with disability	5
Minority & Vulnerability group	6

Q20a. Select your occupation before COVID-19 outbreak? [SA]

Q20b. After COVID-19 outbreak do you have to change your profession? Select your occupation after COVID-19 outbreak? Or remain same. [SA] **DON'T READ THE OPTIONS**]

	Q20a. Before COVID-19 outbreak	Q20.b After COVID-19 outbreak
Electrician	1	1
Welder	2	2
Plumber	3	3
Carpenter	4	4
Mason	5	5

Blacksmith	6	6
Pottery	7	7
Cobbler	8	8
Tailor/Seamstress	9	9
Barber/Hair dressing	10	10
Driving own rickshaw/van	11	11
Driving own CNG/motorcycle	12	12
Renting out rickshaw/van	13	13
Renting out CNG/Motorcycle	14	14
Driving rented-in rickshaw/van	15	15
Driving rented-in motorcycle/car/CNG (including Uber/Pathao/Obhai)	16	16
Clothes washer/laundry	17	17
Motor cycle/car mechanic	18	18
Refrigerator-AC Mechanic	19	19
Mobile servicing business	20	20
Saloon business	21	21
Small departmental store	22	22
Tea stall (including betel leaf and cigarette)	23	23
Computer operator	24	24
Flexi load/bkash/Rocket Agent	25	25
Repairman (appliances)	26	26
Private tutor	27	27
Contractor	28	28
Hotel/café	29	29
Handicrafts	30	30
Beauty Parlour	31	31
Block-Batik/tie-dye	32	32
Garment worker	33	33
Selling food items in van	34	34
Selling non-food items in van	35	35
Weighing machine provider	36	36
Selling food items in footpath or alike	37	37
Selling non-food item in or alike	38	38
Poultry birds and eggs	39	39
Livestock (animals and dairy products)	40	40
Crop agriculture	41	41
Horticulture	42	42
Aquaculture	43	43
Religious leaders	44	44
Teacher	45	45
Beggar	46	46
Sweeper/cleaner	47	47
Construction labour	48	48
Shopkeeper	49	49

Day-labour	50	50
Private sector office service	51	51
Government/semi-government office service	52	52
NGO worker	53	53
Housemaid	54	54
Transport worker	55	55
Security service	56	56
Other unskilled workers	57	57
Student	58	58
Unemployed	59	59
Physically/mentally not able to work	60	60
Child	61	61
Housewife	62	62
Others (specify)		

Q21. What is your level of education? [SA] DON'T READ THE OPTIONS

	Code
Illiterate	1
Literate with no formal education	2
Class 4	3
Class 5 to 9	4
S.S.C/ Dakhil / H.S.C/Alim	5
Have some college/university education but not graduate	6
General Graduate or above	7
Professional Graduate or above	8
Technical Education	9
Religious education	10

Q22.	How many earning members in your household?	

Q23a. What is your monthly Household Income (in BDT) before COVID-19 outbreak? [SA] **DON'T READ THE OPTIONS**

Q23b. After COVID-19 outbreak has been your monthly Household Income changed? If yes, how much (in BDT)? [SA] **DON'T READ THE OPTIONS**

Income range/	**Q23a. Before COVID-19 outbreak**		**Q23.b After COVID-19 outbreak**	
	a1. Exact Amount	**a2. Income range**	**b1. Exact Amount**	**b2. Income range**
No income		01		01
less than 3000 BDT		02		02
3001-5000 BDT		03		03

5001-7000 BDT		04		04
7001-10000 BDT/		05		05
10001-15000 BDT /		06		06
15001-20000 BDT /		07		07
20001-25000 BDT/		08		08
25001-30000 BDT /		09		09
30001-35000 BDT /		10		10
35001-40000 BDT /		11		11
40001-45000 BDT /		12		12
45001-50000 BDT /		13		13
More than 50000 BDT /		14		14
Refused to answer /		99		99

HOUSING & SANITATION FACILITY

Q25. What is the main source of drinking water of your household? [SA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

	Code
Tap water piped into dwelling	1
Tap water piped to community/slum yard/plot	
Tube well / deep tube well inside community/slum	2
Public tap/ tube well / deep tube well outside community/slum	3
Well	4
Pond	5
River / Canal	
Others	

Q26. What type of toilet is used by your household? [SA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**]

	Code
Sanitary (water-sealed)	1
Pit latrine with slab	2
Pit latrine without slab/open pit	3
Non-sanitary/hanging / Katcha toilet	4
Open space / No toilet	5
Others (specify)	

Q27. Do you share the toilet with another family/household? [SA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

	Code
Used by own household/family	1
Shared by other household/family in the slum/community	2

Q28. Do you have water to wash hand near the toilet? [SA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

	Code
Yes, inside the toilet	1
Yes, near the toilet	2
No water near or inside toilet	3

Q29. Do you have soap or liquid hand wash to wash hand near the toilet? Is it inside or outside? [SA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

	Code
No soap or liquid hand wash or ash	1
Soap or liquid hand wash outside the toilet	2
Don’t have soap or liquid hand wash, but ash to wash hands	3
Soap or liquid hand wash inside the toilet	4

COVID-19 AWARENESS & SOURCE OF KNOWLEDGE

Q30a. Were you aware of the Corona Virus Disease/COVID-2019 before LG/NUPRP-UNDP started its emergency response programme because of Corona Virus Disease 2019/Covid-19 outbreak in Bangladesh?
Q30b. Have your awareness on Corona Virus Disease/COVID-2019 increased after LG/NUPRP-UNDP started its emergency response programme?

	Q30a. Before COVID-19 outbreak	**Q30b. After COVID-19 outbreak**
Yes	1	1
No	2	2

Q31a. What do you know about Coronavirus? **Instructions for interviewers: Don’t READ THE OPTIONS. Listen to them.** [MA]
Q31b. What do you know about Coronavirus? **Instructions for interviewers: Probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

	Q31a. Spontaneous	**Q31b.Aided/ Probed**
Corona virus /Covid-2019 is a contagious virus	1	1
Corona virus /Covid-2019 spreads through sneezing and coughing	2	2
Fever (over 100 degrees Fahrenheit / 38 degrees Celsius), sore	3	3

throat, cough and shortness of breath can be Corona virus /Covid-2019 infection		
There is no treatment for the coronavirus/ Covid-2019 disease	4	4
To prevent Corona virus/Covid-2019, wash hands frequently with soap	5	5
To be safe from the Corona virus /Covid-2019, wear a mask when leaving the house	6	6
Social distance from the person infected with the Corona virus /Covid-2019 should be maintained	7	7
Others (specify)		
Cannot say	99	

Q32. Now I am going to readout some statements about the awareness Corona virus /Covid-2019. After hearing each of them, you will say – do you know about them or not? **[READ EACH STATEMENT]**

	Yes	**No**
I am aware of corona virus/Covid-19	1	2
I am aware of corona virus/Covid-19 symptoms	1	2
I am aware of the prevention of corona virus/Covid-19	1	2
I follow the practices to prevent the corona virus/Covid-19	1	2
I share the information/messages about corona virus/Covid-19 awareness with others in the community including disable people, elderly, and minority/vulnerable groups	1	2

Q33. Have you heard of any awareness campaign run by LG/NUPRP-UNDP program about COVID-19 in your community/slum?

	Code	
Yes	1	Go to Q34
No	2	Go to Q39

Q34a. What preventive steps are being conveyed regarding Corona virus /Covid-2019 by LG/NUPRP-UNDP program team? **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them.** [MA]

Q34b. What preventive steps are being conveyed regarding Corona virus /Covid-2019 by LG/NUPRP-UNDP program team? **Instructions for interviewers: Probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

Responses	Q34a. Spontaneous	Q34b.Aided / Probed
Hand Washing		
Wash your hands regularly for 20 seconds, with soap and water	1	
Clean your hands with alcohol-based hand rub	2	
Protect others from getting sick		
Cover your nose and mouth with a disposable tissue or flexed elbow when you cough or sneeze	3	
Dispose used tissue in bin immediately & properly wash hands with soap after cough or sneeze	4	
Avoid close contact with people who are suffering from flu or cough or fever	5	
Avoid spitting in public	6	
If you have fever, cough, and difficulty breathing seek medical care early and share previous travel history with your health care provider	7	
Don't Touch your eyes, nose, or mouth if your hands are not clean or after touching anything	8	
Stay home and self-isolate from others in the household if you feel unwell	9	
Practice food safety		
Thoroughly cook meat and eggs	10	
Sick animals and animals that have died of diseases should not be eaten	11	
Working in outside or wet markets		
If possible avoid or otherwise maintain social distance in crowd, market, and social/religious gatherings	12	
Using mask outside home	13	
Frequently wash your hands with soap and water after touching animals and animal products	14	
Wear protective gowns, gloves, masks and facial protection while handling animals and animal products, especially those who work in wet markets	15	
Remove protective clothing after work, wash aprons daily and leave at the work site, especially those who work in wet markets	16	
Workplaces should be cleaned and disinfected at least once a day, especially those who work in wet markets	17	
Avoid exposing family members to soiled work clothing and shoes, especially those who work in wet markets	18	
Sharing information		
Share information on coronavirus prevention to a person with disability in your family or in your neighborhood, if any	19	
Others (please specify)		
Cannot say	99	

Q35a. At which occasions should you/your family wash hands are being conveyed by LG/NUPRP-UNDP program to prevent the Corona Virus Disease 2019/Covid-19? **[MA] DO NOT READ OCCASSIONS Listen to them.**

Q35b. At which occasions should you/your family wash hands are being conveyed by LG/NUPRP-UNDP program to prevent the Corona Virus Disease 2019/Covid-19? **Instructions for interviewers: Probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

	Q35a. Spontaneous	**Q35b.Aided/ Probed**
Before cooking	1	
During cooking	2	
After cooking	3	
Before eating	4	
Before feeding the child	5	
After cleaning the child's feces	6	
After going to the toilet	7	
If hands are dirty	8	
After coming home from outside	9	
After touching things and packets purchased from the market	10	
After any sort of contact with animals or cleaning their fecces	11	
After carrying or coming in contact with a person infected with the corona virus	12	
Others (please specify		
Cannot say	99	

Q36a. What has been used to convey information on Corona Virus Disease/COVID-2019 in LG/NUPRP-UNDP program? **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them.** [MA]

Q36b. What has been used to convey information on Corona Virus Disease/COVID-2019 in LG/NUPRP-UNDP program? **Instructions for interviewers: Probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

Source	**Q36a. Spontaneous**	**Q36b.Aided / Probed**
Announcement through Hand mic/Loud speaker	01	
Poster/Festoon/Booklet	02	
Newspaper	03	
Domestic online newspaper	04	
News on TV	05	
News on radio	06	
CDC leaders	07	
Text message	08	
Social Media/Facebook		
Other Social Media like (Twitter, Instagram, TikTok, etc.)	09	
Others (please specify)		
Cannot say	99	

Q37. Is anyone or any organization conveyed any information on what to do or where to contact if you or any person in your family or community shows COVID 19 symptoms? **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

	Code	
No one	1	Go to Q39
From LG/NUPRP-UNDP	2	Go to Q38
Other government initiatives	3	Go to Q39
Other non-govt. initiative's	4	
Other (please specify)		

Q38a. What information has been conveyed by LG/NUPRP-UNDP program team? [MA] **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them.**

Q38b. What information has been conveyed by LG/NUPRP-UNDP program team? **Instructions for interviewers: Probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?** [MA]

	Q38a. Spontaneous	**Q38b.Aided/ Probed**
Will stay home maintaining self-isolation	1	
Will stay home and take medicine from local pharmacies without consulting any doctors	2	
Will contact local health facility or doctor over the phone and take primary health care services prescribed by them	3	
Will contact IEDCR or Govt. designated heath facility hotline numbers by phone and follow their instructions	4	
Will directly go to health facilities in person to test for corona virus without consulting any other options	5	
Will do nothing or maintain normal social life	6	
Other (please specify)		
Cannot say	99	

HAND WASH - INTERVENTION

Q39. Have you got any hand washing soap for your household after the Corona Virus Disease 2019/Covid-19 outbreak? [MA] **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

Response	Code	
Did not get soap	1	Go to Q42
From LG/NUPRP-UNDP program	2	Go to Q40
From other government initiatives	3	Go to Q42

From other non-govt. initiatives	4	
From personal initiatives	5	
Others (Please specify)		

Q40. How much soap did your household get from LG/NUPRP-UNDP program?

Q41. What will you do when the soap received from LG/NUPRP-UNDP program is over? [MA]
Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.

	Code
Will use Tipitap/hand washing corner where soap is available	1
Will collect soap	2
Will purchase soap	3
Others (Please specify)	

Q42. Is there any handwashing corner or Tippy-Tap established in your community/slum after the Corona Virus Disease 2019/Covid-19 outbreak? Who established it? [MA] **Instructions for interviewers: Don't READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?**
Instructions for interviewer: The Tippy Tap is a simple device for handwashing with running water. A container with a small hole near the cap is filled with water and tipped with a stick and rope tied through a hole in the cap. As only the soap is touched with the hands, the device is very hygienic. And handwashing corner is temporary or permanent solution made of water container with water tap accommodating soap (e.g. soap dish, dispenser for liquid soap, bottle with soapy water) placed on a van.

	Code	
None	1	Go to Q46
From LG/NUPRP-UNDP program	2	Go to Q43
From other government initiatives	3	Go to Q46
From other non-govt. initiatives	4	
From personal initiatives	5	
Others (Please specify)		

Q43. Can you or your household use the handwashing corner or Tippy-Tap established by LG/NUPRP-UNDP program?

	Code
Yes	1
No	2
Don't know	9

Q44. Have you or your household faced any problem or challenges in using or not using the handwashing corner or Tippy-Tap established by LG/NUPRP-UNDP program?

	Code	
Yes	1	GO to 45
No	2	GO to 46

Q45. If yes, what types of challenges or problems? [MA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times**.

	Code
Soap/liquid hand wash/detergent (any cleaning agent) is not available	1
Hand washing arrangement is partially or fully broken	2
Hand washing point is not clean	3
Broken container/bucket	4
Broken tap	5
Broken basin	6
Filling this bottle/bucket from time to time is a problem	7
Supply dirty water	8
No supply of water	9
Lack of or don't have a proper drainage system	10
Suitable for children and women's use	11
Suitable for disabled and elderly person's use	12
Others (Please specify)	

Q46. After the Corona Virus Disease 2019/Covid-19 outbreak do you properly wash your hands to prevent the virus?

	Code
Yes	1
No	2

Q47a1. Can you tell me at which occasions are you/your family washing hands after the Corona Virus Disease 2019/Covid-19 outbreak? [MA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times**. **Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?**

Q47a2. Please rank the first 3 occasions of washing hands after the Corona Virus Disease 2019/Covid-19 outbreak answered by respondent?

Q47b1. Can you tell me at which occasions you/your family washed your hands before the Corona Virus Disease 2019/Covid-19 outbreak?? [MA] **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times**. **Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?**

Q47b2.Please rank the first 3 occasions of washing hands before the Corona Virus Disease 2019/Covid-19 outbreak answered by respondent?

	Q47a. After the Corona Virus Disease 2019/Covid-19 outbreak		Q47b. Before the Corona Virus Disease 2019/Covid-19 outbreak		Not Applicable
	Q47a1.	**Q47a2. Rank first 3**	**Q47b1.**	**Q47b2. Rank first 3**	
Before cooking					
During cooking					
After cooking					
Before eating					
Before feeding the child					
After cleaning the child's feces					
After going to the toilet					
If hands are dirty					
After coming home from outside					
After touching things and packets purchased from the market					
After any sort of contact with animals or cleaning their fecces					
After carrying or coming in contact with a person infected with the corona virus					

Q48a. What, if anything, did you use to clean your hand after the Corona Virus Disease 2019/Covid-19 outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?**
Q48b. What, if anything, did you use to clean your hand before the Corona Virus Disease 2019/Covid-19 outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.**

	Q48a. After the Corona Virus Disease 2019/Covid-19 outbreak				**Q48b. Before the Corona Virus Disease 2019/Covid-19 outbreak**			
	Water only	Water and ash	Water and soap	Hand samitizer/Alcohol based hand rub	Water only	Water and ash	Water and soap	Hand sanitizer/Alcohol based hand rub
Before cooking								
During cooking								
After cooking								
Before eating								
Before feeding the child								
After cleaning the child's feces								
After going to the toilet								
If hands are dirty								
After coming home from outside								
After touching things and packets purchased from the market								
After any sort of contact with animals or cleaning their fecces								
After carrying or coming in contact with a person infected with the corona virus								

SHOW IF Q49 & 50 ONLY IF Q1=2

FOOD BASKET/CASH TRANSFER - INTERVENTION

Q49. After the Corona Virus Disease 2019/Covid-19 outbreak did you or your family get any aid as food basket and cash transfer from LG/NUPRP-UNDP program? [SA]

	Code	
Yes	1	Go to Q50
No	2	Go to Q51

Q49a. How long (in days) has your family been able to meet food expense with the cash assistance you received from the Corona Virus Disease 2019/Covid-19 outbreak program from LG/NUPRP-UNDP program?

Q50. Have you faced any sort problems in receiving the cash tranfer from LG/NUPRP-UNDP program? If yes, what were the problems? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [MA]

	Code
Faced no problem	1
Got money but could not cash out or partial cash	2
Got less money than promised	3
Others (Please specify)	

DIETERY DIVERSITY & FOOD SECURITY

Q51a. Before the Corona Virus Disease 2019/Covid-19 outbreak how are you primarily sourcing your food for your household? Have you received any food aid for your household? [MA]
Q51b. After the Corona Virus Disease 2019/Covid-19 outbreak how are you primarily sourcing your food for your household? Have you received any food aid for your household? [MA]

	Q51a. After the Corona Virus Disease 2019/Covid-19 outbreak	**Q51b. Before the Corona Virus Disease 2019/Covid-19 outbreak**
Own production, gathering, hunting, fishing		
Purchased from market/shop		
Borrowed, bartered, exchanged for labour, gift from friends or relatives		
Food aid (government, non-govt, and personal		

initiatives)		
Others (Please specify)		

Q52a. Before the Corona Virus Disease 2019/Covid-19 outbreak did you or your family have access to food or cash to meet basic needs?

Q52b.After the Corona Virus Disease 2019/Covid-19 outbreak did you or your family have access to food or cash to meet basic needs?

	Q52a. Before the Corona Virus Disease 2019/Covid-19 outbreak	Q52b. After the Corona Virus Disease 2019/Covid-19 outbreak
Yes	1	1
No	2	2

Add "Other" option. Add "Did not take any food" option for After breakfast Snack, After lunch Snack, After dinner Snack

Q53. Please describe the average foods (meals and snacks) that you or any member of the household ate or drank during the day and night the month before Ramadan, whether at home or outside the home after the Corona Virus Disease 2019/Covid-19 outbreak. Start with the first food or drink of the morning.

Instructions for interviewers: Write down all foods and drinks mentioned. Exclude foods purchased and eaten outside the home. When composite dishes are mentioned, ask for the list of ingredients. When the respondent has finished, probe for meals and snacks not mentioned. Exclude unusual days, like a celebration, feast day, fasting, sickness etc. when you or any member of the household ate special foods or more or less than usual or did not eat because of fasting.

When the respondent recall is complete, fill in the food groups based on the information recorded above. For any food groups not mentioned, ask the respondent if a food item from this group was consumed.

	Food group	Examples	Breakfast		After breakfast Snack		Lunch		After lunch Snack		Dinner		After dinner Snack	
			YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2
1	CEREALS	corn/maize, rice, wheat, sorghum, millet or any other grains or foods made from these (e.g. bread, noodles, porridge or other grain products)												
2	WHITE ROOTS AND TUBERS	white potatoes, white yam or any other foods made from white-fleshed roots												
3	VITAMIN A RICH VEGETABLES AND TUBERS	pumpkin, carrot, squash, or sweet potato that are orange inside + other locally available vitamin A rich vegetables												
4	DARK GREEN LEAFY VEGETABLES	dark green leafy vegetables, including wild forms + locally available vitamin A rich leaves such as amaranth, cassava leaves, kale, spinach												
5	OTHER VEGETABLES	other vegetables (e.g. tomato, onion, eggplant) + other locally available vegetables												
6	VITAMIN A RICH FRUITS	ripe mango, cantaloupe, apricot (fresh or dried), ripe papaya, dried peach, and 100% fruit juice made												

	Food group	Examples	Breakfast		After breakfast Snack		Lunch		After lunch Snack		Dinner		After dinner Snack	
			YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2
		from these + other locally available vitamin A rich fruits												
7	OTHER FRUITS	other fruits, including wild fruits and 100% fruit juice made from these												
8	ORGAN MEAT	liver, kidney, heart or other organ meats or blood-based foods												
9	FLESH MEATS	beef, pork, lamb, goat, rabbit, game, chicken, duck, other birds, insects												
10	EGGS	eggs from chicken, duck, guinea fowl or any other egg												
11	FISH AND SEAFOOD	fresh or dried fish or shellfish												
12	LEGUMES, NUTS AND SEEDS	dried beans, dried peas, lentils, nuts, seeds or foods made from these (eg. hummus, peanut butter)												
13	MILK AND MILK PRODUCTS	milk, cheese, yogurt or other milk products												
14	OILS AND FATS	oil, fats or butter added to food or used for cooking												
15	SWEETS	sugar, honey, sweetened soda or												

	Food group	Examples	Breakfast		After breakfast Snack		Lunch		After lunch Snack		Dinner		After dinner Snack	
			YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2
		sweetened juice drinks, sugary foods such as chocolates, candies, cookies and cakes												
16	SPICES, CONDIMENTS,	spices (black pepper, salt), condiments (soy sauce, hot sauce)												
17	BEVERAGES													
18.	Others													

Q54. Please describe the average foods (meals and snacks) that you or any member of the household ate or drank during the day and night, whether at home or outside the home before the Corona Virus Disease 2019/Covid-19 outbreak. Start with the first food or drink of the morning.

	Food group	Examples	Breakfast		After breakfast Snack		Lunch		After lunch Snack		Dinner		After dinner Snack	
			YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2	YES=1	NO=2
1	CEREALS	corn/maize, rice, wheat, sorghum, millet or any other grains or foods made from these (e.g. bread, noodles, porridge or other grain products)												
2	WHITE ROOTS AND TUBERS	white potatoes, white yam or any other foods made from white-												

		fleshed roots												
3	VITAMIN A RICH VEGETABLES AND TUBERS	pumpkin, carrot, squash, or sweet potato that are orange inside + other locally available vitamin A rich vegetables												
4	DARK GREEN LEAFY VEGETABLES	dark green leafy vegetables, including wild forms + locally available vitamin A rich leaves such as amaranth, cassava leaves, kale, spinach												
5	OTHER VEGETABLES	other vegetables (e.g. tomato, onion, eggplant) + other locally available vegetables												
6	VITAMIN A RICH FRUITS	ripe mango, cantaloupe, apricot (fresh or dried), ripe papaya, dried peach, and 100% fruit juice made from these + other locally available vitamin A rich fruits												
7	OTHER FRUITS	other fruits, including wild fruits and 100% fruit juice made from these												
8	ORGAN MEAT	liver, kidney, heart or other organ meats or blood-based foods												
9	FLESH MEATS	beef, pork, lamb, goat, rabbit, game, chicken, duck, other birds, insects												
10	EGGS	eggs from chicken, duck, guinea fowl or any other egg												
11	FISH AND	fresh or dried fish or shellfish												

	SEAFOOD													
12	LEGUMES, NUTS AND SEEDS	dried beans, dried peas, lentils, nuts, seeds or foods made from these (eg. hummus, peanut butter)												
13	MILK AND MILK PRODUCTS দুধ ও দুগ্ধ জাতীয় খাবার	milk, cheese, yogurt or other milk products												
14	OILS AND FATS	oil, fats or butter added to food or used for cooking												
15	SWEETS	sugar, honey, sweetened soda or sweetened juice drinks, sugary foods such as chocolates, candies, cookies and cakes												
16	SPICES, CONDIMENTS,	spices (black pepper, salt), condiments (soy sauce, hot sauce)												
17	BEVERAGES													
18.	Other													

Q55. Please tell me about the incidence happened the month before Ramadan after Covid-19 outbreak which I am going to readout now. **[READ EACH QUESTIONS]**

		Rarely (1-2 times)	**Sometimes (3-10 times)**	**Often (>10 times))**	**Never**
Q55.1	After Covid-19 outbreak in the month before Ramadan, did you worry that your HH would not have enough food?	1	2	3	4
Q55.2	After Covid-19 outbreak in the month before Ramadan, were you or any HH member not able to eat the kinds of foods you preferred because of a lack of resources?	1	2	3	4
Q55.3	After Covid-19 outbreak in the month before Ramadan, did you or any household member have to eat a limited variety of foods due to a lack of resources?	1	2	3	4
Q55.4	After Covid-19 outbreak in the month before Ramadan, did you or any HH member eat food that you did not want to eat instead of other foods because of a lack of resources?	1	2	3	4
Q55.5	After Covid-19 outbreak in the month before Ramadan, did you or any HH member eat a smaller meal than you felt you needed because there was not enough food?	1	2	3	4
Q55.6	After Covid-19 outbreak in the month before Ramadan, did you or any HH member eat fewer meals in a day because there was not enough food?	1	2	3	4
Q55.7	After Covid-19 outbreak in the month before Ramadan, was there ever no food at all in your HH because there were no resources?	1	2	3	4
Q55.8	After Covid-19 outbreak in the month before Ramadan, did you or any HH member go to sleep at night hungry because there was not enough food?	1	2	3	4
Q55.9	After Covid-19 outbreak in the month before Ramadan, did you or any HH member go a whole day without eating anything in at least 2 meals because there was not enough food?	1	2	3	4

Q56. Please tell me about the incidence happened the month before Covid-19 outbreak which I am going to readout now. [READ EACH QUESTIONS]

		Rarely (1-2 times)	**Sometimes (3-10 times)**	**Often (>10 times)**	**Never**
Q56.1	The month before Covid-19 outbreak, did you worry that your HH would not have	1	2	3	4

	enough food?				
Q56.2	The month before Covid-19 outbreak, were you or any HH member not able to eat the kinds of foods you preferred because of a lack of resources?	1	2	3	4
Q56.3	The month before Covid-19 outbreak, did you or any household member have to eat a limited variety of foods due to a lack of resources?	1	2	3	4
Q56.4	The month before Covid-19 outbreak, did you or any HH member eat food that you did not want to eat instead of other foods because of a lack of resources?	1	2	3	4
Q56.5	The month before Covid-19 outbreak, did you or any HH member eat a smaller meal than you felt you needed because there was not enough food?	1	2	3	4
Q56.6	The month before Covid-19 outbreak, did you or any HH member eat fewer meals in a day because there was not enough food?	1	2	3	4
Q56.7	The month before Covid-19 outbreak, was there ever no food at all in your HH because there were no resources?	1	2	3	4
Q56.8	The month before Covid-19 outbreak, did you or any HH member go to sleep at night hungry because there was not enough food?	1	2	3	4
Q56.9	The month before Covid-19 outbreak, did you or any HH member go a whole day without eating anything in at least 2 meals because there was not enough food?	1	2	3	4

If coded Q55.9=1-3 or Q56.9=1-3

Q57. If there is situation that any HH member go a whole day without eating anything in atleast 2 meals because there was not enough food usually who do not eat? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [SA]

	Code
Female HH/family member	1
Male HH/family member	2
Whole family/HH	3

VULNERABILITY, RISH RESILIENCE, & COPING STRATEGY

Q58. Please let us know about the crisis you or your family faced in the last 3 months after corona virus outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [MA

	Code
No crisis faced	1
Crisis in drinking water	2
Serious illness of household members	3
Huge expense for medical treatment/ rehabilitation	4
Victim of violence/threats	5
Sudden business loss	6
Complications related to pregnancy and delivery	7
Loss of job	8
Damage/loss to household assets	9
Decrease/ disruption in regular income	10
Price hike	11
Mental trauma	12
Others (Please specify)	

Q59. Now I am going to readout some statements. Tell me to meet HH basic needs in the last 3 months after corona virus outbreak did your HH have to do this things? **READ THE STATEMENTS.**

	Yes	No
Take a cash loan from outside HH	1	2
Take an in-kind loan from outside HH (e.g. Shop/boutique)	1	2
Sell assets (e.g. furniture, jewelry)	1	2
Sell livestock	1	2
Sell land	1	2
Others (Please specify)		

Q60. If your household needs to borrow money, does your HH have anyone or organization to access credit/money?

	Code	
Yes	1	Go to 61
No	2	
Don’t know	9	

Q61. Where does your HH go to access credit/money? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [MA]

	Code
None	1
Family or friends	2
Micro credit agency or organization	3
Bank or credit union	4
Money lender (individual)	5
Others (Please specify)	

HEALTH STATUS & HEALTH SEEKING BEHAVIOR

Q62. After the Corona Virus Disease 2019/Covid-19 outbreak do you think government and non-government health facility remains accessible for all? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [SA]**

	Code
Remains the same, meeting the need	1
This service is not enough now, not meeting the need	2
Patients are not coming to the health care facility	3
Helath care facility refuses to take patients	4
Do not know	9

Q63. Have you or anyone in your family been sick in the past one month because of any Non-COVID 19 diseases?

	Code	
Yes	1	Go to Q64
No	2	Go to Q70

Q64. For what types of health problems? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [MA]**

	Code
Flu, cough, fever	1
Diabetes	2
Heart disease	3
Lung disease	4
Eczema or long-term breathing problems	5

Kidney disease	6
Liver disease	7
Cancer	8
High blood pressure	9
Dental issues	10
Others (Please specify)	

Q65. Have you or your family been to a doctor or hospital/clinic/health facility in the past month? **DON'T READ THE OPTIONS [SA]**

	Code	
Went but did not get service	1	Go to Q66
Went and got service	2	
Did not go	3	Go to Q69

Q66. Where did you go? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [MA]**

	Code
Government hospital	1
Private hospital or clinics	2
Non-govt. health facilities	3
Doctor's chamber	4
Others (Please specify)	

Q67. Why did not you get services? What types of challenges you faced? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [MA]**

	Code
Hospital/health facility rejected to admit patient without diagnosis of Corona Virus Disease 2019/Covid-19	1
Hospital/health facility does not have enough doctors/health workers	2
Others (Please specify)	

Q68. Please rate the quality of services of the health facility/hospital general health?

	Code
Very good	1
Good	2
Moderate	3
Bad	4
Very bad	5
Don't know	9

Q69. Why did not you go? What types of challenges you faced? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [MA]**

	Code
Afraid of being infected by Corona Virus Disease 2019/Covid-19	1
Did not have money	2
Others (Please specify	

IMPACT ON LIVELIHOOD

Q70. What is your family/household income status during the last one month? Is there any income at all? Increased or decreased? If how much? More or less? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [SA]**

	Code
No income	1
Decreased a lot	2
Decreased by almost half	3
Remained same	4
Increased to almost double	5
Increased a lot	6

Q71. In the last one month has your family expenses, both food and other expenses, increased or decreased? If how much? More or less? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times. [SA]**

	Decreased a lot	**Decreased by almost half**	**Remained same**	**Increased to almost double**	**Increased a lot**
Food expense	1	2	3	4	5
Other expense	1	2	3	4	5

Q72. How long can you or your family continue in locked-down state with your savings and stocks of food and other necessities (if any)? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand properly, probe. If they find it difficult to understand, read it 1-2 times.** [SA]

Maximum one day more	1
Maximum one week more	2
Maximum two weeks	3
Maximum 3/4 weeks	4
More than 4 week	5
For 2 months	6
More than 2 months	7

OVERALL IMPACT & SATISFACTION

Q73. Do you think the services and information such as, awareness campaign, food and cash transfer, soap, hand washing corner etc. provided by LG/NUPRP-UNDP program in your community/slum during the Corona Virus Disease 2019/Covid-19 outbreak are relevant for your household need in that moment? If found to be useful, how much?

	Code
Not at all	1
Little	2
Useful	3
Very	4
Very much	5

Q74. Are you satisfied or unsatisfied with the services and information such as, awareness campaign, food and cash transfer, soap, hand washing corner etc. provided by LG/NUPRP-UNDP program in your community/slum during the Corona Virus Disease 2019/Covid-19 outbreak?

	Code
Very unsatisfied	1
Unsatisfied	2
Neither unsatisfied nor satisfied	3
Satisfied	4
Very satisfied	5

Q75. Did the women, disabled, elderly people, and people from the minority/vulnerable groups in your community get priority in getting the services and information such as, awareness campaign, food and cash cash transfer, soap, hand washing corner etc. from LG/NUPRP-UNDP program?

	Code
Yes	1
No	2
Don’t know	9

CDC Related

Q76. What activities are doing in CDC after Corona Virus Disease 2019/Covid-19 outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand, probe. If they find it difficult to understand, read it 1-2 times.** [MA]

	Code
Conducted door-to-door as well as community awareness activities on Corona Virus Disease 2019/Covid-19	1
Distributed Soap, Hand Sanitizer, PPE	2
Work in the establishment of hand washing corner and Tipitap	3
Distributed food basket	4
Work in the distributed cash transfer	5
Others (Please specify)	

Q77. Have the needs of the population been identified before providing the services and information such as, awareness campaign, food and cash transfer, soap, hand washing corner etc. from LG/NUPRP-UNDP program after Corona Virus Disease 2019/Covid-19 outbreak?

	Code
Yes	1
No	2
Don’t know	9

Q78. Have the emergency response design of NUPRP considered the need of all the vulnerable people including women, children, elderly people, minority/vulnerable groups, and people with disability?

	Code
Yes	1
No	2
Don't know	9

Q79. How often times Community Development Committee (CDC) volunteers and leaders interact with you in a month after Corona Virus Disease 2019/Covid-19 outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand, probe. If they find it difficult to understand, read it 1-2 times.** [SA]

	Code
At least once a week	1
2-3 times a week	2
2-3 times a month	3
Once a month	4
None	5

Q80. What types of help do you get Corona Virus /Covid-19 from Community Development Committee (CDC) volunteers and leaders after Corona Virus Disease 2019/Covid-19 outbreak? **Instructions for interviewers: DON'T READ THE OPTIONS. Listen to them. If they do not understand, probe. If they find it difficult to understand, read it 1-2 times. Ask them, did the CDC leader or the CF or the Nutrition Apa told you anything like that?**

	Code
Informed us about Corona Virus /Covid-19 and what is its symptoms	1
Shared information on how to prevent Corona Virus /Covid-19	2
Helped in learning to wash hand properly	3
Helped in learning to wear and dispose mask properly	4
Respond to any need or problem faced	5
In case of emergency or any queries, informed us hotline number/where to call	6
Others (Please specify)	

Now I am going to readout some questions about the intervention, CDC and its capacity. After hearing each of them, tell me you opinion? **[READ EACH QUESTIONS]**

		Yes	**No**	**Don't know**
Q81	Have you/your household follow the message/information/learning/practice of the LG/NUPRP-UNDP program?	1	2	3
Q82	Have you/your household shared the message/information/learning/practice with in the community including disable people, elderly, and minority/vulnerable groups about the learning of the LG/NUPRP-UNDP program?	1	2	3
Q83	Will you/your household continue the hand washing practice you have learned from the LG/NUPRP-UNDP program in the future?	1	2	3
Q84	Do you/your household have the capacity to arrange/buy hand washing agent in the future after end of this intervention?	1	2	3

Q85	Are you/your household/community willing to maintain the handwash corer/tippy-tap after end of this intervention?	1	2	3

Q86. Do the CDCs have capacity to face the emergency situation like Corona Virus Disease 2019/Covid-19 outbreak?

	Code
Yes	1
No	2
Don't know	9

Q87. What could be done to increase their capacity to face the emergency situation like Corona Virus Disease 2019/Covid-19 outbreak?? How? **[Briefly write the opinion of the respondent]]**

Q88. In the future, if we want to communicate with you for your opinion in any similar research, will you be interested to join?

	Code
Agree	1
Disagree	2

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

KII with Health Officials

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, we would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

Key Informant's Information	
a)	Name of the key-informant:
b)	Age in Years:
c)	Education:
d)	Designation/position:
e)	Length of service (in years) in current position:
f)	Address:
g)	Mobile Phone Number:

1. Could you please tell us something about COVID 19 situation in your area?
2. During current situation, what are the main challenges that the health professionals are facing? What about the general health care service? How do you ensure that that people with general health problems are getting services during this emergency situation? Why do you say so?
3. The NUPRP team has provided the WHO online training link the different health professionals? Have the team members of NUPRP discussed with you regarding this online training link and shared this with you? Have you get the opportunity to go through the training link? What is your overall feedback on the online training in terms of content, length of training, future requirement?
4. A) Have you forwarded the online training link to the health officials of your departments? Have they completed the training? Do you have any record on how many health professionals have completed the training? (ask for total number of health professionals received the training link and the number of the health professionals completed the training)

   B) Those who have completed the training, what is their overall feedback on the online training in terms of content, length of training, future requirement?

   c) Those who have not completed the training, why don't they do the training? What were the challenges?

5. The UNDP NUPRP team is providing PPE to the health professionals. Have you received the PPE from UNDP NUPRP team for the health professionals working under you? If yes, what is your overall feedback (relevance, effectiveness, quality of PPE etc.) on this?
6. What is your opinion on the overall coordination of NUPRP team with the health professionals like you and with the local government stakeholders in order to provide emergency response due to COVID 19? Why do you say so?
7. How do you evaluate the overall emergency responses provided by the NUPRP to safeguard human rights and ensure social cohesion among urban poor during COVID 19? What could be done in in a better way? Please share your opinion in details.

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

IDI with NUPRP Beneficiaries

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, we would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

In Depth Interview Information										
a)	Name of the Respondent:									
b)	Age in Years:									
c)	Education:									
d)	Occupation:									
e)	Respondent Category (select from the category):									
f)	Mother of under 5 years children /Pregnant women	1	Women of Reproductive age	2	Husband of women of reproductive age	3	Old Age People (55+)	4	People with disability	5
g)	Address:									
h)	Name of slum/ settlement									
i)	Name of City Corporation/Town									
j)	District:									
k)	Division:									
l)	Mobile Phone Number:									
m)	Name of PG:									
n)	Name of CDC:									
o)	Duration of membership in CDC (Month)									

1. Could you please tell us something about you & your family members i.e. number of family members, number of children, monthly household income & expenditure & so on?

2. Have you heard about COVID 19/ Coronavirus? What do you know about Coronavirus? Do you know the symptoms of COVID19/Corona Virus? How does corona spread? Please tell me in details. Where did you get the information on Corona Virus Disease/COVID-2019?

3. Have you heard of any awareness campaign run by LG/NUPRP-UNDP program about COVID-19 in your community/slum? What preventive steps are being conveyed regarding Corona virus /Covid-2019 by LG/NUPRP-UNDP program team? Did you find that information useful? DO you feel you are now more aware on COVID 19? How? Tell me in details

4. What has been used to convey information on Corona Virus Disease/COVID-2019 in LG/NUPRP-UNDP program? Among all the mediums used to raise awareness, which one is the best medium to raise awareness among people like you? Why do you say so?

5. Have you received any hand washing soap for your household from NUPRP? If yes, how many? Do all the vulnerable people i.e. women; people with disability, elderly people, and minor receive the soap from NUPRP? Please tell me some example.

6. Is there any hand washing corner & tipi tap established by NUPRP team during COVID 19 situation? If yes, where? How many people use those establishments? Do the people i.e. women, children, elderly people, people with disability have access to those establishments? Please tell us in details

7. Do the community people practice hand washing using the soaps and hand washing corners from NUPRP team regularly to protect themselves from COVID 19 transmissions? If yes, can you share some stories with us? On which occasions do they practice hand washing? If no, why do you think people are not practicing handwashing?

8. Now I would like to know about the impact of COVID 19 on your livelihood situation. What was the main earning source of your family before COVID 19? Has it been impacted due to current situation? How? Tell us in details?

9. After the Corona Virus Disease 2019/Covid-19 outbreak, how are you managing your livelihood? Is there any change in the dietary practice of your family due to COVID 19 situation? If yes, please tell me in details.

10. Have you faced any situation in the last 30 days when you or your family members ate less or stayed without eating? If yes, was it you or any of your family members ate less food and did not eat anything? Please tell me in detail.

11. How do ensure nutritional requirement of your family members especially for the pregnant women, lactating mother, mother of children under 5 years, children during this COVID 19 pandemic? What are the challenges do you face to ensure nutritional requirement of your family members? How do you cope with this situation?

12. Have your received any cash transfer or food basket from NUPRP? If yes, how much money or food assistance did you receive? Do all the vulnerable people i.e. women; people with disability, elderly people, and minor receive cash/food aid from NUPRP? Please tell me some example.

13. Have you faced any difficulty in receiving cash or food aid from NUPRP? If yes, what are the challenges did you face in receiving cash or food aid from NUPRP?

14. Have you or any of your family members been sick in the last one month? If yes, what types of health problem did you and your family members face? Have you or your family been to a doctor or hospital/clinic/health facility to consult for health problem? What was your experience about the quality of health service during COVID 19 situation?

15. What activities have taken to build the capacity of the CDC to respond to the emergency situation and to address the need and to ensure the participation of all community people including women, children, minority, people with disability, elderly people? Please tell me in details.

16. What activities are the CDCs undertaking during Covid-19 outbreak to respond to the emergency situation and to address the need and to ensure the participation of all community people? Do you think these activities are sufficient? What else could be done to build the capacity of the CDC members to respond to emergency situation?

17. What is your overall opinion on the emergency response of NUPRP in terms of establishment of hand washing corner, tipi-tap station, distribution of soap, one time cash transfer or food basket distribution, dissemination of awareness message on COVID 19? To what extent are the activities of emergency COVID 19 response relevant to the need of people like you? Why do you say so?

18. Do these interventions undertaken considering the need of vulnerable people especially the need of women, children, people with disability, minor, and people with disability? How? Tell me some example?

19. Are you satisfied with the emergency response of NUPRP? Why do you say so?

20. Would you follow the learnings you have gained from the emergency response of NUPRP in terms of hand washing with soap, ensure protective measures i.e. gloves, mask, maintaining social distance in future? Why do you say so?

21. Can the program approach or results be replicated by CDC? What support would you require to replicate the approach during emergency situation?

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

KII with CDC Members

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, we would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

In Depth Interview Information										
a)	Name of the Respondent:									
b)	Age in Years:									
c)	Education:									
d)	Occupation:									
e)	Respondent Category (select from the category):									
f)	Mother of under 5 years children /Pregnant women	1	Women of Reproductive age	2	Husband of women of reproductive age	3	Old Age People (55+)	4	People with disability	5
g)	Address:									
h)	Name of slum/ settlement									
i)	Name of City Corporation/Town									
j)	District:									
k)	Division:									
l)	Mobile Phone Number:									
m)	Name of PG:									
n)	Name of CDC:									
o)	Duration of membership in CDC (Month)									
p)	Role in CDC									
	Primary Group- General Member	01								
	Primary Group – President/Leader	02								
	Primary Group – Secretary	03								
	CDC Chairperson	04								
	CDC Vice-chairperson	05								
	CDC Secretary	06								
	CDC Joint Secretary	07								
	CDC Cashier	08								
	CDC Cluster President	09								
	CDC Cluster General Member	10								
	Federation General Committee Members	11								
	Federation Executive Committee Members	12								
	Federation Advisory Committee Members	13								
	Others (specify)									

1. Could you please tell us something about you & your family members i.e. number of family members, number of children, monthly household income & expenditure & so on?

2. Have you heard about COVID 19/ Coronavirus? What do you know about Coronavirus? Do you know the symptoms of COVID19/Corona Virus? How does corona spread? Please tell me in details. Where did you get the information on Corona Virus Disease/COVID-2019?

3. Have you heard of any awareness campaign run by LG/NUPRP-UNDP program about COVID-19 in your community/slum? What preventive steps are being conveyed regarding Corona virus /Covid-2019 by LG/NUPRP-UNDP program team? Did you find that information useful? DO you feel you are now more aware on COVID 19? How? Tell me in details

4. What has been used to convey information on Corona Virus Disease/COVID-2019 in LG/NUPRP-UNDP program? Among all the mediums used to raise awareness, which one is the best medium to raise awareness among people like you? Why do you say so?

5. Have you received any hand washing soap for your household from NUPRP? If yes, how many? Do all the vulnerable people i.e. women; people with disability, elderly people, and minor receive the soap from NUPRP? Please tell me some example.

6. Is there any hand washing corner & tipi tap established by NUPRP team during COVID 19 situation? If yes, where? How many people use those establishments? Do the people i.e. women, children, elderly people, people with disability have access to those establishments? Please tell us in details

7. Do the community people practice hand washing using the soaps and hand washing corners from NUPRP team regularly to protect themselves from COVID 19 transmissions? If yes, can you share some stories with us? On which occasions do they practice hand washing? If no, why do you think people are not practicing handwashing?

8. Now I would like to know about the impact of COVID 19 on your livelihood situation. What was the main earning source of your family before COVID 19? Has it been impacted due to current situation? How? Tell us in details?

9. After the Corona Virus Disease 2019/Covid-19 outbreak, how are you managing your livelihood? Is there any change in the dietary practice of your family due to COVID 19 situation? If yes, please tell me in details.

10. Have you faced any situation in the last 30 days when you or your family members ate less or stayed without eating? If yes, was it you or any of your family members ate less food and did not eat anything? Please tell me in detail.

11. How do ensure nutritional requirement of your family members especially for the pregnant women, lactating mother, mother of children under 5 years, children during this COVID 19 pandemic? What are the challenges do you face to ensure nutritional requirement of your family members? How do you cope with this situation?

12. Have your received any cash transfer or food basket from NUPRP? If yes, how much money or food assistance did you receive? Do all the vulnerable people i.e. women; people with disability, elderly people, and minor receive cash/food aid from NUPRP? Please tell me some example.

13. Have you faced any difficulty in receiving cash or food aid from NUPRP? If yes, what are the challenges did you face in receiving cash or food aid from NUPRP?

14. Have you or any of your family members been sick in the last one month? If yes, what types of health problem did you and your family members face? Have you or your family been to a doctor or hospital/clinic/health facility to consult for health problem? What was your experience about the quality of health service during COVID 19 situation?

15. What activities have taken to build the capacity of the CDC to respond to the emergency situation and to address the need and to ensure the participation of all community people including women, children, minority, people with disability, elderly people? Please tell me in details.

16. What activities are the CDCs undertaking during Covid-19 outbreak to respond to the emergency situation and to address the need and to ensure the participation of all community people? Do you think these activities are sufficient? What else could be done to build the capacity of the CDC members to respond to emergency situation?

17. What is your overall opinion on the emergency response of NUPRP in terms of establishment of hand washing corner, tipi-tap station, distribution of soap, one time cash transfer or food basket distribution, dissemination of awareness message on COVID 19? To what extent are the activities of emergency COVID 19 response relevant to the need of people like you? Why do you say so?

18. Do these interventions undertaken considering the need of vulnerable people especially the need of women, children, people with disability, minor, and people with disability? How? Tell me some example?

19. Are you satisfied with the emergency response of NUPRP? Why do you say so?

20. Would you follow the learnings you have gained from the emergency response of NUPRP in terms of hand washing with soap, ensure protective measures i.e. gloves, mask, maintaining social distance in future? Why do you say so?

21. Can the program approach or results be replicated by CDC? What support would you require to replicate the approach during emergency situation?

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

KII with Government Officials/City Task Force

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, I would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

Key Informant's Information	
a)	Name of the key-informant:
b)	Age in Years:
c)	Education:
d)	Designation/position:
e)	Length of service (in years) in current position:
f)	Address:
g)	Mobile Phone Number:

1. Could you please tell us something about COVID 19 situation in Bangladesh?
2. Do your area/town have preventative measures in place within urban poor settlements during COVID-19 pandemic? What sorts of preventive measures you have taken within poor settlements? (ask for details).
3. Do your cities/towns have a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response? (ask for details).
4. Could you please tell us about the National Urban Poverty Reduction Programme (NUPRP) supported emergency response during COVID 19 pandemic? What are the activities taken under this intervention? Please tell me in details.
5. How many evidence based advocacy forum/tools developed and shared under this intervention to protect the rights of the urban poor who are particularly vulnerable to the pandemic?
6. How your department/work area do related with the project? (ask for details).
7. Tell us about level of engagement by the NUPRP Town teams at the City/Ward level Taskforce Meeting to coordinate COVID response? Please rate the engagement in terms of high, medium and low. What were the challenges, if any?
8. How frequently the meeting were conducted with UNDP/NUPRP personnel, and CDC, CDC cluster and Federation members? How many? Did you participate in each meeting? What was your experience?
9. How did you/your team assess the need of affected urban poor settlements in planning the activities of emergency COVID 19 response? What were the challenges you faced? What steps were taken to mitigate them? What has been learnt from this experience?
10. How the activities were planned with other UNDP/NUPRP personnel, and CDC, CDC cluster and Federation members for awareness building and establishing hand washing facilities and distributing hygienic package, food assistance & cash transfer for the urban poor? Are there activities consistent with the overall goal of the NUPRP?
11. Could you please share us the number of NUPRP supported COVID Response interventions that are aligned with the ULG Taskforce?
12. How CDC volunteers were engaged and trained in this project? How they are trained? What were the challenges you faced in you works?
13. How the beneficiaries are selected and verified for the food basket and cash assistance? How the pre and post verification carried out across all Towns/Cities? Was this process transparent? What was your experience? What were the challenges you faced? What were steps taken to mitigate them? What has been learnt from this experience?
14. Do your cities/towns report on M&E Trackers for Weekly Reporting? What was your experience? What were the challenges you faced?
15. How do you think the project can contribute in terms of health and nutrition status of the urban poor who are most vulnerable to COVID-19? (In terms of cost, time and equity)?
16. How do you think the project can contribute in terms providing livelihood support, e.g. cash transfers, food basket, etc. to urban poor who are most vulnerable to COVID-19? (In terms of cost, time and equity)?
17. According to you to what extent were the objectives achieved or are likely to be achieved? What were the major factors influencing the achievement or non-achievement of the objectives?

18. Were the activities cost-efficient? Were objectives achieved on time? Was the program or project implemented in the most efficient way compared to alternatives?
19. Please tell us your opinion, are the project results, achievements and benefits likely to be sustainable? Are the results anchored in national institutions? Can the partner maintain them financially at end of the program?
20. Can the program approach or results be replicated or scaled up by national partner? What would support their replication and scaling up? In which areas do you think the scheme/project should be expanded? And why?
21. How do you evaluate the overall emergency responses provided by the NUPRP to safeguard human rights and ensure social cohesion among urban poor during COVID 19? What could be done in in a better way? Please share your opinion in details.

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

KII with UNDP/NUPRP Personnel

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, I would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

Key Informant's Information	
a)	Name of the key-informant:
b)	Age in Years:
c)	Education:
d)	Designation/position:
e)	Length of service (in years) in current position:
f)	Address:
g)	Mobile Phone Number:

1. Could you please tell us about the emergency response activities during COVID 19 pandemic under the National Urban Poverty Reduction Programme (NUPRP)? How the COVID-19 pandemic impacted this program?
2. How did you/your team assess the need of affected urban poor settlements in planning the activities of emergency COVID 19 response? What were the challenges you faced? What steps were taken to mitigate them? What has been learnt from this experience?
3. How the activities planned such as communication & outreach activities for awareness and establishing, hand washing facilities and hygienic package, food assistance for Urban Poor consistent with the overall goal of the NUPRP?
4. How the beneficiaries are selected and verified for the food basket and cash assistance? How the pre and post verification carried out across all Towns/Cities? What were the challenges you faced? What were taken to mitigate them? What has been learnt from this experience?
5. How many evidence based advocacy forum/tools were developed and shared to protect the rights of the urban poor who are particularly vulnerable to the pandemic? What are the roles of tools in this programme?

NUPRP communication & outreach team

6. How does your department related with the project? (ask for details).
7. How you /your team do design and implement the communication activities for the affected urban poor settlements regarding COVID-19 awarenss? What were the challenges in designing and implementing the communication materials? What was your experience?
8. How many evidence based advocacy forum/tools developed and shared to protect the rights of the urban poor who are particularly vulnerable to the pandemic?
9. Could you please share us the number of Articles published by the print & digital media about the emergency response activities during COVID 19 pandemic under the National Urban Poverty Reduction Programme (NUPRP)?

Field operation staff & programmed implementation team

10. How does your department related with the project? (ask for details).
11. How did you/your team procure and distribute the soaps, hand sanitizer, hygiene kit, PPE food basket? What was you experience? What were the challenges?
12. How the cash transfer to affected urban poor settlements was done? How you/your team work in conducting this activity? What was your experience? What were the challenges?
13. Could you please share us the response time taken to procure supplies?
14. Could you please share us the response time taken to distribute supplies to household/beneficiaries?
15. Could you please share us total number of health personnel and workers who received complete set of PPE?
16. How CDC volunteers were engaged and trained in this project? How they are trained? What were the challenges you faced in you works?

17. Could you please share us total number of health officials and workers who have underwent the online training of COVID19 of DGHS, GOB?
18. Could you please share us the number of Town staff who had access to PPE gear to undertake field operation?
19. Could you please share us total number of hand washing Corners that are accessible to people at the Household/CDC area?
20. Could you please share us total number of people who have access to soaps for hand washing?
21. Could you please share us total number of people who have access to other hand washing facilities and hygienic packages - i.e. Tipi-taps/Hand sanitizers Hygiene kit (in your area)?
22. Could you please share us total number of people who are most vulnerable to COVID-19 have received livelihood support, e.g. cash transfers, food basket, etc. (in your area)?
23. Tell us about level of engagement by the NUPRP Town teams at the City/Ward level Taskforce Meeting to coordinate COVID response? What are the challenges?
24. How the resources are mobilized and disbursed for social safety programme? What were challenges? What were the steps taken to mitigate them? What has been learnt from this experience?

General:

25. How do you think the project can contribute in terms of health and nutrition status of the urban poor who are most vulnerable to COVID-19? (In terms of cost, time and equity)?
26. How do you think the project can contribute in terms providing livelihood support, e.g. cash transfers, food basket, etc. to urban poor who are most vulnerable to COVID-19? (In terms of cost, time and equity)?
27. According to you to what extent were the objectives achieved or are likely to be achieved? What were the major factors influencing the achievement or non-achievement of the objectives?
28. Were the activities cost-efficient? Were objectives achieved on time? Was the program or project implemented in the most efficient way compared to alternatives?
29. Please tell us your opinion, are the project results, achievements and benefits likely to be sustainable? Are the results anchored in national institutions? Can the partner maintain them financially at end of the program?
30. Can the program approach or results be replicated or scaled up by national partner? What would support their replication and scaling up? In which areas do you think the scheme/project should be expanded? And why?
31. How do you evaluate the overall emergency responses provided by the NUPRP to safeguard human rights and ensure social cohesion among urban poor during COVID 19? What could be done in in a better way? Please share your opinion in details.

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.

Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme

Case Study Guideline

Beneficiary/CDC

Introduction

The National Urban Poverty Reduction Programme (NUPRP) is providing emergency response to the vulnerable population in urban settlement During COVID 19 pandemic. The aim of providing emergency response is to safeguard human rights and ensure social cohesion among urban poor. UNDP has assigned The Nielsen Company Bangladesh Limited to carry out "Third Party Monitoring for COVID-19 Response for National Urban Poverty Reduction Programme"– to collect the data and information to evaluate the overall emergency response. In this respect, today, we would like to discuss some issues on COVID 19 response for National Urban Poverty Reduction Programme with you. I cordially request you to participate in this discussion. All information provided by you will be confidential and shall not be used for any purpose other than this research study.

Conducted by

Respondent's Information			
a)	Name of the respondent:		
b)	Age in Years:		
c)	Education:		
d)	Occupation:		
e)	Name of the slum/settlement		
f)	Mahalla	h)	Paurashava
g)	Ward	i)	City Corporation
j)	Name of PG:		
k)	Designation/position in PG		
l)	Name of CDC:		
m)	Duration of membership in CDC (year):		
n)	Division:		
o)	Mobile Phone Number:		

1. *Ask for respondent introduction.*

- Can you please tell me something about yourself?
  Notes to the interviewer: Let the respondents talk about their name, age, and education level, no of family members, no of children, current status of children whether they go to school or work and so on. Ask them about their settlement/slum area. What are the best things to live in this area? What are the worst things? Overall views about this settlement/slum area. This will be a brief introduction session – an icebreaking activity. Also probe from respondents about family income, earning persons, and so on.

2. How are you invoved in the Community Development Committee (CDC) activities? In which level/post are you invoved in the Community Development Committee (CDC) activities? Tell me about your experience.
3. Are you aware of Corona Virus /COVID-2019? What do you know about it? Do you know about its symptoms? And how do you know about it? From where do you get the information?
4. Have you heard of any activities run by LG/NUPRP-UNDP program/CDC about COVID-19 in your community/slum? What are their activities? (Awarenss campaign, soap, hand wash, hygiene kit, and PPE distribution livelihood support, e.g. cash transfers, food basket)
5. ***If not CDC members (only PG members)***, How CDC volunteers and leaders are conducting their activities in you slum community? What is your experience? Are you satisfied with their activities? Do you get their support in your need?
6. ***If CDC members***, How CDC volunteers and leaders are conducting their activities in you slum community? What are they? What is your experience doing this? Are you satisfied?
7. What do you know about the awarenss campaign run by LG/NUPRP-UNDP program/CDC about COVID-19 in your community/slum? What did you learn about the prevention of COVID-19 from this activity? What is your experience? Are you satisfied?
8. Have you get the soaps from any government, NGO or private aid initiatives? Did you get the soaps distributed by LG/NUPRP-UNDP program/CDC? How many soaps did you get? Did you face any problem receiving it? What are they, if any?
9. Is there any hand washing corner or Tippy-Tap established in your community/slum after the Corona Virus Disease 2019/Covid-19 outbreak? Who established it? Did you see/heard about hand washing corner or Tippy-Tap established by LG/NUPRP-UNDP program/CDC? Have you used it? What is you experience?
10. ***If CDC members***, have you received the hand sanitizer, hygiene kit, and PPE in a timely manner? Are you satisfied with the service? What is your experience?
11. Are you following the Covid-19 prevention guidelines about hand washing, food safety, working outside, protecting others from infection promoted by LG/NUPRP-UNDP program/CDC in the slum/community? Are sharing the information and knowledge with others especially with disable and elderly population?
12. If you or anyone from our family or slum/community infected by Covid-19, do you know what to do? Did the LG/NUPRP-UNDP program/CDC team share you the necessary information and guidelines about it?
13. How the Covid-19 pandemic impacted you health and livelihood opportunity?
14. Did you suffer any sort of health problems (other than Covid-19) after the Covid-19 outbreak? What did you do? Did you go to any health facility? What was you experience? Did you face any problems? What are they?

15. After the Corona/Covid-19 outbreak how are you primarily sourcing your food for your household? Have you received any food aid? Has your diet pattern changed after the pandemic? Is there any incidence when you or any of your family member was hungry because of lack of food?
16. Did you get the food aid from LG/NUPRP-UNDP program? When? What types of food were included in that package? Tell me about your experience? Did you face any problem? Do you think the food aid received were useful for your household need in that moment?
17. What is your current employment status? Did your occupation and income get impacted due to Covid-19 pandemic? How are you coping it? Did you get support from any organization or individuals in cash or in other things?
18. After the Corona Virus/Covid-19 outbreak did you get any aid as cash transfer from LG/NUPRP-UNDP program/CDC? What was the experience (ask about MFS usage behaviour)? Did you face any problem? Do you think the cash transfer received were useful for your household need in that moment?
19. Did the disabled and elderly people in your community get food basket and cash transfer from LG/NUPRP-UNDP program?
20. How do you evaluate the overall emergency responses provided by the LG/NUPRP-UNDP program? Do you think the services and information such as, awareness campaign, food and cash transfer, soap, hand washing corner etc. provided by LG/NUPRP-UNDP program in your community/slum were useful for your household need in that moment? Are you satisfied with the experience? What could be done in in a better way? Please share your opinion in details.

Note for the Interviewers

Offer thanks to the respondents for their valuable time and cooperation extended throughout the interview process. Wish them all the very best for the future.