ABZ
Allgemeine
Baugenossenschaft
Zürich

Reporting Vergabekonferenz 2020

Projektname	Bangladesch: Auch in dichter Besiedlung gesund bleiben
Organisation	Schweizerisches Rotes Kreuz
Adresse, PLZ, Ort	Rainmattstrasse 10, 3001 Bern
Website	www.redcross.ch
Eingesetzter Betrag	27’804

Projektbeschrieb

Welche Meilensteine wurden erreicht?	Abfallentsorgung ist ein wesentlicher Teil gesunden Wohnens. Neben einem neu errichteten Entsorgungszentrum wurde die Abfallsammlung von Haus zu Haus, die Trennung der Abfälle wie auch die Kompostierung eingeführt. Veranstaltungen wurden mit der lokalen Stadtverwaltung zum Thema Abfallwirtschaft und Katastrophenvorsorge durchgeführt. Dadurch erhöhte sich die Zahl der Haushalte, welche die Abfallwirtschaft-Dienste in Anspruch nahmen von 2’380 (12.2020) auf 2’434 (06.2021)
Welche Meilensteine stehen noch bevor?	Das Hauptaugenmerk für den verbleibenden Teil des Jahres wird auf dem Bau einer Müllverbrennungsanlage in Zusammenarbeit mit der lokalen Stadtverwaltung liegen um einen Minimalstandard beim Wohnen sicherzustellen. Darüber hinaus wird das Projekt die Abfallentsorgung fortsetzen, welche die Sammlung, Verwertung und Kompostierung umfasst. Ebenso sind die Einrichtung von Modelllatrinen und Handwaschstationen vorgesehen. Es werden verschiedene Schulungen, Workshops und Veranstaltungen lanciert.
Wie wurde der Betrag des ABZ-Solidaritätsfonds eingesetzt?	Mit dem Betrag wurde das Ziel 1 des Projektes unterstützt. Dabei wurden 2505 Haushalte über verbesserte Wasser-, Sanitär-, Hygiene- und Gesundheitspraktiken aufgeklärt und 64 Freiwillige und Mitarbeitende geschult um dieses Wissen langfristig weiterzugeben und das Wohnen im eigenen zu Hause sicherer und gesünder zu machen. 87% der Haushalte verfügen nun über Seife und Wasser an Handwaschstationen.
Wie viele Menschen profitieren vom Projekt?	Im Rahmen des Projekts konnte das SRK seit Projektbeginn über 11'600 Menschen in drei Blocks direkt erreichen. Weitere 22'260 Personen haben in den umliegenden Blocks indirekt von den durch das SRK unterstützten Aktivitäten profitiert.

Was gibt es noch zu erzählen?	Sabina Akter Sharmin wohnt in einem dieser drei Blocks. Sie sagt: "Now I know even some of our social and cultural norms can be harmful, as we do not know the truth, and follow bad practices blindly. (…) So, in the health session I ensure that they all understand everything we discuss and also follow them up at their homes, as they are all neighbors. The best thing is I share my experience and cite my example, which they appreciate very much."

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Swiss Red Cross

Annual Country Report 2020

Country programme at a glance

Country	***Bangladesh***
Projects	***Long-term development projects (implemented by BDRCS)***
	440517, Urban Empowerment and Resilience II, Ershadnogor
	440514, Combining Disaster Risk Management (DRM) & Emergency response with stronger National Society (NS) partnership (DRM Programme), Gaibandha
	Long-term development projects (implemented by DASCOH)
	440519, Public health improvement in Rajshahi (PHIIR) Phase III
	440511, Integrated Water Resource Management (IWRM) Phase II
	Relief + Recovery Projects (implemented by BDRCS)
	440518, Primary and Environmental Health in Ukhiya
	440521, Covid Response at Cox's Bazar
	440495, Monsoon Flood Response 2020
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1 Abbreviations

A2I	Access to Information
AAN	Asian Arsenic Network
ACF	Action Contre la Faim (Action Against Hunger)
ADB	Asian Development Bank
AGM	Annual General Meeting
ANC	Antenatal Care
APO	Annual Plan of Operation
ASOD	Assistance for Social Organization and Development
BADC	Bangladesh Agriculture Development Corporation
BARI	Bangladesh Agricultural Research Institute
BCC	Behaviour Change Communication
BCDB	Bangladesh Cotton Development Board
BDRCS	Bangladesh Red Crescent Society
BDT	Bangladeshi Taka (Currency)
BFA	Basic First Aid
BMC	Block Management Committee
BMDA	Barind Multi-purpose Development Authority
BOCA	Branch Organizational Capacity Assessment
BP	Blood Pressure
BRAC	Bangladesh Rural Advancement Committee
BRC	British Red Cross
BWA	Bangladesh Water Act 2013
BWDB	Bangladesh Water Development Board
BWR	Bangladesh Water Rules 2018
CBHC	Community Based Health Care
CBHFA	Community Based Health and First Aid
CC	Community Clinic
CCDMC	City Corporation Disaster Management Committee

CEA	Community Engagement and Accountability
CEmONC	Comprehensive Emergency Maternal Obstetric and Neonatal Care
CFR	Crude Fatality Rate
CG	Community Group
CHCP	Community Health Care Provider
CHF	Swiss franc (currency)
CHV	Community Health Volunteers
CHW	Community Health Worker
CIC	Camp in Charge
CIP	Common Investment Plan
CMC	Community Management Committee
ComHF	Community Health Facilitators
CP	Contingency Plan
CPP	Cyclone Preparedness Programme
CQI	Continuous Quality Improvement
CRP	Community Resource Person
CS/C-section	Caesarean Section
CSG	Community Support Group
CV	Community Volunteer
CXB	Cox's Bazar
DAE	Department of Agricultural Extension
DASCOH	Development Association for Self-reliance, Communication and Health
DDFP	Deputy Director Family Planning
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHOD	Deputy Head of Delegation (SRC)
DMC	Disaster Management Committee
DP	Development Partner
DPHE	Department of Public Health Engineering
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
EDD	Expected Date of Delivery
EPI	Extended Program on Immunization, WHO program
ERT	Emergency Response Team
ESP	Essential Service Package of the Government of Bangladesh
FbF	Forecast-based Financing
FD	Foreign Donations
FDMN	Forcibly Displaced Myanmar Nationals (Rohingya refugees)
FF	Field Facilitators
FHF	Fred Hollows Foundation
FMC	Facility Management Committee
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
FYP	Five Year Plan
GCC	Gazipur City Corporation
GDP	Gross Domestic Product
GED	General Economics Division
GIS	Geographic Information system
GoB	Government of Bangladesh
HA	Health Assistant
HFA	Head of Finance and Administration
HH	Household
HNPSIP	Health Nutrition and Population Strategic Investment Plan

HNS	Host National Society
HoSD	Head of Sub-Delegation in Cox's Bazar (SRC)
HP	Health Promoter
HQ	Head Quarter
HR	Human Resource
HSP	Health Service Provider
HWS	Hand Washing Station
ICCO	Inter Church Organisation for Development Cooperation
ICRC	International Committee of the Red Cross
IDE	International Development Enterprise
IDDRR	International Day for Disaster Risk Reduction
IEC	Information, Education and Communication
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IOM	International Organization for Migration
IPAS	International Project Assistance Services
IPC	Infection Prevention and Control
IRC	International Rescue Centre
ISCG	Inter-Sector Coordination Group
ITC	Isolation and Treatment Centre
IWRM	Integrated Water Resources Management
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Association
LDC	Least Developing Country
LGED	Local Government Engineering Department
LGI	Local Government Institution
LGSP	Local Governance Support Programme
LMP	Last Menstrual Period
LRRD	Linking Relief, Rehabilitation and Development
MAM	Moderate Acute Malnutrition
MAR	Managed Aquifer Recharge (scheme for artificial recharge to groundwater)
MCH	Maternal and Child Health
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MHCP	Mental Health and Care Practices
MHPSS	Mental Health and Psychosocial Support
MIS	Management Information System
MNC&AH	Maternal, New-born, Child and Adolescent Health
MNCH	Maternal, New-born and Child Health
MoHFW	Ministry of Health and Family Welfare
MO-MCH	Medical Officer-Maternal and Child Health
MO-MCHFP	Medical Officer-Maternal, Child Health and Family Planning
MoU	Memorandum of Understanding
MoWCA	Ministry of Women and Child Affairs
MoWR	Ministry of Water Resources of Government of Bangladesh
MP	Member of the Parliament
MRF	Material Recovery Facility
MSME	Micro, Small and Medium Enterprise
MUAC	Mid Upper Arm Circumference
NCA	National Char Alliance
NCD	Non-Communicable Diseases
ND	Naogaon District
NDPD	National disaster Preparedness Day
NDRT	National Disaster Response Team
NGO	Non-Government Organization
NGOAB	NGO Affairs Bureau
NHQ	National Head-Quarter

NILG	National Institute of Local Government
NOC	No Objection Certificate
NRP	NGO Resilience Platform
NVD	Normal Vaginal Delivery
NWRD	National Water Resources Database
O&M	Operation and Maintenance
OCAC	Organisational Capacity Assessment and Certification
ODF	Open Defecation Free
OP	Operation Plan
OPD	Out-Patient Department
ORS	Oral Rehydration Solution
P-A test	Presence-Absence Test
PASSA	Participatory Approach for Safe Shelter and Settlements Awareness
PCU	Programme Coaching Unit (SRC)
PER	Preparedness for Effective Response
PGI	Protection, Gender and Inclusion
PHC	Primary Health Care Centre
PHIIR	Public Health Improvement Initiative Rajshahi
PLW	Pregnant and Lactating Women
PMER	Program Monitoring, Evaluation and Research
PMO	Population Movement Operation
PNC	Postnatal Care
POA	Plan of Actions
POCM	Project Officer Community Mobilization
POH	Project Officer Health
PPH	Post-Partum Haemorrhage
PRA	Participatory Rural Appraisal
Prodoc	Project document
QRC	Qatar Red Crescent
RCY	Red Crescent Youth
RD	Rajshahi District
RDRS	Rangpur Dinajpur Rural Service Bangladesh
RFL	Restoring Family Linkages
RMG	Ready Made Garments
RMCH	Rajshahi Medical College and Hospital
RMNCH	Reproductive Maternal, Newborn and Child Health
RP	Resource Pool
RRAP	Risk Reduction Action Plan
RRRC	Refugee Relief and Repatriation Commission
RTM-I	Research, Training and Management International
SACMO	Sub Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SANEM	South Asian Network on Economic Modelling
SARI	Severe Acute Respiratory Infection
SBA	Skilled Birth Attendant
SDC	Swiss Agency for Development and Cooperation
SDG	Sustainable Developing Goals
SEG	Strategic Executive Group
SGBV	Sexual and Gender Based Violence
SKS	Samaj Kallyan Sangstha
SRC	Swiss Red Cross
SRDI	Soil Resource Development Institute
SRH	Sexual and Reproductive Health
SSN	Senior Staff Nurse
SSNP	Social Safety Net Programme
STS	Secondary Transfer Station
SWM	Solid Waste Management

TAPP	Technical Assistance Project Proforma/Proposal
TBA	Traditional Birth Attendant
ToT	Training of Trainers
TQM	Total Quality Management
TRC	Turkish Red Crescent
UDC	Union Digital Centre
UDMC	Union Disaster Management Committees
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
ULO	Unit Level Officer
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNO	Upazila Nirbahi Officer (Chief executive officer in an Upazila/sub-district)
UP	Union Parishad
UP/PS	Union Parishad / Pourashava (Municipality)
UzDMC	Upazila Disaster Management Committee
UZP	Upazila Parishad
VDMC	Village Disaster Management Committees
VP	Village Profile
VWC	Village Water and Sanitation Committee
WARPO	Water Resources Planning Organisation
WASH	Water, Sanitation and Hygiene
WDCC	Ward Development Coordination Committee
WHO	World Health Organization
WRC-BARI	Wheat Research Centre of Bangladesh Agricultural Research Institute
WRMA	Water Resources Management Association (at union level)

2 Introduction

2.1 Short description of the country programme

Bangladesh has been an SRC focus country since its independence in 1971, it is now one of 25 Programme countries of the SRC IC Department. The SRC country programme has moved from a sectoral, project-centered towards a holistic programming approach over the outgoing programme phase 2017-20. Through its partner organizations BDRCS and DASCOH, SRC has been working in both urban and rural contexts, strengthening the resilience of vulnerable communities. Central to all programming has been the formal linkage with sub-national and national governance structures. Brokering partnerships and stakeholder management with government entities and development partners have been particular strengths of SRC and helped to maximize the programme impact through harmonization of resources while fostering good governance.

In Cox's Bazar, where the engagement of SRC with displaced and host communities started in 2017, the collaboration with the Government of Bangladesh (GoB) has been facilitating formal collaboration and integration of RCRC movement partners and services with the UN system. The unique Primary Health Care concept implemented by BDRCS-SRC in the camps laid the ground for complementary provision of several services under one roof from different organisations. Further achievements under the previous programme phase include the integration of conflict sensitivity in all programming, the piloting of IFRC's Roadmap to Resilience as well as the influence of SRC and partner organizations on the national water and health policy.

The following graph shows SRC's presence in Bangladesh in 2020:

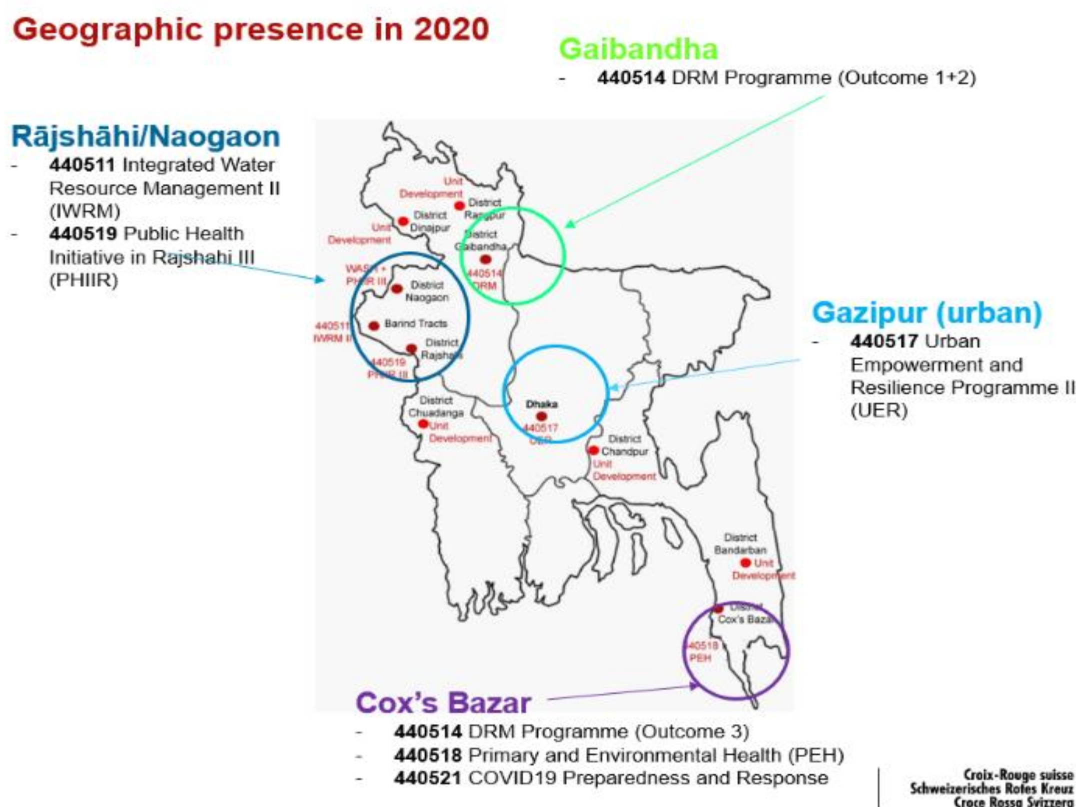


Figure 1: Geographical presence of SRC Bangladesh in 2020

With regard to joint resilience programming of SRC and BDRCS, the disaster risk management programme at Gaibandha (which was to end in December 2020) was extended by 6 months till June 2021 with a view of complete unfinished tasks that were impacted by Covid-19 and allow for sufficient time for the review and planning of a new phase of programming. The urban empowerment and resilience project in the slums of Gazipur is into a second phase since April 2019. Both have resilience objectives and manifest similarity in the programme design, approach, and strategy while being contextualized to address rural and urban vulnerabilities that are different in nature. Nonetheless, both the programmes are designed following IFRC's roadmap to resilience, which not only establishes a framework for reinforcing resilience but elaborates on quantitative and qualitative methodologies that can be applied for any resilience programming in diverse contexts. In parallel, the SRC country programme is moving towards a larger cooperation with BDRCS beyond the existing projects in Gaibandha, Gazipur slum, and Cox's Bazar operations. The aim is to engage with the wider organizational development of the National Society, without which programmatic successes will be difficult to attain and sustain. National society development measures are planned in the framework of our ongoing programs aiming at widening the organizational development beyond NHQ and few branches where the projects operate.

The other national partner – DASCOH foundation - is registered as a national NGO in Bangladesh and has a focus on community mobilization work and a strong governance approach. It is working closely and formally with local government institutions and the state's sub-national administrative apparatus. SRC is extending financial and technical support for the third phase of the health project (PHIIR III), which is implemented in Rajshahi district, whereas the IWRM project is an SDC mandate being implemented by SRC in association with DASCOH across the 3 districts of Rajshahi, Chapai Nawabganj and Naogaon.

During the reporting period, all programmes were re-purposed to rationalize activities that could be realistically carried out within the wider framework of restrictions and containment measures imposed by the government to combat Covid-19. Such rationalization released resources that were eventually re-directed to fund Covid-19 response in all programmatic areas and even beyond in the case of Gaibandha and

Gazipur. This has allowed the deepening of the LRRD approach across all programmes where immediate subsistence needs have been addressed by response programmes, while the long term development needs that are bound to be potentially influenced by the impact of Covid-19 will be addressed by the long term development cooperation programmes. In the longer term it will be crucial to adjust development programming and focus on those elements of resilience that have been severely impacted by Covid – 19 or found wanting by the communities themselves. To comprehensively ascertain the impact of Covid-19 in the rural and urban areas, an impact study of Covid-19 was carried out in the project areas of Gaibandha and Gazipur. Based on the findings of the assessment, response and recovery programmes were established and submitted to SDC and Swiss Solidarity, which have been approved and shall be implemented in 2021.

With an overall actual turnover of 4.15 Mio. CHF, the Bangladesh programme proves that it is very attractive to donors which in turn proves its high relevance. The graph below shows programme-wise budget, adaptation/projections, and achievements / utilisation. Some of the projections could not be met under the conditions of Covid – 19, but the overall performance can be rated as fairly satisfactory. Reasons for under-expenditure are further explained under the various projects.

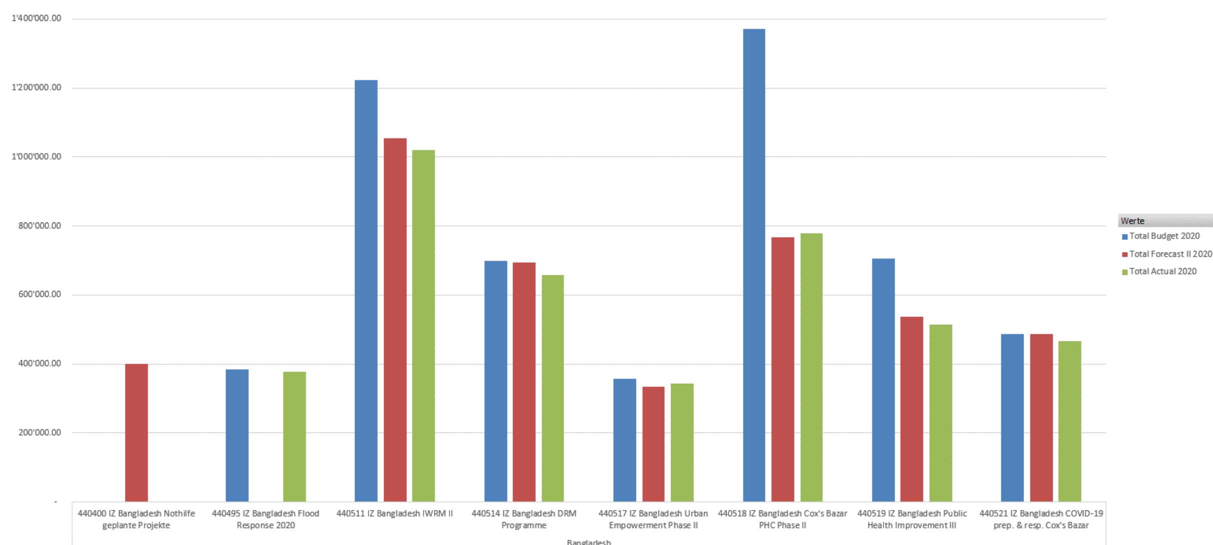


Figure 2: programme-wise budget, adaptation/projections, and achievements / utilisation

2.2 Context changes

COVID-19 pandemic

The COVID-19 pandemic has had a severe impact worldwide. Surprisingly, developed countries, such as the United States, United Kingdom, Italy, and Spain, had their highly efficient medical infrastructure greatly stressed and suffered from high death tolls. Even though Bangladesh is not impacted to same levels as other countries, which is in large measure is being attributed to low testing and the favourable demographic dividend of having a significant youth population, still the socio-economic impact of the pandemic has been widespread and quite significant. The impact of Covid-19 has plunged the country into a protracted crisis of its own kind that also exacerbated the impact of all other hazards.

On the positive side, according to official statistics and in comparison, with other countries, by the end of 2020 neither (confirmed) infection rates nor COVID-related fatalities matched the gloomy predictions of experts and epidemiologists (which is particularly valid for the context of the camps in Cox's Bazar, where they had expected the pandemic to have a dramatic impact due to the extremely high population density and cramped and unhygienic living conditions).

Nevertheless, the crisis has revealed or once again brought to the fore the maladies afflicting the country's deteriorating health care system, which are: 1) poor governance and increased corruption, 2) inadequate healthcare facilities, and 3) weak public health communication. As one of the world's most densely

populated countries (1,115 people/km^2) with 21.8% of people living below the poverty line[1], Bangladesh has a healthcare system that lacks reliability, responsiveness, and empathy, and that has consistently failed in delivering adequate health care to the public.[2,3]. Covid-19 exposed the inadequacies of the state health system and complete lack of preparedness to cope with and combat the pandemic. A systematic approach involving detection, isolation, contact tracing and quarantine, remains at best weak and fragmented in Bangladesh. However, the government ramped up its efforts and established a national response plan for Covid-19 with the support from WHO and placed the country under lockdown to prevent and contain the spread of virus.

The pandemic as a health crisis has impacted all walks of life. As of 24 January 2021, according to the DGHS Press Release[4], 3,555,558 COVID-19 tests were conducted in Bangladesh with the overall positivity rate of 14.96%. There were 531,799 COVID-19-positive cases confirmed by rRT-PCR, GeneXpert and Rapid Antigen tests including 8,023 related deaths with a CFR 1.51%. As far as number of positive cases are concerned, Bangladesh is among the top 30 countries in the world and accounts for 0.55% of the COVID-19 disease burden of the world.

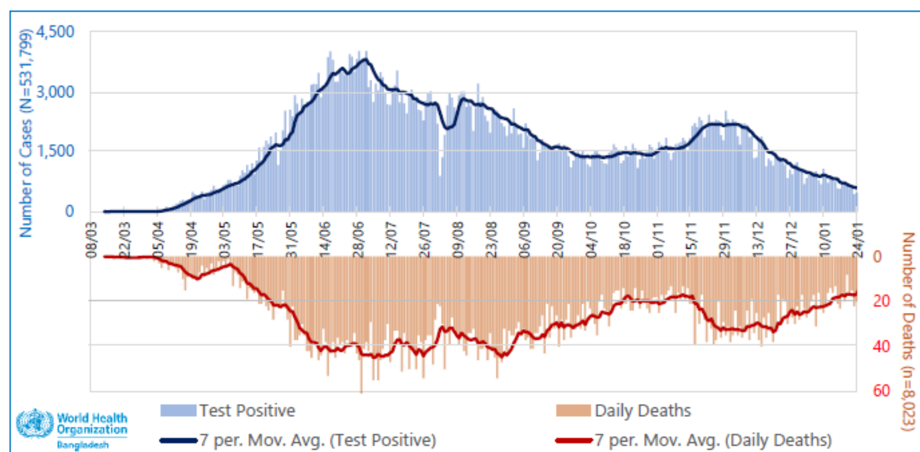


Figure 3: Trend of COVID-19 Cases and Deaths, 08 March 2020 – 24 January 2021, Bangladesh

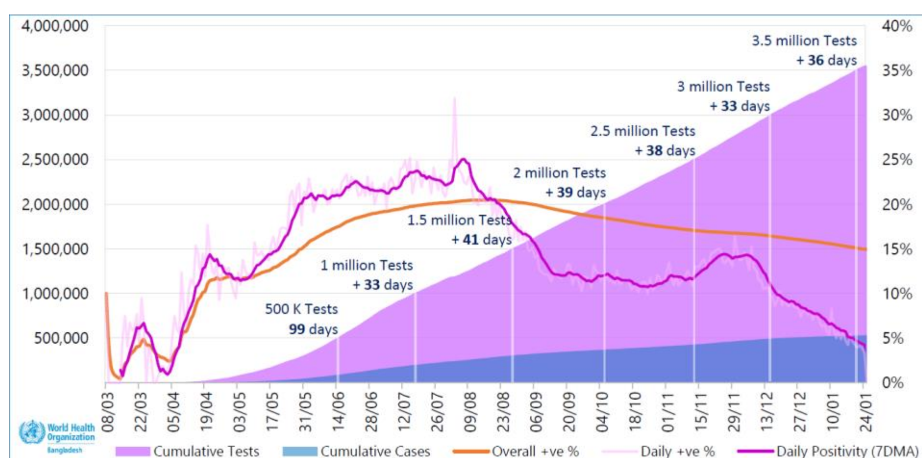


Figure : Trend of COVID-19 Test and Positivity, 08 March 2020 – 24 January 2021, Bangladesh

To combat the spread and impact of Covid – 19, the GoB established a National Response Plan for Covid -19. The main goal of the plan is to prevent and control the spread of COVID-19 in Bangladesh in order

[1] Chowdhury T, 2020. Bangladesh: one in five people live below poverty line. Al Jazeera, January 26. Available at: https://www.aljazeera.com/news/2020/01/bangladesh-people-livepoverty-line-200126100532869.html.

[2] Mohiuddin A, 2019. Diabetes fact: Bangladesh perspective. Int J Diabetes Res 2: 14–20.

[3] Saad Andaleeb S, Siddiqui N, Khandakar S, 2007. Patient satisfaction with health services in Bangladesh. Health Policy Plan 22: 263–273.

4 https://corona.gov.bd/press-release

to reduce its impact on the health, wellbeing and economy of the country, as well as to set out the framework to treat the population that has been infected. The key interventions to achieve this goal include: the enforcement of compulsory mask-wearing and safe hygiene practices outside the home, including within the workplace; a zoning approach to containment; community-based prevention practices, case identification, and quarantining utilizing local community health capacity for slowing spread of disease and sustaining behaviour change following lockdown; the maintenance of physical distancing regulations based on latest expert guidance; and the empowerment of frontline health workers and other essential workers to make them agents of change to turn the epidemic around and address their potential COVID-19 related fears and concerns.

Regional and global supply chains were severely impacted and as a result, many enterprises and factories in Bangladesh operating along the domestic and international value chain collapsed, at least temporarily. In addition, deceleration in economic activity abroad forced the return of hundreds of thousands of Bangladeshi migrant workers. This dynamic added pressure on local job markets as returning migrants sought employment[5]. Assessments indicate that the slowdown in economic activity in key sectors is leading to reduced working hours, and job and income losses.

The findings of a recent research by A2I[6] titled "Post Covid-19 Jobs and Skills in Bangladesh"[7] reveals that by June 2020 over 20.4 million were unemployed across 11 high-impact sectors of the economy. The sectors include the informal sector and small and medium enterprises SMEs, transportation, construction, furniture, readymade garments (RMG) and textile, leather goods and footwear, tourism and hospitality, light engineering, migration, real estate and housing, and ceramic. Of these, the informal and SME sectors, transportation, and construction were the immediate losers. An estimated 18 million jobs were lost in these sectors. The study has made a forecast that an additional 5.5 million workers will lose their jobs by the end of this year while over 2.53 million more by the end of 2021. Another report by International Labour Organization (ILO) and the Asian Development Bank (ADB)[8] projected that some 1.11 million to 1.67 million youths in Bangladesh might lose jobs in 2020.

Overall, the Covid-19 crisis is amplifying long-standing challenges in the Bangladesh economy and labour market – namely constraints to business sustainability, limited job growth and pervasive poor quality jobs – while intensifying the need to support vulnerable groups, including informal workers and micro, small and medium enterprises (MSMEs), women, youth, the elderly, and returning migrant workers. The COVID-19 pandemic has adversely affected income, livelihoods, food security and the ability to meet basic needs throughout Bangladesh. The recent survey of Bangladesh Planning Commission reveals that poverty and extreme poverty have dropped below 2010 levels (see graph on the right). In other words, all the poverty reduction gains made over the last decade have been undermined by the economic impact of the pandemic. According to the South Asian Network on Economic Modelling (SANEM), levels of poverty may double to 40.9% compared to before the onset of the pandemic.[9]

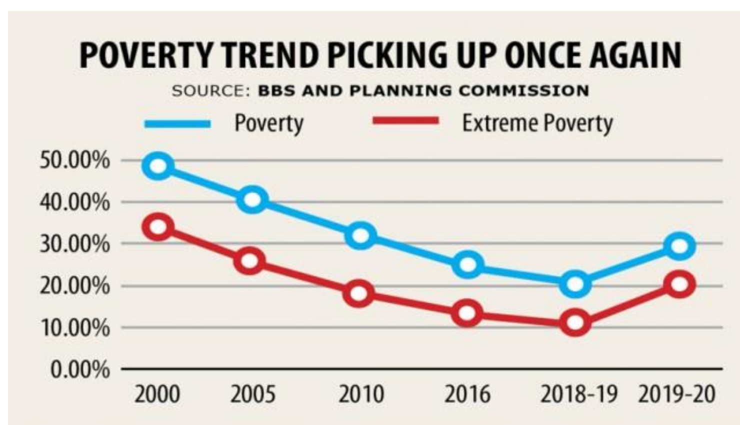


Figure 4: Poverty Trend in Bangladesh

[5] https://www.weforum.org/agenda/2020/06/bangladesh-faces-a-remittances-crisis-amid-covid-19/ (accessed on 26 November 2020)
[6] A2I, access to information, is a government program of ICT Division under Ministry of Communications and Information Technology
[7] http://skills.gov.bd/files/frontend/resources/c7b0884f-1ae2-4753-b60d-4c1d59ef062b.pdf (accessed on 23 November 2020)
[8] https://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/documents/publication/wcms_753369.pdf (accessed on 23 November 2020)
[9] The Business Standard (1 May 2020): https://tbsnews.net/economy/covid-19-impacts-may-double-poverty-bangladesh-says-think-tank-76027, retrieved 07.11.2020.

The initial policy response of the GoB to the economic and jobs crisis has consisted of four main strategies[10]: 1) prioritize government spending that creates and protects jobs; 2) create loan facilities through commercial banks at subsidized interest rates for the affected industries and businesses; 3) expand the coverage of the government's social safety net programmes to protect the extreme poor and low paid workers in the informal sector from the sudden loss of earnings; and 4) increase the money supply while balancing inflationary pressure.[11] Specific measures include, among others:

- establishment of a Government fund to support export-oriented industries to continue to pay salaries and allowances to their workers and employees
- creation of a working capital loan facility with subsidized interest rates to assist both large industries and MSMEs
- provision of honorarium pays to frontline medical workers and financial compensation in case of illness or death from Covid-19
- delivery of food assistance to those affected by job losses resulting from Covid-19
- expansion of social safety net programmes to offset job and income losses, including direct cash transfers to selected families and extending coverage of the old age allowance scheme
- support to the agriculture sector through subsidies to incentivize farm mechanization and Government procurement and distribution of rice; and
- extension of low-credit facilities to poor farmers, recently repatriated overseas workers and skilled but unemployed youth in rural areas to foster entrepreneurship in agricultural production and agro-based services

Impact of Climate Change

Bangladesh is faced by a number of humanitarian crises, including an increase in the frequency and severity of extreme climatic events, a protracted refugee crisis and high risk of earthquakes and fires in urban centres. In 2020, besides having a cyclone that devastated the coastal districts of the country, Bangladesh also witnessed several rounds of floods rated as among the worst in recent history (more information under project 440495). It is of fundamental importance to shift from a reactive approach to an anticipatory approach, especially for predictable natural hazards such as floods and cyclones. BDRCS has a pervasive network of volunteers all around the country and the capacity to respond to emergencies. It has a robust early warning system in all coastal districts through the Cyclone Preparedness Programme (CPP), a joint flagship program with the Government of Bangladesh (GoB). It also continues to support vulnerable communities in their longer-term disaster risk reduction efforts, being well known for its success in community-based programs. The International Federation of Red Cross and Red Crescent and all the partners are supporting BDRCS in its strategic priorities, to further strengthen local capacities, in line with the Sendai Framework while adhering to the current humanitarian standards.

Evolving situation in the camps of Cox's Bazar

In the camps at Cox's Bazar, fencing was initiated and GoB aims to finish it by June 2021. In Ukhia, it is nearly finished with exception of some access points under consideration by military; some "pocket gates" have been closed, resulting in reports of fewer FDMN seeking primary health assistance due to new distance to facilities. Fencing in Teknaf has begun and further relocations are anticipated in light of this. The ISCG has shared summary of concerns (from both guest and host communities) related to access due to fencing, have had relatively positive reaction from RRRC and military, and they have agreed to more regular discussions internally and bilaterally with ISCG to consider the issues.

Despite legal developments urging examination of Myanmar's accountability, the displaced population remain stateless and without legal status. They continue to rely on basic humanitarian aid in the camps. National policy is primarily focused on humanitarian assistance supporting basic needs of the displaced population. Access to activities that are perceived as facilitating longer-term settlement – including education, livelihoods, freedom of movement – continues to be constrained. Meanwhile discussions between states in the region regarding repatriation continue (pushing for requisite conditions of safety, dignity, voluntariness). However, no repatriation was carried out in 2020.

[10] https://home.kpmg/xx/en/home/insights/2020/04/bangladesh-government-and-institution-measures-in-response-to-covid.html (accessed on 26 November 2020)
[11] Bangladesh Ministry of Finance, op. cit.

Relocation of FDMN to Bhasan Char

Instead, the Government of Bangladesh began relocating hundreds of people who were living in the camps in Cox's Bazar to Bhasan Char island. Before, there were already 306 people, mostly women and children, on the island who were sent there in April initially for COVID-19 quarantine after being rescued at sea off the Bangladeshi coast.

The United Nations, humanitarian and human rights groups have expressed grave concerns about the finished and planned relocations due to a lack of information about the relocation process and the absence so far of any independent technical assessment of conditions on the island. Questions have also been raised about the voluntary nature of the recent relocations. RC/RC Movement is not involved in any procedural aspects of relocating people, such as planning and implementing relocation. For any past and future relocation, the position of the Federation wide membership is clear: the relocation of displaced people must be voluntary, with safety and dignity assured. Suitable living conditions must be guaranteed on the island. The RC/RC Movement is advocating for independent assessments to take place of the island, to provide clarity on the risks and opportunities to make the island more suitable for living, achieving wellbeing and establishing livelihoods. As the leading humanitarian organisation in the country, BDRCS was approached by the GoB to provide humanitarian assistance to people who have been relocated to Bhasan Char. A high-level team of BDRCS visited Bhasan Char to conduct a quick initial review and while on the island distributed essential relief items. Recognising the humanitarian imperative and the auxiliary role of BDRCS, IFRC decided to extend financial of 100'000 CHF to support BDRCS initiatives at Bhasan Char.

8th Five Year Plan of the Government of Bangladesh

The duration of the Seventh Five Year Plan (7FYP) ended in June 2020. However, due to Covid-19 the Eighth Five Year Plan (8FYP) has been delayed. The General Economics Division of the Planning Commission (GED) had to revisit and revise the targets and strategies in view of the pandemic. The 8FYP will be implemented during 2021-25. The 8FYP titled "Promoting Prosperity and Fostering Inclusiveness", focuses on a pro-poor growth strategy. This strategy includes seven themes. These are labour-intensive, export-oriented manufacturing-led growth, agricultural diversification, dynamism in cottage, small and medium enterprises, modern services sector, ICT based entrepreneurship, and overseas employment. During the sixth five-year plan (6FYP) the actual average growth rate of gross domestic product (GDP) was 6.3 percent. This increased to 7.1 percent during the 7FYP (2016-2020). The 8FYP aims to have 8.5 percent GDP growth by 2025.

During the implementation period of the 8FYP, the government will face a number of challenges. The four specific ones include: Covid-19 pandemic, graduation from the least developed country (LDC) category, the implementation of the Sustainable Development Goals (SDGs) and climate change vulnerability. The achievement of the 8FYP targets will hinge on how effectively these challenges are confronted. As the GoB explicitly demands that all non-state (NGO, INGO, UN, RC/RC) programming is aligned with the five year plan objectives and contributes to attainment of SDG objectives (NGOAB uses this lens to approve projects), this imperative cannot be ignored by SRC and its partners in terms of ongoing and future programming.

As described above, the pandemic has put pressure on the economy, which has resulted in a rise in poverty and inequality. Informal workers, the urban poor, migrant workers, small businesses and women are among the most affected segments. Though exports and remittances have improved since the peak of the pandemic, inflation is low and foreign exchange reserves are comfortable, the economy is still not out of the woods, therefore, high priority needs to be assigned to combat the pandemic without which the economic objectives cannot be achieved. On the other hand, despite the uncertainty surrounding vaccine availability, even if adequate vaccines are obtained, vaccination of the whole nation will take a long time. Therefore, those who will remain outside the coverage of vaccination should be under strict health protocol till they are vaccinated according to government and experts. Dedicated resources for both vaccination and strengthening medical facilities such as test and treatment will be needed for this.

In case of economic recovery from the Covid-19 pandemic, although the government has taken monetary policy measures to support affected sectors, these have not reached the affected micro, small and medium enterprises (MSMEs). Women MSMEs have faced more difficulties to access the support. Banks are less interested to provide loans to them due to risk factors and high operational costs. Constraints

for accessing funds by them should be removed through proactive policies since the MSMEs are the engine of growth and sources of employment. Bringing the economy back to the pre-pandemic level will also require much greater fiscal interventions. In order to bring people out of poverty—both the pandemic-induced new poor and the pre-existing ones—there should be more public expenditures. Fiscal stimulus provided in the form of various social safety nets including cash support is not adequate. Large investment is required in areas such as health, education and technology.
Second, Bangladesh will graduate from the LDC category in 2024. Therefore, Bangladesh will have to prepare for a smooth graduation and minimise the impact of the removal of various trade benefits and international support measures. In order to compete in the global market, the country has to improve on social, environmental and labour related compliances.
Third, at the end of the 8FYP, only five more years will be left for the implementation of the SDGs. Bangladesh's achievement in many areas including poverty reduction, gender parity in primary education and reduction of maternal mortality have come under threat due to the pandemic. This will not only require strong commitment and resources but also policy reforms in areas such as education, labour market, gender, tax system, public expenditure, investment, international trade, and accountability of the institutions.
Fourth, despite Bangladesh's resilience to various shocks including natural disasters, dealing with the impact of climate change will require negotiations at the global level to receive funds for climate change adaptation. During the 8FYP period Bangladesh needs to invest more in green energy.

2.3 The Delegation

The SRC Bangladesh office is located in Gulshan, Dhaka City. The delegation team currently consists of 23 staff, of which two are international delegates and one is an expat Junior Programme Coordinator. Staff replacements were made at various levels in 2020: the positions of health manager at Dhaka level and programme manager at CXB were successfully replaced, and the recruitment of the successor to the field delegate (who had himself started in early 2020) was also completed at the end of the year. For a proper handing over between the two field delegates, the field delegate was given an extension of one month till end January 2021. One driver who retired in 2020 has been given a contractual extension till November 2021.

In order to make the delegation more efficient, discussions were held to change the HR structure at the delegation from “one project – one manager” mode to carving out positions that are aligned to the thematic domains of SRC. The partnership and risk assessment of BDRCS planned for 2021 will give more clarity on the HR needs of BDRCS, and SRC secondments will be aligned to the emerging needs. At the same time, a management review of SRC delegation is planned for 2021, which will recommend measures to heighten cost efficiency of the delegation while suggesting an appropriate partnership model after a thorough analysis of risks and opportunities inherent in bilateral and multilateral cooperation models. Compared to some other PNS supported programme implementation, where direct implementation is increasingly discernible, SRC delegation strives to facilitate greater engagement of the National Society.

The creation of a Senior Management Team (CC, DHOD, HFA + Head of Sub-Delegation in Cox’s Bazar) in mid-2019 significantly contributed to the strategic discussions, responsible delegation of roles and responsibilities, and trouble shooting. The SMT was closely involved in the formulation and adaptation of business continuity plans in view of Covid – 19 restrictions. Additionally, a guidance note was developed for home and split office mode. The business continuity plans were well aligned to the Covid – 19 prevention and protection advisory of GoB and WHO. A detailed risk analysis was carried out along with accompanying risk mitigation measures considering the unfolding Covid-19 conditions and its impact on programming, partnerships, and financial management. Consequently, partnership management, implementation of the national society development component and HR and security management have registered discernible gains. A local security plan following the template circulated by HQ and under the guidance of head of Asia / Europe was prepared and approved. The process was led by the security focal at PCU and was carried out in a highly participatory manner.

The long drawn discussions on PCU office relocating to BDRCS campus finally took shape in 2020. BDRCS decided to construct a semi-permanent building of pre-fabricated materials (in line with SRC’s PHCs at CXB) and allocate space for movement partners and its own staff. IFRC and PNSs are financing this based on their respective budget capacity. SRC was nominated to hire an expert agency to establish

the plan, design, and bills of quantity for the new building. SRC hired an expert who within a month submitted his recommendations to BDRCS, which has been approved by its governing board. It is expected that the construction will be completed by June 2021 and SRC can move into BDRCS premises. At CXB, SRC signed an administrative service agreement with IFRC which will allow the sub-delegation to integrate and have a desk at PMO and access to a range of services offered by IFRC including security advisory. This special arrangement is expected to bring the SRC sub-delegation closer to PMO's working modalities while allowing more efficient access to a variety of information that sometimes gets lost due to being located separately.

Regarding M&E systems and capacities, SRC is consistently reviewing progress against plans and advises on course correction options. Due to Covid -19 restrictions regular online meetings were organised to appraise the conditions while taking stock of plans versus progress. Once domestic travel restrictions were lifted, SRC programme managers resumed regular field visits not only to support implementation of ongoing projects but also to plan and support various Covid – 19 response projects along with assessments on Covid – 19 economic impact. Virtual monthly review meetings with national partners BDRCS and DASCOH and budget tracking was done remotely as long as the travel restrictions were there. The submission of monthly financial reports, the operational / programmatic reports by partners remained unhindered. Annual outcome surveys were carried out for all the projects to examine progress against key outcome and output indicators. The results of the outcome survey are reported in the present annual report and shall inform the development of annual plans for the succeeding year.

In February 2020, a delegation preparedness exercise was carried out under the lead of the then regional DRM advisor, to develop a delegation preparedness plan that could establish a roadmap as well as a framework to support BDRCS in their response programming and implementation while enhancing the delegation's own preparedness to do this successfully. Finally, in consultation with the delegation, the programme coordinator for Bangladesh at HQ led and drafted the finalization of the Country Programme covering the period 2021 – 2024.

2.4 Partnership

2.4.1 National RCRC Society: Bangladesh Red Crescent Society (BDRCS)

BDRCS is SRC's national partner for the DRM programme in Gaibandha, the urban empowerment and resilience project and the projects in Cox's Bazar. As an auxiliary to government, BDRCS enjoys independent humanitarian access manifesting in its immunity from having to obtain approvals from NGOAB (FD-approvals). This allows BDRCS / SRC partnership to act and respond quickly, which is of particular importance in a fragile context like Cox's Bazar.

The four-year Strategic Plan (2017-2020) of BDRCS has four strategic goals - (1) Strengthened Preparedness, response and recovery services in reducing impacts of disasters, emergencies and other humanitarian consequences; (2) Strengthened community towards making them resilient to multi hazard and induced phenomena; (3) National Society development initiatives contributed towards building strong and sustainable NS and (4) Quality health services for people in need at all level improved and ensured while Gender and Diversity, CEA, Staff and Volunteers Safety Security, Child Protection are considered as cross cutting issues.

In 2020, besides having to deal with multiple crises, BDRCS initiated the development of its new strategic plan (SP) for the duration 2021 – 2025. BDRCS wants to start the new strategic planning cycle from 2021 to address the changing circumstances including the current COVID-19 pandemic, population movement crisis in the Cox's Bazar area as well as the recurrent disasters in the country. To be a relevant and sustainable organization, it is important that BDRCS identifies the big changes in the framework conditions and addresses them through their next strategic planning cycle. It is equally important that BDRCS analyses the barriers and opportunities in achieving financial sustainability which will include, but not restricted to, internal financial analysis using the whole of organisation approach, conducts a thorough market assessment to tap into existing and potential funding opportunities, reviews the existing resource mobilisation policy and strategy, and builds a robust mechanism to follow through on systematic implementation of its resource mobilisation policy and strategy. The strategic planning exercise has been broadly divided into two interlinked processes: a comprehensive evaluation of the earlier SP through the

engagement of all relevant stakeholders and subsequent planning exercise that is grounded in the findings of the evaluation yet accounts for changing conditions and addresses emerging challenges and opportunities in fulfilling its mandate. Though remotely, SRC's health advisor has been closely involved with the evaluation process and her inputs and feedback have informed the evaluation outcome. As the strategic planning process has been delayed, BDRCS has extended the current SP till March 2021. On the other hand, BDRCS has also initiated the operational planning process for 2021 so that they can continue the ongoing priorities from the beginning of the year.

During the last four years, BDRCS has been involved in managing many emergency response programmes and one of the largest crisis in the world, the population movement operation in Cox's Bazar. Hence, BDRCS has faced difficulties in focussing on its longer-term development priorities like HR optimization, financial sustainability, legal base, volunteer management and decentralization. Even the plans of bringing all the affiliated institutions of BDRCS under one planning and reporting mechanisms have remained unaddressed. Nevertheless, the findings of 2018 Organisational Capacity Assessment and Certification (OCAC) external evaluation, 2019 Preparedness for Effective Response (PER) assessment, and 2020 leaders' forum commitments have identified thematic priorities to address the macro level development priorities. All these analysis and priorities are expected to inform the thrust areas of the new SP.

At the end of 2020, in the annual general meeting (AGM), all BDRCS units collectively issued a declaration of commitments for their positive transformation. The key commitments enshrined in the declaration are as follows:

- → Expand life membership
- → Expand their volunteer base to include members from other age groups
- → Target oriented local resource mobilisation by units to meet their core costs. This will be done through raising individual and private sector contribution while, more importantly, including part of core costs in the annual development budget of local government ministry
- → BDRCS NHQ to support development of social business models into which units will plug in
- → Strengthened auxiliary role of the units – greater collaboration with Local Government Institutions and line departments
- → Increased use of digital technology and platforms for effective services and transparency
- → Improve accountability and transparency to minimise reputational risks

Interestingly, many of these commitments are currently being supported through the unit development component of SRC's DRM programme. In the last steering committee meeting of BDRCS and SRC leadership, the SG and DSG reiterated the high relevance they see in such a mode of programming with the units, which has replaced externally driven plans with plans that are owned and developed by the units themselves. The BDRCS leadership is keen to organise a lessons learned workshop as the present phase of unit development support concludes so that learnings lead to establishment of another phase of expanded engagement with the units.

2.4.2 Development Association for Self-reliance, Communication and Health (DASCOH)

The national partner for the long-term projects PHIIR (II/III) and IWRM (I/II) is DASCOH Foundation, a National NGO since 2014. DASCOH complements and supplements the GoB's national programs as a key non-state development partner in Bangladesh. One of the major strategic objectives of DASCOH is "to strengthen the management capacity of public health care institutions at community, UPs and Upazila level in order to enable them to render universal and quality health services as per national health standards". The two phases of the SRC supported health project are closely linked and contribute to DASCOH's health objective – whereas improving local governance and administration of public services have been central to DASCOH's engagement in the WASH sector.

DASCOH continues to command credibility and trust with the LGIs and due to this, the PHIIR and IWRM project made significant advances in engaging the elected representatives with project initiatives. Further, in recognition of its work in the area of health system strengthening, the district health authorities request DASCOH's support to intensively engage with risk communication strategies in the project area, infection prevention and control (IPC) at the health facilities covered by the project, and provisioning of Covid-19

protection measures (masks and handwashing stations) at health facilities. The latter support was also extended to Union Parishads. At the regional level, DASCOH works, both formally and informally, with a range of govt/non govt water sector actors.

Ironically, the achievements of PHIIR II and IWRM projects are begetting new programming opportunities for DASCOH, but despite being operational in the same area, the synergies are weak in spite of several opportunities especially for LGI engagement and community sensitisation and awareness. The expansion in DASCOH's funding base, finally, creates good conditions to end bilateral SRC programming. PHIIR III has already been declared as the last phase of bilateral support from SRC to DASCOH. A roadmap will be established for the phasing out process.

Further, DASCOH operates from a rented premise and asked in late 2019 by the property owner, which is the Lutheran mission, to vacate the premises by June 2020. Due to Covid - 19 this is on hold and the lease has been extended till end of 2021. Thus, DASCOH, which has already bought a suitable land for building a new office needs to plan a smooth transition to the new premises by completing the construction of new building otherwise an abrupt eviction in future will undermine organisational functioning and performance especially as Rajshahi does not afford many options to house an organisation like DASCOH, meeting all its requirements.

DASCOH Switzerland when transitioning into DASCOH Foundation as an independent NGO in Bangladesh created a Reserve Fund to establish a corpus fund to cover unforeseen expenses of the DASCOH Foundation in case of financial shortages to cover the organisation's costs or in the case of emergencies threatening the survival of the organization. Rules were established to regulate all aspects of the DASCOH Reserve Fund. The reserve fund was formally established on November 26, 2014 with the amount of BDT 8,000,000 deposited in the Standard Chartered Bank under the Special Notice Deposit (SND) and under the fixed deposit account amounting BDT 4,000,000. The rules laid out that from the establishment of the reserve funds till 3 years, the fund will be under the joint oversight of DASCOH Switzerland (represented by CC) and DASCOH foundation. It was further agreed that after the lapse of this three-year interval DASCOH Switzerland shall transfer the entire Fund plus interest back to the DASCOH Foundation, where after it shall fall under their full responsibility and benefit and continue to be managed as per the agreed Reserve Fund Regulations. However, in this regard even after lapse of six years 2014 *status quo ante* prevails.

2.4.3 Other partner organisations

2.4.3.1 WARPO

WARPO, in charge of the national component of the IWRM project, remains a steady and reliable partner of SRC. There exists a strong sense of mutual trust between the national and sub-national component of the project. After a long waiting period, WARPO received approval from all relevant government ministries in the early months of 2020 to its technical proposal that will be supported by SDC as part of the IWRM project. WARPO's approved technical assistance project proforma/proposal (TAPP) that defines the objectives and obligations of the national component of IWRM project, the sub-national component's Logical Framework was reviewed to synchronize with the TAPP. WARPO's TAPP supports the following key strategies:

- Investigate the present water resources availability, use and demand through field survey, modelling and stakeholder consultation in the three districts of Barind region
- Develop suitable water resources management in solving practical contents of water scarcity
- Provide necessary comprehensive data, maps and information for operationalizing Bangladesh Water Rules, 2018; and
- Capacity development of WARPO in implementing and monitoring the Bangladesh Water Rules, 2018.

2.4.3.2 Other development partners

While the WDCC is a key stakeholder, ensuring the participation of the community and acting as an apex of the community institutions i.e. Community Clusters, and Block Management Committee, it also serves as a coordinating body for the GO/NGOs working in the field, like World Vision, Tongi Development Programme, BRAC, JICA, UPPR, SOS, Department of Social Welfare etc. Two stakeholder meetings were arranged during the project period where all NGO representatives working in Ershadnagor, GCC

representatives, and the Social Welfare Officer were present. Thereby it was agreed to work together through a single community organization, which is the WDCC. During the Covid-19 assessment, the project was able to establish a rapport with skill development training providers like Montage Polytechnic Institute and TMSS. These organizations will become important partners in implementing the skill development component of the SDC-supported Covid-19 recovery project in Gazipur. At Gaibandha, the NGO resilience platform (NRP) gained in strength through expansion of its membership base: 4 new partners RDRS, CARE, ICCO and IDE, joined the NRP taking is membership strength to 8. Not only the NRP was able to formulate a common investment plan for the region but it also fostered a high level of coordination in Covid-19 response and recovery work. A discernible expansion in impact can be seen due to the coordination NRP has built not only amongst the development partners but also with the government as the administrative head of the sub-district heads the NRP. Unfortunately, due to the constraints posed by Covid-19, the NCA (National Char Alliance) did not report any progress with the formation of Char Board, a national level body to ensure sustainable development of Chars.

Novartis Bangladesh made an in-kind contribution worth CHF 250’000 to support the protection of front line staff at Dhaka Hospitals engaged with Covid – 19 detection and treatment. This included distribution of N-15 masks, medical gowns, and goggles.

2.4.3.3 Local Government Institutions: Union Parishad and Upazila level

Strong partnerships with local government institutions (LGIs) have been extended to all SRC supported programmes. These partnerships that have been there for the IWRM, PHIIR and DRM projects were extended for the first time to Cox’s Bazar. To implement the host community component of Covid-19 response at CXB (440521), a formal agreement with the Union Parishad was signed. The Union Parishad (UP), through elected officials, administrative staff and volunteers supported the project endeavour in awareness raising, selecting locations for posters and billboards, setting up and maintaining hand-washing points, and in linking the project to health facilities in the Union. Further, all health facility support activities were planned and jointly conducted with the Upazila Health & Family Planning Officer and the relevant Facility-in-Charges were consulted for all activities. The COVID-19 training was chaired and co-facilitated by the Upazila Health & Family Planning Officer.
Under the DRM programme, the LGIs have been strengthened through the DMC structures at the Union and Upazila level and the coordination with governmental and non-governmental organizations has improved with the onboarding of the executive head of the sub-district (who is known as UNO – Upazila Nirbahi Officer). For the cash distribution under 440521, the project worked closely with the UNO for area and beneficiary selection. The partnerships with UPs/LGIs resulted in leveraging resources from these institutions: a minimum of 10% contribution, except for response actions, has been successfully raised for all activities across all the projects. In Gazipur, the project has a formal MoU with the Gazipur city corporation (GCC) which defines the respective roles and responsibilities of BDRCS and GCC.

2.4.3.4 Partners in Cox’s Bazar

The MoHFW, through IOM, takes the lead in providing primary health care services by deploying trained medical and para-medical staff. ACF, as a technical partner, is responsible for providing nutrition and PSS services along with the capacity building of all PHC staff and volunteers in these areas. Further, UNFPA and its implementing partner Hope Foundation provide specialized SRH services, including ANC, PNC and NVDs. Ipas and IRC, other UNFPA partners operating from the PHCs, provide family planning and SGBV services, respectively.
In June 2020, BDRCS and SRC received a request by Research, Training and Management International (RTM-I) to provide Infant and Young Child Feeding (IYCF) and breastfeeding counselling for lactating mothers/caregivers of children under 2. After consultations with the lead nutrition partner ACF, the nutrition sector and MoHFW, it was concluded that RTM-I’s services are complementary to ACF’s services, and hence BDRCS signed an operation agreement with RTM-I.
In November 2020, IRC contacted BDRCS and SRC and proposed they could start delivering SRH, family planning and GBV in one centre. After consultations with UNFPA, lead partner in this domain and with which SRC already has an MoU, the process to elaborate a separate agreement with IRC was initiated. IRC will start providing their services at camp 2E PHC from February 2021 onwards.
The Fred Hollows Foundation (FHF) has been providing eye health services in two PHCs. With the aim to scale up this partnership to other centres, a consortium among BDRCS, the Qatar Red Crescent (QRC), Turkish Red Crescent (TRC), SRC and the FHF was established, where eye health would be scaled up to all SRC and 2 TRC centres while at the same time amending the vision screening with

cataract screening and systematic eye health outreach. The agreement is in the process of being finalized and activities should start in the first quarter 2021.

. Overall, different service providing agencies meet the following conditions when working at the PHC:

a) The partner follows the guidance provided by the BDRCS PHC Officer who functions as facility manager in-charge.
b) The partner provides the specified number of staff per PHC and works in the specified room.
c) The partner covers all costs related to equipment and supplies needed to adequately provide services.
d) The partner reports daily anonymous patient/service data to the BDRCS PHC Officer.
e) The partner actively participates in coordination meetings at PHC level.
f) The partner contributes to operational and running costs as per practices at PHCs.
g) The partner closely collaborates and seeks synergies with other service providing agencies at the respective PHC.

Collaborating with the GoB has been a stimulus in facilitating the integration of Red Cross Red Crescent services with the UN system. The table below gives an overview of different partners' roles in the PHCs (under Outcome 1 of project 440518) while noting that partners and their roles slightly vary over the different PHCs:

Partners and their Roles / Services in PHCs (Outcome 1).

Partner Name	***Role / Services***
Bangladesh Red Crescent Society (BDRCS)	Coordination and PHC management, Referral Support
Ministry of Health and Family Welfare, Directorate General on Health Services (MoHFW-DGHS)	Monitoring Support of all activities, General Health Counselling and Medicine Supply (Out-Patient Department - OPD) through IOM, Immunization, Referrals through IOM
International Organisation for Migration (IOM)	Employment of HR to operate OPD under guidance of MoHFW-DGHS
Action Against Hunger (ACF)	Nutrition screening and counselling, PSS and referrals
International Project Assistance Services (IPAS)	Family planning, menstrual regulation, post abortion care and referrals
Hope Foundation	Antenatal and postnatal care, normal deliveries, and referrals
International Rescue Committee (IRC)	GBV / PSS, and referrals
Fred Hollows Foundation (FHF)	Eye health and referrals
BDRCS Cox's Bazar Unit/Branch with support from International Committee of Red Cross and Red Crescent (ICRC)	Restoring family links and protection
Research, Training and Management International (RTM-I)	IYCF and breastfeeding counselling for lactating mothers/caregivers of children under 2
United Nations Fund for Population Assistance (UNFPA)	Donor agency of Hope Foundation, Ipas and IRC. SRC has signed an MoU in this regard with UNFPA.

Table 1: Partners and their roles/services in PHCs

The UNFPA and its implementing partners committed that they would support the new PHC in camp 6. Furthermore, the IRC, also being a partner of UNFPA, will support the PHC in camp 2E with own funding. In line with the agreement, ACF showed willingness to support BDRCS-SRC on PHCs in camps 2 E and 6.

For the SWM endeavour in Palongkhali Union an agreement was elaborated with UNDP, its implementing partners BRAC and Practical Action, and the Union Parishad in Palongkhali. The agreement regulates roles and responsibilities of setting up and operating a financially sustainable SWM system covering the whole Union. This can be considered as a milestone for the SWM component. The MRF is jointly constructed by BDRCS and UNDP.

The coordination mechanisms begin from the camp level and are extended to the district and national level. At the same time, coordination needs are equally high and relevant between and within the UN and RC/RC platforms. Since BDRCS is in the lead in the latter (supported by IFRC) the access and participation in this platform is easy and permits plugging into existing capacities. On the other hand, IFRC represents the RC/RC movement in the Head of Sub-Office meetings at Cox's Bazar, and at Dhaka level at the Strategic Advisory Group (SEG) meetings.

2.5 Advocacy and policy dialogue

All development projects have a strong governance approach that relies on advocacy and unwavering commitment to work with the GoB. However, advocacy and the policy dialogue was severely impacted in 2020 because of government's overwhelming pre-occupation with combating Covid-19 spread and impact. Some of the noteworthy gains and missed opportunities in this domain are outlined below:

a. In the PHIIR III project, despite repeated attempts, the project was unable to organise a national level coordination meeting between the two directorates DGHS and DGFP under the MoHFW. The main reason for this was the heavy engagement of all government directorates and associated departments in Covid-19 prevention, protection, treatment and response but in small measure this was also due to change of the DG at DGHS: a new DG was appointed in the 3rd quarter and rapport building is taking quite some time. At the sub-national level, there was a fair level of coordination on project and Covid-19 activities; open forums and public hearings were organised that permitted the health service providers and LGIs to draw the attention of district health authorities to special measures for strengthening the primary health care system. In particular, the urgent need to deploy and fill vacant positions at various health facilities was highlighted.
b. Further, DASCOH was able to leverage financial support from LGIs and FMCs to pay the salaries of the newly appointed midwives at FWCs. Though it is a small amount (10% contribution to salaries), it has been a first initiative of this kind and is expected to result into higher contribution from these sources
c. For the IWRM project, despite WARPO's absence, the decentralised IWRM committees were formed and strengthened. Remarkably, contrary to foresee restraint in implementing the regulatory instruments enshrined in the Bangladesh Water Rules, the UP level IWRM committees displayed a high level of pro-activeness in abiding by the rules and enabling the citizens to do the same. This was also possible because of SRC – DASCOH's successful advocacy with WARPO to publish UP guidelines, which was finally notified by the government in 2020. The guidelines elaborate the processes and steps to be followed by UPs for the implementation of the BWR.
d. SRC-DASCOH was engaged in advocating with WARPO to support the inclusion of BWR and UP guidelines in the NILG's (National Institute of Local Government that is responsible for countrywide training and capacity building of LGIs) training curriculum. WARPO in the tripartite meeting with SDC and SRC-DASCOH has agreed to issue a formal letter to NILG to include the water rules and guidelines in their training curriculum.
e. At the regional level, DASCOH is working formally and informally with different government agencies that comply with the IWRM agenda. The IWRM project has good cooperation and coordination with some of the government and autonomous actors with similar perspective such as BMDA, DAE, BADC and Geology & Mining Department of Rajshahi University. The IWRM project is going to establish 50 demonstration plots for cotton cultivation in the High Barind area in formal collaboration with BCDB (Cotton is a rain-fed low water consuming crop).
f. Noteworthy is the commitment made by GCC to co-finance the MRF through 50% cost contribution. This is expected to materialise in 2021. Finally, under DRM and urban slum programming the project has enabled the UPs and GCC to correctly administer and target the various safety net programmes. This is not only bringing benefits to people eligible for welfare and development entitlements but has significantly contributed to enhanced capacity of local bodies to administer pro-poor / vulnerable safety net programmes.
g. At Cox's Bazar, when planning for the opening of the 4th PHC, several discussions were held with the partners between January and March 2020. While the MoHFW and IOM seemed not to have allocated staff for the PHC at first, the issue was resolved after discussions with the Civil Surgeon, the MoHFW Chief Coordinator in Cox's Bazar as well as the focal person from IOM. The Civil Surgeon allocated staff from an underutilized Community Clinic to the PHC. Out of 9 staff mentioned in the MoU with the MoHFW-DGHS, 7 staff were allocated and recruited by IOM. Due to remodelling of the centre as a Severe Acute Respiratory Infection (SARI) Isolation and

Treatment Center (ITC), the IOM staff was temporarily deputed to an IOM ITC but redeployed to the PHC at camp 2E from November 2020.

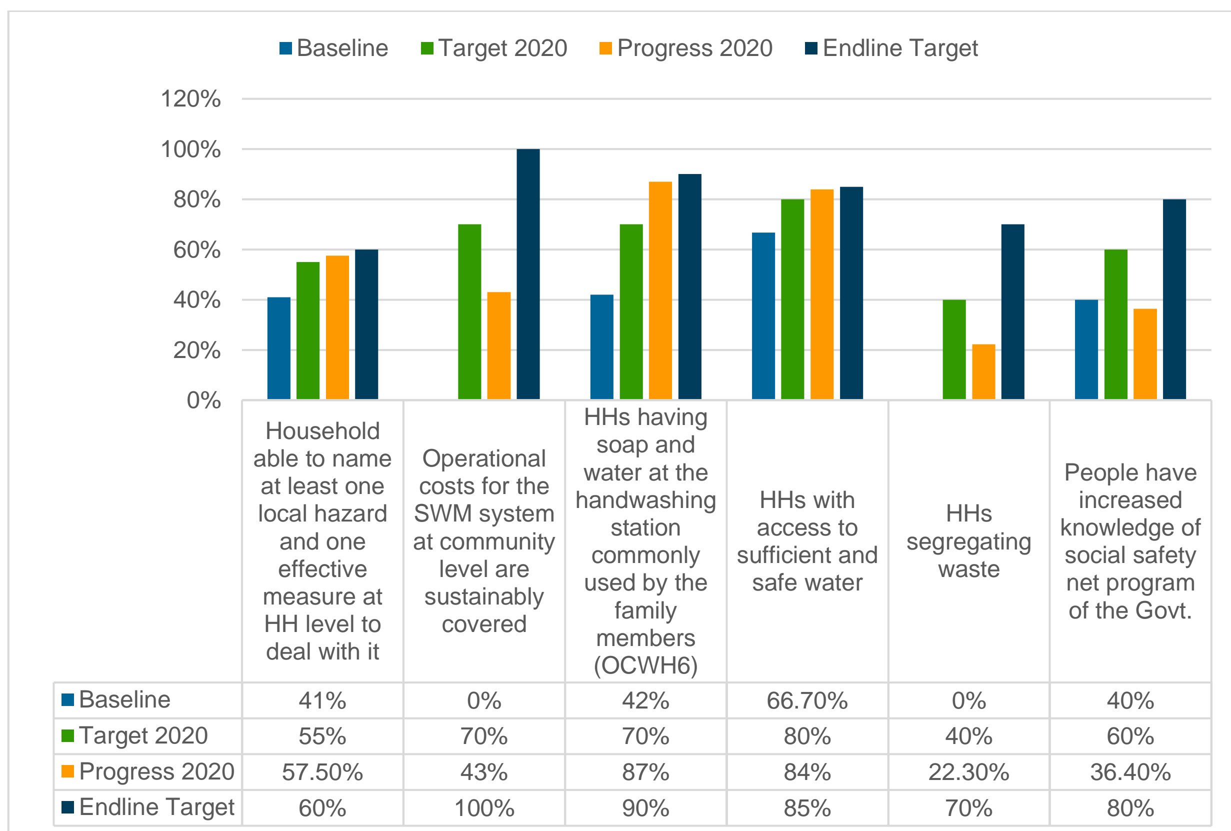
h. Another step forward at CXB was the completion of a detailed Cooperation Agreement between the Union Parishad in Palongkhali, Practical Action, BRAC and BDRCS. The agreement will be signed by UNDP and SRC as witnesses. The partnership has the objective to establish a financially sustainable SWM system owned by the local community and led by Palongkhali Union Parishad.

3 Project impact, outcomes and outputs

3.1 Long-term development projects implemented by BDRCS

3.1.1 440517, Urban Empowerment and Resilience II, Ershadnogor

To assess the progress achieved in 2020, an annual outcome monitoring was conducted in November that looked at outcome and output level indicators. The methodology included household survey, review of project management information system (MIS) & documents and Focus Group Discussions (FGD). The following chart shows the progress of all (except 2) the project outcome indicators, in comparison with baseline data, year-end target and project-end target. The outcome indicator on people receiving municipal services has not been portrayed here as there is no baseline value for that. Moreover, the capacity-building component of the Gazipur branch (OC3) is going to get a new shape considering the experience of branch development process of BDRCS-SRC and as a result of that, this indicator has not been measured through the outcome monitoring. The results are shown in the following graph:



	Household able to name at least one local hazard and one effective measure at HH level to deal with it	Operational costs for the SWM system at community level are sustainably covered	HHs having soap and water at the handwashing station commonly used by the family members (OCWH6)	HHs with access to sufficient and safe water	HHs segregating waste	People have increased knowledge of social safety net program of the Govt.
Baseline	41%	0%	42%	66.70%	0%	40%
Target 2020	55%	70%	70%	80%	40%	60%
Progress 2020	57.50%	43%	87%	84%	22.30%	36.40%
Endline Target	60%	100%	90%	85%	70%	80%

Figure 5: Outcome monitoring survey findings, 2020

This chart shows significant improvements in most of the outcome indicators related to health, Disaster Risk Management (DRM) & Water, Sanitation and Hygiene (WASH), which are higher than the annual target for 2020. On the other hand, the indicators related to solid waste management (SWM) and the knowledge level indicator related to the safety-net program continue to fall short of the annual targets. Although the SWM targets could not be fully achieved, significant progress in comparison with last year's

results was made. The impact of COVID-19, such as economic hardship experienced by different strata of the community proved inhibitive in attaining the annual targets for SWM and SSNP: on the one hand, it disabled the community to pay a service fee regularly, on the other hand, the key service provider – GCC – was under pressure to implement new Covid–19 measures as planned by the GoB. Keeping in view the Covid–19 restrictions, the project plan and budget were revised in the second half of 2020, which allowed to include a cash response of CHF 90'927 for people affected by the impact of COVID-19. With the lifting of restrictions, the project acquired the desired momentum leading to the completion of most of the activities that were re-calibrated for 2020. This is also reflected in the high annual budget utilization of the project.

Outcome 1: Target communities are better protected and prepared against natural and health hazards through improved environmental sanitation services and community based DRM measures

There was a significant increase (18%) of HHs having soap and water at hand-washing station commonly used by the family members (OCWH6) throughout 2020. To date, 87% of the households have soap and a continuous source of water at hand washing stations, compared to 69% in 2019 and 42% in 2018.

The measures[12] for maintaining a safe water system have been shared with the community through the awareness raising programs using an awareness raising flipchart. Annual outcome monitoring survey reveals that their implementation contributed to the HH access to sufficient and safe water, which has increased from 66.7% in 2018 and 74.1% in 2019 to 84.4% in 2020.

The project also successfully promoted the use of[13] safe water by informing the community about potential reasons and sources of contamination, and by facilitating mitigation and protection measures. This has led to an increase in the use of safe water from 79.8% in 2019 to 89.3% in 2020. In the project location, generally the ground water is collected through submersible pump and then stored into overhead tanks, which are then linked to HH level taps that are used for collecting the water. The following table shows the contamination area and percentage which again reveals that the interventions of the project, which is focusing on the mechanisms of cleaning water after collecting from the main water sources, are very efficient. However, the project will try to advocate with WDCC in coming days so that the problems, which includes not having a proper pipe network for the slum communities to supply the water, regarding the source could be minimized.

Types of Sources	# Samples	# Safe	# Unsafe	% Safe	% Unsafe
Main Source (Up to overhead tank)	104	94	10	90.4%	9.6%
Sub Source (Overhead tank)	326	290	36	89%	11%
End Source (HH level tap)	119	106	13	89%	11 %
Total	549	490	59	89.5%	10.5%

Table 2: Water testing findings in Ershadnagor

12 The measures which were promoted through these sessions are 1) disinfect the water tank twice a year, 2) use bleaching powder instead of detergent for the tank cleaning, 3) avoid joints in water distribution pipe that are either close or pass through drains, 4) stop using cloth filter on the water tap, 5) stop using the magic pipe (a piece of low quality pipe which is used temporarily by the users to collect water from a distance tap) for collecting drinking water, and 6) keep the water tank cover locked.

13 Water which is found negative during P/A test by AAN kits, means it does not contain any bacteria.

The results above show that the basic health and WASH practices in community have significantly improved through intensive awareness raising sessions on health & WASH, of which many more have been carried out than originally planned to foster the Covid-19 preventive behaviour. In 2020, a total number of 2'706 court yard sessions were conducted by the trained 64 community volunteers, using the same flip-chart 'Our Environment, Our Health' (click here to view the flip-chart) as mentioned above. The content of this flip-chart is delivered through five sessions. To date, 2'505 (76.67%) HHs have participated in all the sessions. During the annual outcome monitoring survey, 78.1% HHs said that they participated in all the sessions as elaborated above.

In addition to awareness raising, the project also supported the installation of low-cost handwashing stations and hygienic latrines. In 2020, a total of 224 handwashing stations and 20 model latrines were installed through a cost-sharing mechanism: the beneficiary households contributed 30% of the cost and the remaining 70% were covered through the project. The installation of handwashing stations was well received by the community and another 256 HHs replicated the installation of hand washing station on their own cost, following the example of the project-supported stations. The Covid-19 pandemic has contributed to a greater realisation of the importance of a handwashing station in households. Moreover, the project has mobilised the households to disinfect their water tank twice a year with bleaching powder, an intervention that is assumed to have a high impact in increasing water safety. All the 450 water tanks in the project location were disinfected twice in 2020.
In the area of Solid Waste Management (SWM), in 2020, 91% of the HHs were covered through regular waste collection. The project is making efforts to cover the remaining 9%. This includes awareness campaigns and door to door visits by the WDCC members and community volunteers etc. Till now, only 2'380 HHs (72.9%) are subscribed to the SWM services and pay the HH fees, among which 1'589 HHs (49% of HHs are covered through doorstep collection) are regularly paying service fees. The number of SWM subscriber households has increased by 798 (24.4%) in 2020, from 1'582 (48.5%) HHs in 2019 to 2'380 (72.9%) HHs in 2020. The number of regularly paying HHs has increased by 248 (7.9%) from 1'341 (41.1%) in 2019 to 1'589 (49.0%) in 2020. Because of Covid-19 and its subsequent impact, the HH service fee collection could not achieve the annual targets of covering the operational cost. Though we have reached our yearly target of covering 46% (1'500 HH) with regular HH fees by 2020. However, the project will continue to push for increasing the HH fees collection and HH waste collection in 2021.

In 2020, 43% of SWM the operational costs were sustainably covered, 19% more than the 24% last year, but not enough to achieve the target of 70% of 2020. The project needs to collect more than 90% of HH fees/increase the HHs fee with targeted 70% regular connection, ensure proper marketing of compost and obtain a subsidy for ensuring regular drain cleaning from GCC to reach at the breakeven point at the end of the project period. Here, the project also spent high indirect cost like building the awareness among the people, train the SWM workers, testing the compost etc because the project is piloting a system where it needs awareness (community) from the demand side and capacity from the supply side (SWM workers) which might not be required at the end of the project. The following table shows the income and expenditure of the SWM system in 2020:

Operational income (2020)		**Operational expenditure (2020)**	
HH service fee (BDT)	9,96,985.00	Salary (BDT)	23,05,942.00
Compost selling (BDT)	11,050.00	Vehicle maintenance (BDT)	29,996
Recyclable selling (BDT)	1,962.00	PPE (BDT)	31,598.00
		Total	23,67,536
		Indirect expense	
		Awareness raising	8,84,733.00
		SWM Training	47,525.00

		Drain cleaning	3,09,776.00
		Others (SWM Card Printing, Compost test, MRF materi-als etc)	38,120.00
		Total (Indirect Expense)	12,80,154
Total income	10,09,997.00	**Total expenditure**	**3,647,690**
Total deficit for 2020		**BDT 2,637,693**	

Table 3: Income and expenditure status for SWM operation in Ershadnagor, Gazipur

Since the beginning of the current year, the project started motivating the community to segregate waste at household level and a portion of households follow this practice. During the outcome monitoring survey, 70.6% of all respondents said that they segregate waste – organic and inorganic waste in separate bins - at household level. But from direct observation it is found that only one-fifth (22.3%) households segregate the waste at household level regularly, which means 70.6% have got the right kind of knowledge and they have understood the process of source segregation, but the practice continues to be on the lower side.

Photograph 1: Extended decentralized/alternative MRF station (on the left) and the composting pit (on the right). December 2020. BDRCS

During the reporting period, the project could ensure a proper value chain for only 17.8% of waste that is being generated in the project area. This is largely due to the inadequate MRF facility, which lacks the capacity to process the organic waste into compost. The project is seeking inputs from the consultant how best to expand the composting capacity so that all collected waste can be processed adequately. Along with the central MRF facility that is to be built in collaboration with the GCC, the project is exploring options to set up decentralised processing facilities (smaller MRF) so that all collected waste can be processed in 2021. The following table shows that in the targeted three blocks, around 1000 tons of waste will be generated per year, and if we have both centralized and decentralized MRF options, we could be in a position to process all the waste. The capacity of the present alternative would be to handle 190 tons/year, the second one, which has already been in a process of construction would be able to manage 549 tons/year and the centralized MRF will be able to handle 529 tons/year. To make the blocks as *zero waste blocks* ensuring all the three options is necessary. In addition, expert opinion is being sought to reduce the composting duration, which presently takes 55 days. The sale of recyclables and disposal of rejects is yet to be systematised, as it has been quite ad-hoc during the reporting period. GCC, that has the responsibility to dispose the rejects, is still not on boarded to support disposal of rejects in a regular manner. This is expected to be streamlined in 2021 through stronger advocacy.

MRF options	Composting capacity (KG) in a cycle of 55 days	Organic waste (KG) managed per year	Rejects (KG) per year	Recyclables recovered at MRF	Recyclable by SWM worker @200kg per van per month	Total waste (KG) managed per year	Total Waste (Per year) @ .9 kg/day/ HH	Percentage of managed waste
Present Capacity (Piloted one + the extended decentralized MRF)	18000	119455	55354	1482	14400	190691	1,071,896	17.8%
If the third alternative/decentralized MRF is constructed	74000	491091	227567	6094	14400	739152		69.0%
If both Centralized and decentralized MRF is functioning	128000	849455	393629	10542	14400	1268025		118%

Table 4: Capacity of present and future MRF centres

The produced compost was tested in Soil Resource Development Institute (SRDI) and it met most of the standards set by the GoB. People in the targeted community bought the produced compost with a price range from BDT10-20/kg and used it for their kitchen gardens to produce vegetables. During the Covid-19 pandemic, it was quite difficult to continue the communication with GCC regarding the joint construction of the centralized MRF centre, as their priority shifted at that time from development to combating Covid-19 and the lock down measures were imposed. Moreover, there were changes in several key positions in GCC, i.e. Chief Waste Management Officer, Secretary, and CEO. These changes and the pandemic context have delayed the MRF construction which will be completed in 2021.

As the permanent/centralized MRF centre construction is being delayed, the project extended the composting shed with a temporary structure. One composting shed construction is completed and a first round of composting is ongoing, while another composting shed is under construction. After completion of the third alternative/decentralized MRF, the composting capacity would be increased to 74 tons/cycle which is 18 tons/cycle now. For constructing the MRF stations and expanding the operation while ensuring that all collected waste is adequately processed, a major challenge is to find land in the congested slum setting which has hindered/delayed project's efforts to construct a decentralised MRF so far.

From the data, it is clear that the project needs to focus on all stages of SWM. This means collection of waste from 100% HHs, collection of HH fees from more than 80% HHs, rearrange the HR structure regarding the SWM, construct a third decentralized MRF along with the planned centralized system, streamline marketing of compost and recyclables, and ensure proper disposal of rejects by GCC. At the time of reporting, the project was seeking advice from the consultant to establish the entire SWM value chain in the project area with a special focus on the above mentioned issues. While the project team plans to conduct a market assessment for streamlining and optimising the sale of compost and recyclables, the inputs from the consultant will lead to the fine-tuning of milestones for SWM and an attendant action plan will help the team to achieve SWM unattained objectives, as described above, within the project duration.

By the end of 2020, 58% of the HHs were able to name at least one local hazard and one effective DRM measures at household level, compared to 31% in 2019 and 41% in 2018. This change is due to household level awareness raising sessions through the PASSA exercise. In 2020, a total number of 355 PASSA sessions have been conducted. 15 out of 32 community clusters (CC) in the project area have completed all the steps, such as formation of a PASSA team, understanding the nature of disasters, analysis of hazards, classifying the houses considering their risks, preparing CC wise action plans for mitigating the risks, execution of the action plans and reporting. The initial target for this year was to conduct 384 PASSA sessions and increase the awareness level up to 55%. Due to Covid-19, the PASSA exercise could not be carried out for three months.

In addition to the awareness raised, through the PASSA exercises the community identified HH level risks and also prepared an action plan to mitigate these risks. There is a PASSA team, consisting of 20-

25 community people and community volunteers in each community entrusted with following up the risk mitigation action plans. The table below shows the HH level risks identified and the number of HHs who have mitigated these risks.

Sl. No	Types of Problem	Risk category	Number of HH associated with the risk	Number of HH which solved the problem	% of problem solved by the household
1	High Voltage Electricity line over the household roof	High	37	0	0%
2	Gas Cylinder inside of living room	High	164	5	3%
3	Damaged walls and roof	High	136	6	4.4%
4	Damaged walls and roof	Medium	138	55	40%
5	Inside house open electricity wire	Medium	150	27	18%
6	Household base beneath the road level	Medium	33	2	6%
7	Low ceiling with a fan	Medium	174	24	14%
8	Water Tank on roof posing risk of damage to the roof	Medium	212	3	1%
9	Showcase and Almira is closely setup with wall inside the House	Low	299	62	21%
10	Tinned (CI sheet) houses with broken side fence	Low	140	54	39%
11	Unsafely placed electrical plugs	Low	141	27	19%
			1624	265	16%

Table 5: Types of problems identified in the PASSA exercise and mitigated by the individual HH

In addition to the PASSA exercise, other DRM measures taken in the community include the preparation of a ward contingency plan, update four DRM plans in four schools, implement one disaster mitigation activity (repairing of doors and windows) in one school, and organize a City Corporation Disaster Management committee (CCDMC) meeting with the GCC. For implementing the DRM activity in one school, the respective school contributed 52% of the cost, where the other 48% were born by the project. The project is planning to advocate with the GCC to support mitigation measures that are beyond the capacity of individual HHs, for example addressing the risk of high voltage electricity lines being stretched over houses or elevating houses above road level. On the other hand, it continues working with the community for implementing the risk mitigation initiatives which could be addressed by themselves.

BDRCS supported the GCC to organize a CCDMC meeting on 6th December 2020. In that meeting, BDRCS explained the terms and conditions of the GoB's 'Standing Orders on Disaster (SOD) – 2019' to the committee members. According to the SOD, there is a provision to form a Disaster Management Committee (DMC) in each of the wards of the City Corporation. BDRCS stressed the need of having the DMC at ward level and explained BDRCS' role as a humanitarian organization as stated in the SOD. Another topic discussed was the scope of collaboration between BDRCS and GCC. Amongst others, it was agreed that BDRCS would support the GCC to form a ward level DMC in Ershadnogor, will create a volunteer's team and strengthen their capacity, and facilitate the formulation of a contingency plan at ward level.

Outcome 2: Social and financial inclusion of target communities in basic municipal services is improved

The Ward Development Coordination Committee (WDCC) - along with BMC and CC - functions as a platform for coordinating development interventions and ensuring community engagement in decision-making and implementation of the project. Disaggregated block level annual development plans were formulated which then were consolidated by the WDCC into a ward level development plan. During the Covid-19 emergency cash distribution, the WDCC played a key role in validating the selected beneficiaries. They reviewed the published list, made changes against complaints and validated the final lists. Apart from the Covid-19 cash grant distribution, the major areas of WDCC engagement throughout the year were the selection of beneficiaries for handwashing stations and model latrines, serving as an interface for negotiation with GCC, and the organization of several community level consultations to establish the

MRF. In this reporting period, total 38 formal meetings were organized by the WDCC and BMCs. Moreover, 270 CC meetings were organized to mobilize the community around different thematic areas addressed by the project.

The WDCC mobilized a community contribution of BDT 375,598, which is 36% of the total expenditure related to all cost-relevant activities, through a cost-sharing modality. The details are given below in the table.

Sl.No	Activity	No of unit	Total Cost (BDT)	Project Contribution (BDT)	Community Contribution (BDT)	Project Contribution (%)	Beneficiary Contribution (%)
1	Installation of model latrine	20	594,817	390,494	204,323	66%	34%
2	Installation of hand-washing station in HH	224	322,841	224,441	98,400	70%	30%
3	School DRR mitigation activity	1	109,600	52,925	56,675	48%	52%
4	Mock drill on fire safety and controlling	1	16,300	4,300	12,000	26%	74%
5	Hand-washing day observation	1	7,062	2,862	4,200	41%	59%
	Grand Total		**1,050,620**	**675,022**	**375,598**	**64%**	**36%**

Table 6: DRM measures and community contribution in 2020

The results of people's knowledge on Social Safety Net Programmes (SSNP) have improved marginally to 36.4% in 2020 compared with that of 34% in 2019. The results are measured using the monitoring framework definition where the person is expected to recall at least three safety net programmes along with their objectives. Though three mass awareness-raising programmes were planned to increase SSNP awareness, the project could carry out only one due to Covid–19 restrictions. To achieve the project target of 80% awareness among community members on SSNP, awareness raising will be enhanced in 2021.

Despite faltering progress in mass awareness raising, the project has supported the community in identifying people eligible for SSNP and supported their linkage with relevant SSNPs. In the first year, the project identified 378 people who were eligible for the safety net program. Out of these 378 people, 80 are not living anymore in the project location and three of them have died. Out of the remaining 295, 248 people have been already included in the safety net program. For the remaining 47 people, it was required to correct the information and project supported them to correct the information and resubmit it to the department of social services. To facilitate the linkage to the SSNP and other municipal services project organized three dialogues between community and service providers, which included the department of youth, the city corporation slum development department and the Ministry of Women and Child Affairs (MoWCA). The annual outcome monitoring says that 67.1% of the eligible HHs are linked and affirmed receiving municipal services, where the end of the project target is to reach 40% by 2022.

Last year's financial report revealed that the day-care centre was not financially viable and to continue its operation it would need to be consistently subsidized. Given that the day-care operation cannot run on a cost recovery basis, the plan was to mainstream it with similar initiatives of MoWCA, the nodal agency in Bangladesh to run day-care centres across the country. The cut-off time to handover the day-care was June 2020, and the budget was allocated accordingly. Though discussions for handing over from WDCC to MoWCA were initiated in 2018/19, the follow up was weak and could not be revived this year. In the meantime, MoWCA came out with circular laying down a set of criteria for running the day-care centre. Unfortunately, the project supported day-care centre is not compliant with most of the regulations prescribed by the government. Moreover, because of Covid-19, the GoB closed all the schools and day care centres until further notification. Taking into account all considerations it was decided to close the day care centre.

Outcome 3: Organizational capacity of Gazipur Unit/BDRCS strengthened in line with the NS strategic priorities and to enable the unit for engagement in urban development context

The Unit's capacity has been enhanced with the development of the RCY team in Tongi Upazila. This RCY team along with the unit level RCY supported the project activity in the field throughout the reporting period. For example, the volunteers were involved in disinfecting the vehicles, maintaining social distancing through awareness raising, ensuring the lockdown procedures, beneficiary data collection for Covid-19 response etc. For that purpose, three formal meetings were organized with them. The RCYs also arranged and participated in mass awareness raising campaigns related to SWM.

There was one discussion session held between the secretary and the project team around them obtaining land for the unit building. Eventually, the capacity building plan has shifted to 2021 realizing that the initial plan needs to be adapted with the changing context after Covid-19 and considering the election of the Gazipur Branch in December 2020. Moreover, the branch development initiative (under 440514) has given both BDRCS and SRC many insights, which foster above-mentioned the decision.

Covid – 19 response

Due to the lockdown that took effect from 26th March 2020, factories were closed, transportation shut down, daily trades discontinued, and construction works stopped. In short, the major sources of income for the slum communities in Gazipur were lost which ranged from complete erosion of daily wage opportunities to loss of contractual and permanent jobs. The Covid-19 impact assessment conducted by BDRCS-SRC in July 2020 shows that the percentage of households with a monthly income of less than 5'000 BDT increased from 21% before Covid-19 to 74% after the outbreak of Covid-19. With the reduction of the income, households in slum communities struggled to meet their subsistence needs. Therefore, BDRCS and SRC decided to provide multi-purpose cash grants to households in Gazipur, which were impacted worst by the pandemic and related containment measures.

To reduce the sufferings of urban poor who were severely affected by the Covid-19 pandemic and ensuing containment measures, BDRCS-SRC supported 1'500 households with multi-purpose cash grants of 5'000 BDT (approx. CHF 50) per household (one-time payments). Out of 1'500 households, 1'200 households were selected from the project location (blocks 3, 5 and 6) and the remaining 300 households were selected from Ward- 17, 26, 28 of GCC, based on BDRCS' request that the response support should not be just confined to the intervention area and should include vulnerable people from other areas of Gazipur as well.

The response component followed the Cash SoP of BDRCS. Quality control was done through monitoring, supervision and technical support by SRC and BDRCS-NHQ at every stage (pre, during and post) of the cash distribution. The intervention area was selected following a rigorous discussion amongst BDRCS-NHQ leadership, Gazipur Branch of BDRCS and SRC delegation through reviewing the secondary information. Following up the Covid-19 impact assessment, beneficiary households were prioritized based on pre-selected vulnerability assessment criteria. These criteria included income poverty exacerbated by Covid–19, no previous cash grants in response to the pandemic, and other commonly used socio-economic vulnerability criteria such as: women headed household, having elderly household members, pregnant woman in the family etc. All the targeted HHs were surveyed, which allowed the project not only to identify the right kind of beneficiaries considering their intersectional identity for the response programs, but also to determine their recovery and development needs, which dovetails with the LRRD approach.

The community, along with the WDCC, was consulted to ensure a community-approved final list. The distribution was carried out on 26 & 27 July 2020 in Ershadnagor (Ward 49) and on 24 September 2020 in Wards 17, 26, & 28. Beneficiary verification was done before distribution, by checking 10% samples of the final list. It was found that beneficiaries were selected according to the agreed selection criteria. The distribution process was monitored, and an exit survey was conducted covering 10% of the beneficiaries. After three weeks of cash grants' distribution, a post distribution monitoring (PDM) was conducted in October 2020. According to the PDM, 83% of the beneficiaries reported complete satisfaction with the overall process, whereas 16% were somehow satisfied, and 1% was not satisfied at all. The reasons for not being satisfied were errors in the distribution cards, which required beneficiaries to contact the BDRCS office several times to get the corrections done. This led to delays in distribution time. 100% of the recipients confirmed that they have received 5'000 BDT cash grants and that they did not pay any amount to be selected for the grants.

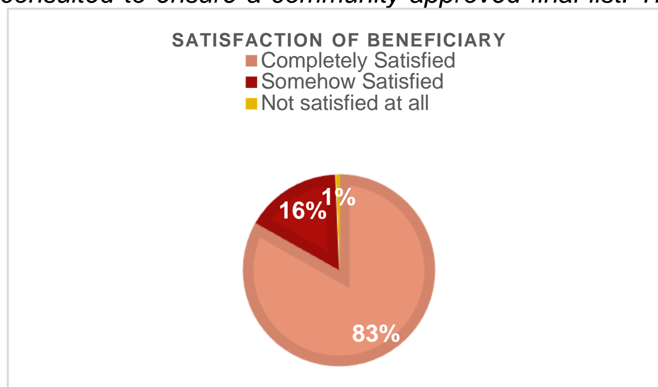


Figure 6: Satisfaction of beneficiary of Covid-19 emergency cash grant distribution

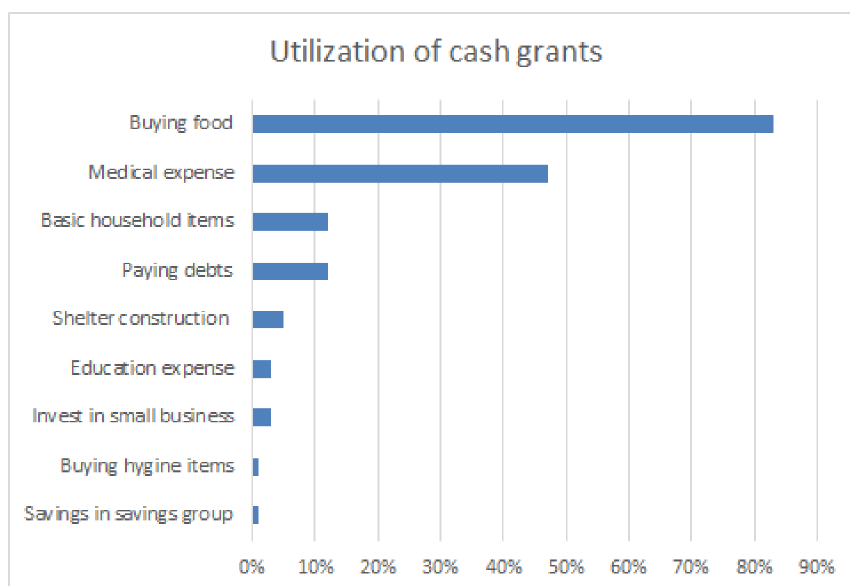


Figure 7: Utilization of Covid-19 emergency cash grants

Up to the time of the data collection for the PDM, 96% of the grant recipients had spent the cash fully and the remaining 4% had spent it partially. As this is a multipurpose unconditional cash grant, all beneficiaries were using it for meeting different basic needs, such as costs related to food and medical expense. 87% of the people have spent the received money for purchasing food items, while 47% used it for medical expenses. The other major categories are basic HH items (12% HH), re-paying debt (12% HH), shelter construction (5% HH), invest in small business (3% HH), meeting the education expense (3% HH). Only very few HHs (less than 2%) used the grants for purchasing hygiene and protection items and ensuring their savings in saving groups.

Though the beneficiary selection process and distribution was cash SOP compliant and quite satisfactory, the CEA process revealed room for improvements in future. Only 43% of the recipients have a moderate knowledge or are confident about how to report any complaints or suggestions regarding the cash distribution to BDRCS, while 22% have some idea, but are not confident. The remaining 35% indicated having no information about any complaint mechanism (BenCom), though the hotline numbers were shared through the beneficiary card and the process of complaint raising was briefed on several occasions among all the beneficiaries. Additional improvements are sought, e.g. arranging sufficient sitting facilities for the cash distribution and to provide the enumerators with a stronger orientation before collecting all sorts of data (to ensure error free data). All these issues, especially those related to BenCom and data verification / validation will be taken up during the proposed review of the Cash SOP in 2021 (under the new project 440470).

Considering the novel pandemic context and the limited accessibility to the field, the whole team, with strong support of BDRCS' Disaster Response Department and the SRC cash focal, did a noteworthy job with the Covid-19 cash grant distribution.

Due to the significant impact of Covid-19 and the associated containment measures on people's lives and livelihoods, BDRCS-SRC agreed to further extend support to the slum communities of Gazipur, beyond the immediate emergency cash response, because these communities were particularly hard hit. This materialized in the development of a concept note for a Covid-19 livelihoods recovery project, which was approved by SDC as the sole donor under the 440511 project. The one-year project (January – December 2021) consists of three components to support people's livelihood and lost income recovery: 1) Skills development; 2) Recovery support for small businesses; 3) Prevention and protection to minimise gender-based violence.

3.1.2 440514, Combining Disaster Risk Management (DRM) & Emergency response with stronger National Society (NS) partnership (DRM Programme), Gaibandha

Outcome 1: Target communities are better protected and prepared against climate, natural hazard and health risks

This outcome is linked to a range of outputs that aim at increasing the capacity of the local community. On the one hand, the community shall be enabled to effectively highlight and prioritize their needs, on the other, they shall have sufficient capacity and experience to support the measures to reinforce their resilience. The success of the outcome derives firstly from linking up with and supporting the sub-national DMCs (that oversee all humanitarian endeavours at community level) so that they could function effectively. In addition, Social Safety net programs are useful tools in mitigating risks faced by the vulnerable groups including those exacerbated by disaster. Secondly, the health risks are minimized by the project mainly focusing on improving the health and WASH facilities, which includes facilitating access to safe water, appropriate sanitation, hygiene, and basic health care services.

Under this outcome, the 44 VDMCs have updated their Risk Reduction Action Plans (RRAP) at the beginning of 2020. Subsequently, the RRAP were displayed in nine strategic locations of Fulchari Upazila as part of the dissemination strategy to enable people's familiarization with them . The evaluation done by the external consultant reveals that 79.2% of families are familiar with RRAPs and see them as beneficial for them.

The formal collaboration of the project with LGIs to implement the RRAP in co-financing mode not only allows access to govt. resources earmarked for risk reduction actions, but also enhances the internalisation of RRAP by LGIs as a risk management tool in line with the govt.'s commitment to mainstream risk reduction at all levels of governance. Public disclosure of all RRAP schemes is encouraged to promote transparency and accountability in disaster management functions of LGIs.

With the co-financing strategy, the project achieved a significant number of civil works that is described in the table below.

Name of activities	Target	Achievement	Project (80%)	UP (10%)	Beneficiary (10%)	Total
HH plinth rising	40	37	648,761	81,095	81,095	810,951
School compound raising	5	5	528,784	66,098	66,098	660,980
Road repair	1	1	194,537	21,615	-	216,152
Grand Total			1,372,082	168,808	147,193	1,688,083

Table 7: Co-financing status for construction of flood mitigation options, 2020

Photograph: HH latrine installed with the support of DRM project

While implementing the civil works, all proposed structural measures were evaluated for its environmental impact with the support from UPs and sub-district administration, using the govt. guideline for Initial Environment Assessment (IEA). All the construction was guided and monitored by the VDMC and UDMC so that the quality of the construction is ensured. Moreover, for quality assurance, as per the MoU with Unions and Upazila Parishads, Joint Monitoring Teams (JMT) checked the quality of civil works. Following their approval and certification, payments were processed. In the reporting year, total 278 family members have directly benefitted by household plinth raising. Raised plinths reduced the suffering of the HH from flood while allowing them to cultivate vegetables at their plinths. Besides addressing the nutrition needs of the family, this permits them to increase income as the surplus produce beyond the HH needs are sold. The five school compounds which were raised during this reporting period were used as a shelter for flood affected communities and their livestock. Road repair work in one of the villages, which entailed raising the level of the road to prevent its submergence during floods, has led to improved and consistent access of the village community to one flood shelter, two primary schools, one Madrasha and the local market. Once the road level was raised, the village committee raised the plinth of the Bazar (local market) by themselves. A positive spin off of the plinth raising initiates has been that many poor households have raised their plinth at their own cost following the design and estimate prepared by the project. From the project MIS, it is evident that 397 HH self-financed plinth raising. Further 94 households received support for plinth raising by other NGOs (SKS and Islamic Relief), and six roads were constructed by ASOD. Additionally, 17 roads constructed and repaired by LGIs with their Local Governance Support Project (LGSP) fund in the project working area.

All the mitigation activities under this outcome have been implemented complying with Covid-related WHO health rules and regulations of social distancing, washing hands frequently and using face mask.

Under WASH-related activities, the project supported drive for Universal Sanitation Coverage (USC) acquired a “movement-like” form in all the villages which has been duly acknowledged and well received by the Upazila administration. In one Union (Gazaria), the project has already achieved 100% sanitation coverage, which means every HH in this union is now using a hygienic latrine. The VDMCs were primarily engaged in identification and listing of beneficiaries considering their economic status through social mapping and door-to-door visits. Village-wise lists were aggregated into a union level beneficiary list. The UDMCs randomly verified the list, leading to its finalization and submission to the project for enlisting its support. After several consultations, the following implementation modality was agreed upon:

a. The latrines will be installed by beneficiaries themselves with the motivation from the project staffs/Emergency Response Teams (ERTs) and VDMCs.
b. The project will provide financial and technical support.
c. The building materials will be supplied by the local SanMark centres.
d. Under the guidance and support from the project, the SanMark centres will increase their production capacity to meet the demands while maintaining quality standards.
e. UP will contribute 10% of the latrine costs.
f. Beneficiaries will bear the costs of the superstructure while the sub-structure of the latrines will be co-financed by the project (80%), UP (10%), and beneficiaries (10%)

Following this implementation modality, 5,502 HH latrines (New-4185, Repair-1317) were installed during the reporting period. This initiative is not only helping the community to improve their health standards but is creating local job and income opportunities through the SanMark centres. SanMark centres in Gazaria union involved eight entrepreneurs who were given a refresher training in quality control and were advised on measures to increase production. The following table describes the WASH initiative, and financial contribution in 2020:

Name of activities	Achievement	Project (80%)	UP (10%)	Beneficiary (10%)	Total
Hygienic Latrine (new)	4185[14]	1,00,20,080	11,13,342	-	1,11,33,423
Unhygienic latrine repair	1317	17,42,268	1,93,585	-	1,93,585
Hygienic latrine @ quarantine centre	5	44,964	0	0	44,964
TW platform construction	50	1,85,996	23,250	23,250	2,32,496
TW arsenic test	50	2,500	0	0	2,500
Grand Total		1,10,07,845	11,53,737	23,250	1,21,84,832

Table 8: Co-financing status for construction of WASH intervention, 2020

To secure a year-round safe drinking water supply, especially in the dry season and flood period, 50 tube well (TW) platforms were constructed during the reporting period. VDMC members have acquired masonry skills to repair/ construct the platforms. Water quality in terms of arsenic contamination of all those water sources was tested using the Arsenic kit. A water-testing card has been introduced to monitor the arsenic level in those tube wells. Though all the HH do not have their own water sources, every HH has regular access to sufficient and safe water following government standards whereby a safe water source is to be established within 50 metres of the HH that can be used by 10-15 HHs. Table 9 shows the overall status of water points in four unions. For appropriate management of the TW at HH level, five training sessions were organized in targeted four unions in September 2020. The VDMCs organized the trainings and ERTs facilitated the sessions for the beneficiaries who got the TW platform support from the DRM project. Through this training, users were oriented in safe drinking water sources and its characteristics and TW maintenance process. 50 TW managers (man 23 and woman 27) were trained through this process. They shall have responsibility for the maintenance of the water source and the platforms.

Name of Union	Total HHs as per 2020 survey	# of Safe water points
Fazlupur	4070	668
Gazaria	4840	1439
Fulchari	5308	1402
Erendabari	8123	1748
Total	22341	5257

Table 9: Union-wise distribution of households and safe water points

Due to heavy floods, many TW were inundated in the working areas and became contaminated, except the DRR TWs constructed by the project. Between August and October 1,655 TW were disinfected (chlorination) by the trained ERTs and VDMCs members with technical assistance from DPHE mechanics. VDMC has initiated this activity by using their fund. Moreover, to ensure coordinated flood preparedness initiatives by development partners, DPHE moderated a sub-national WASH cluster meeting at Gaibandha before the flood event. The DRM project staff participated in the meeting and informed about the response readiness of BDRCS.

Name of Union	Nos of VDMC	Nos of TW disinfected	Total
Erendabari	9	482	2399
Fulchari	8	313	1602
Fazlupur	12	238	1145
Gazaria	9	622	5012
TOTAL	38	1655	10158

Table 10: Union-wise distribution of disinfected tube-wells

[14] In total 4190 latrines were installed. Out of this 4185 were HH latrines while the remaining 5 were installed in a school at the request of the government when they decided to transition the school into a quarantine facility temporarily. Thus, on NGO online we are reporting 4190

Photos: (a) School WASH session

In 2020, 408 school WASH sessions were conducted among 6,120 students in 75 primary schools. Further 90 WASH sessions were conducted with 1,458 students in 9 Madrasahs. 84 Teachers received training on WASH and conducted WASH sessions among the students. Unfortunately, the sessions had to be stopped when the schools and madrasahs were closed due to Covid-19. In addition to conducting school sessions, 2,676 community WASH sessions were organized with 17,400 (3828 male and 13572 female) beneficiaries. The annual target of 4305 sessions in 615 clusters could not be achieved due to Covid – 19 restrictions. Through these sessions, beneficiaries were sensitized in safe drinking water practices including water safety and operation and maintenance of water sources. They learnt about the characteristics of hygienic latrines and the need to install, use and maintain it, as well as personal hygiene and cleanliness. The community volunteers (ERTs) conducted these sessions in their catchment area. Moreover, capitalizing on the need to wash hands regularly to prevent virus infection, the project mounted a strong awareness generation on handwashing, which resulted in 2320 HHs installing self – financed hand washing stations, that includes availability of soap, and regular availability of water.

The contract of Community Health Service Provider (CHSP) in the three CCs has been over from March 2020 since those are taken over by the health department (Civil Surgeon's office) of Gaibandha. The CS Office ensured that they would run the CCs with the government HR and other resources. However, the DRM project followed up of the CGs meeting and other supportive supervision. It is observed that the newly posted Community Health Care Providers (CHCPs) are not regular in the job. Patient flow is decreasing and CGs meeting is not being held regularly. Overall, the population access to basic health care decreased from 81.75% to 66% during 2020. This decline in patient uptake is not only confined to the project area of Gaibandha but reflects the broader trend where health facilities in general across the country reported a fall in patient inflow. Nevertheless, the project will advocate with the Civil Surgeon to ensure the regular presence of CHCP and facilitation support will be extended by the project to ensure more regular meeting of CGs.

CC Name	Total patient	Female	Male	Pregnant	Child	Disabled	Referral	health session
Kunderpara CC Kamarjani	3,352	2,141	776	13	395	18	9	24
Dighalkandi CC Haldia	2,410	1,136	867	10	374	15	8	25
Maizebari CC, Mollarchar	3,506	2,151	906	19	408	13	9	7
Total:3 CCs	9,268	5,428	2,549	42	1,177	46	26	56

Table 11: CC patient status, 2020

Given the critical role of VDMCs, the project felt the need of reforming the VDMC membership, as there was a manifest decline in effectiveness of some of them. 44 VDMCs reformed their membership which resulted in enrolment of 30% new members. 132 VDMC meetings were organized during the reporting period. In these meetings, 1305 members participated, and the agenda of these meetings centred on risk communication on Covid–19, universal sanitation coverage, beneficiary selection for USC and cash grants as a response to Covid– 19 and floods. The impact of Covid–19 on livelihoods and possible strategies for livelihood recovery were also discussed. VDMCs also helped in deepening the connectedness

of people with LGIs /UDMCs to draw their support towards fulfilment of development and welfare entitlements.

In order to strengthen preparedness for effective response, a workshop was organised to review and strengthen response readiness with the participation of all field staff. Following a participatory methodology that included simulation exercises, the workshop reviewed the preparedness in various domains of early warning and its dissemination, trainings needs at community level, logistics, cash readiness, mitigation works to be undertaken pre-disaster, and safety and security during disaster. The review resulted in formulation of a preparedness plan that identified roles and responsibilities of the field team (including volunteers), the project team at Gaibandha, LGIs and district government authorities and BDRCS, NHQ. A response readiness checklist was also drafted. VDMCs through beneficiary contribution raised BDT 156,875 BDT which was spent on activities described in the table below:

Table 12: VDMC fund utilization, 2020

Name Activity	Name of Union							
	Gazaria		Fazlupur		Fulchari		Erendabari	
	Nos	Cost	Nos	Cost	Nos	Cost	Nos	Cost
Blanket distribution	111	24,975	237	35,550	35	7,700	102	23,460
TW chlorination	622	3,137	238	2,160	383	2,200	482	2,410
Road repairing	0	0	1	3,175	0	0	0	0
TW platform construction	0	0	0	0	1	4250	0	0
School compound sand filling	0	0	0	0	2	1400	0	0
Wood bridge approach road repairing	0	0	0	0	3	700	0	0
Total		28,112		40,885		16,250		25,870

Table 6: VDMC fund utilization, 2020

The life members of BDRCS have been included in the UDMC & UzDMC as a veteran member of this DMCs in line with Standing Orders on Disaster (SoD), which is a guideline prepared by the GoB under the leadership of the Ministry of Disaster Management and Relief for all disaster risk management activities. BDRCS is included in all tiers of the DMCs to support the GoB in their mandate of auxiliary to the government. An orientation was organized on 15 October 2020 at the project office of Gaibandha, where five Life Members of BDRCS were identified as representative of UzDMC in line with the SOD.

To disseminate the Early Warning (EW) Massages, VDMC reinstalled 45 flood pillars and 37 bulletin boards inside the community as these were established at the beginning of the project and were damaged. In addition to that, 44 ERTs and 90 UDMC members have been oriented on EW Systems. During the flood, 74 ERTs disseminated EW messages through a megaphone in 37 char villages. They have assisted 48 poor families to evacuate during the flood with the help of the VDMC members. In addition, 22 ERTs and 39 VDMC members jointly distributed safe drinking water for a week among 2068 flood affected HHs in 4 unions. As a result, no water borne diseases were reported from the area. VDMCs will continue this initiative after the project period with their contingency funds.

Based on weather forecast, and just before the floods hit in June 2020, Swiss RC supported FbF covered total 500 beneficiaries with cash grants, of which 300 and 200 belonged to *Erandabari* and *Mollar Char* union of Fulchari and *Sadar* Upazila respectively. 4 NDRT and 40 RCYs were deployed in Gaibandha to support early actions. All the families that were covered belong to the extreme poor population group. Of these, 60% of the families are women headed HH, 13% of the families have a person with disability, and 16% of the families have a pregnant and lactating woman.

The standard protocol of getting the beneficiary list confirmed by the local unit and its submission to the district administration for coordination purposes were followed. The 500 selected families received multipurpose cash grant assistance of BDT 4'500 (*around CHF 55*) through the General Post Office. The cash distribution event was organised following Covid–19 protection and safety rules. In a way, the FbF occasioned further reinforcement of people's awareness on barriers to Covid 19 virus transmission. With this cash support, people along with their belongings evacuated to safer places at short notice.

The NGO Resilience Platform (NRP) gained in strength with the onboarding of new organizations such as RDRS, CARE, ICCO and IDE, increasing the number of member organizations to eight. Through numerous consultations, the NRP developed a common investment plan (CIP) with all the member organizations. The CIP supported coordinated investment of BDT 152 million around resilience-centered activities, which includes investment in WASH, Health, Livelihood, Disaster Risk Management, social safety net etc. while minimizing duplication and expanding synergies. In 2021, NRP will focus on the following common initiatives in order to support UzDMC and to highlight their own activities which are:

- NRP members will take stock of the output of 2020 through the Annual General Meeting.
- Since regular awareness raising sessions were organised on SSNP as part of the DRM project which led to 13'038 people having information and knowledge of various SSNP programmes. This included awareness of how they are administered, the eligibility criteria, and steps that need to be taken to secure entitlement if one is eligible for any of the SSNP. In light of this NRP will prepare database for Fulchari Upazila along with Upazila Administration, in order to support the administration of government SSNP programs.
- NRP will support different DRM initiatives like road repairing, observing National Disaster Preparedness Day (NDPD), International Day for Disaster Risk Reduction (IDDRR) and other important days for promoting DRM
- NRP will document and publish good practices for their dissemination and adoption by LGIs and larger NGO community

These tasks have already been assigned among the NRP members for expediting the process.

Outcome/Component 2: BDRCS at headquarter and branch level applies its improved humanitarian response and DRM capacities

The BDRCS leadership, especially the Secretary General, was keen to pilot a bottom-up branch development process with few selected branches that qualified for small grant support through a competitive call for proposal process. Such an initiative not only supports the localization agenda but has the potential to strengthen BDRCS due to the strong bearing of unit development on overall functionality of BDRCS. On the other hand, genuine capacity building of the units cannot be achieved through organizational and capacity development plans that are externally determined and imposed on the units.

From that perspective, five branches were selected under the guidance of a framework document, which is jointly developed by SRC-BDRCS, keeping the following three objectives in mind.

1. Strengthening RCYs and RCRC identity (operational capacity)
2. Financial sustainability through strengthened local resource mobilisation (resource mobilisation capacity)
3. Visibility of the branches (relevance and credibility reinforcing the above two)

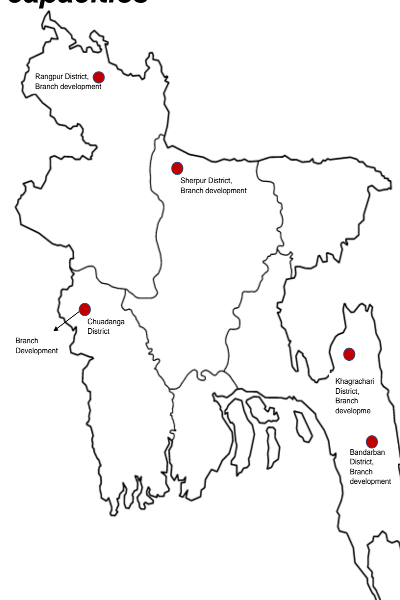


Figure 8: Five branches qualified for small grant

Following the framework document, four units were selected in 2019 after reviewing the project proposals submitted by 64 branches and having a thorough due diligence. The overall project is being steered by a Central Advisory cum Steering Committee, which is reviewing activities undertaken by the units, while advising them on strategic and thematic issues. The technical committee is providing hands on support at all stages of PCM to the branches. For facilitating the process, ten different workshops (six at Dhaka level and four at branch level) and two

special steering committee meetings were organized where the leadership of BDRCS (SG, DSG, directors) and SRC participated. It had been agreed that for branches to qualify for grant support, they had to make a mandatory contribution of 30% of the budgeted amount. Covid–19 not only impeded the progress of this component but led to one branch pulling out as it was unable to make the mandatory contribution. As the call for proposal process had shortlisted nine branches in 2019, it was easy for the BDRCS and SRC steering committee to decide the next possible options and finally *Sherpur* and *Khagrachari* branches willing to make the mandatory contribution were selected for the unit development initiative. The technical committee, comprised with Director Unit Affairs Department (UAD), Senior Resilience Manager (SRM) and Assistant Director -UAD of BDRCS and DHoD of SRC, organized three workshops to define the work plan of the respective branches. As all the branches were focusing on new ways of working to strengthen RCYs and the movement, ensure financial sustainability of the branches, and increase visibility, another workshop was organized in Dhaka in September 2020, where all directors along with DSG and SG reviewed the work plans leading to their finalization. The plans of the branches are provided in the following table.

Area of Intervention	Activities Designed				
	Bandarban	Chuadanga	Rangpur	Khagrachari	Sherpur
Strengthening RCYs and the movement (OC1)	1. Unit Database development 2. EC committee + Life members Orientation 3. RCY Group formation and orientation 4. UDRT equipment	1. RCY Group formation and orientation 2. Training for newly formed Upazila RCY, on RCRC movement and basic first aid 3.EC committee + Life members Orientation	1.Unit Database development 2. EC committee + Life members Orientation 3. RCY Group formation and orientation	1.Unit Database development 2. Life Members Orientation on RCRC Movement	1.Unit Database development 2. UDRT Training on SAR+ General DM 3. RCY Group formation and orientation 4. UDRT equipment 5. EC committee + Life members Orientation
Visibility of the branches (OC2)	1.Coordination meeting to ensure the representation in different DMCs 2. Website design, development and update	1.Ensure representation in DMCs (2) 2. Workshop to prepare flip-chart (manual) on menstrual hygiene to raise awareness of female RCYs. 3. Organize menstrual hygiene awareness sessions 4. Piloting eye camp in UP (4 nos.) 5. Website design, development, and update	1. Website design, development and update	1. Website design, development, and update	1. Office Renovation 2. Publication of Souvenir 3. Blood grouping and donation campaign
Resource Mobilization/ IGA (OC3)	1. Digital Display Board installation 2. Special First aid Team formation 3. Training room renovation and decoration 4. Develop Fund Raising Guideline	1. Digital Display Board installation 2. Organizing fundraising dinner. 3. Unit office extension 4. Equipment for eye hospital 5. organizing eye camp	1. Digital Display Board installation 2. Training room renovation and decoration 3. Stakeholder meeting for Fund Raising	1. Digital Display Board Installation 2. Develop Fund Raising Mechanism/guideline. 3. Upgradation of Hall/Conference Room with modern facilities 4. Fund Raising through streamlined marketing of	1. Stakeholders Meeting for fund raising. 2. Digital Display Board Installation 3. Video Documentation

				traditional local handicrafts	
Budget contribution	Total budget: 21,65,000.00 Project contribution - 15, 15,000 (70%) Unit contribution- 6, 50,000.00 (30%)	Total budget: 26,74,000 BDT Project contribution 16, 04,400 (60%) Unit contribution- 1,069,600 (40%)	Total budget: 21,18,000 .00 Project contribution – 12, 70,800 (60%) Unit contribution- 8, 47,200 (40%)	Total budget: 25,03,000 .00 Project contribution – 15, 01,800 (60%) Unit contribution- 10, 01,200 (40%)	Total budget: 19,81,000 Project contribution 13,86,700 (70%) Unit contribution- 5,94,300 (30%)

Table 13: Plans of the branches

Except Bandarban and Sherpur branch, in all the cases the cost sharing ratio is 60:40, where the project is contributing 60% of the budget. For Bandarban and Sherpur the ratio is 70:30 as they have more software related components compared to the other branches, and this exception was approved by the Steering Committee. All the branches have their separate bank accounts for this project to ensure better financial control. BDRCS audit and finance department is monitoring the expenditures in line with BDRCS procurement policy. Moreover, the planning/development and the training departments are also involved to guide the monitoring and capacity building components of the initiatives.

Bandarban branch, has already implemented most of the activities except branch website development, coordination meeting with the stakeholders in order to ensure the representation in the DMCs and developing the fund-raising guideline. The digital display board and training room has created an avenue for the unit to raise their funds and become financially sustainable in coming days. Bandarban unit has already included 107 life members in 2020 in comparison with four in 2019 which shows that the branch development initiative has contributed significantly to expand RCRC movement membership base. Moreover, Bandarban branch has already invested BDT 1.1 million to renovate the training room which exceeds their committed contribution. The unit EC has been able to tap into 27 million BDT from the district council to construct their office building cum guest house which is expected to emerge as the key income generating source. In addition, the project is supporting capacity development of the First Aid Team (FAT), developing a guideline for fund raising, and efficient management of the digital display board.

Rangpur branch already has the land for constructing their office building cum training centre from the ministry. On the other hand, they have formed the branch level project implementation committee (PIC) to facilitate efficient project management. Furthermore, the unit database consisting of information related to life members, RCYs and EC members, has already been completed. The rest of the works are ongoing, and the unit is confident to finish the tasks by May 2021.

Chuadanga branch already arranged all the planned equipment for their eye hospital and completed all preparatory works for the extension of their unit office. Moreover, a menstrual hygiene awareness program is going on after having a workshop for developing the awareness raising materials. Other activities have been replanned and Chuadanga branch is confident to finish all the tasks by May 2021.

The progress of Khagrachari and Sherpur branches is not satisfactory as after selecting the branches (in September), the branches got involved with their annual election and national AGM. Special attention will be given to these branches so that they can complete their planned activities. Moreover, the procurement process will be thoroughly cross-checked with the branches by BDRCS-NHQ in coming months.

In the central Steering Committee meeting an evaluation of branch development component was proposed. However, the SG opined that instead of an evaluation, a lesson learned workshop should be conducted as not only the initiative is new, but the duration of one year is insufficient to evaluate the impact of the unit development process. Remarkably, the unit development component already includes strategies that is now enshrined in the declaration for positive transformation 2020, which has been collectively committed by all units of BDRCS. It has been agreed that all movement partners will be engaged in the lessons learned workshop in order to encourage and solicit their support for a similar unit development process in future. The SG made a formal request to SRC to expand the unit development initiative to cover more units through next phase of DRM programming.

Outcome/Component 3: Improved Disaster Risk Reduction for Refugees from Rakhine in Cox's Bazar through American Red Cross

This component was completed in 2019 and was covered in the last annual report (2019).

Covid – 19 Emergency response

From the Covid-19 impact assessment conducted by BDRCS-SRC in July 2020, it was found that almost all the HHs (n=3995) in the poor and extreme poor category in Gaibandha reported having an income below BDT 5'000. Therefore, BDRCS and SRC decided to provide multi-purpose cash grants to households in Gaibandha, which were impacted worst by the pandemic and related containment measures. To reduce the sufferings of the rural poor, BDRCS-SRC supported 3'500 households with multi-purpose cash grant of 3000 BDT (approx. CHF 35) per household to cover their basic subsistence needs during one month. For that purpose, SRC-BDRCS analysed the project budget critically along with its targets and plan for a Covid-19 response operation under the LRRD framework. Out of 3500 households, 2800 households were selected from the current project location and the remaining 700 households were selected from six other unions of 3 Upazilas, following BDRCS's request to not confine Covid – 19 response only to the project area.

The cash response component followed the Cash SoP of BDRCS. In line with the cash SoP, quality control was done through monitoring, supervision, and technical support from SRC and BDRCS-NHQ at all stages (pre, during and post) of cash distribution. The area was selected through a rigorous discussion among BDRCS-NHQ leadership, Gaibandha Branch, Local Government and SRC delegation. Secondary information was used to corroborate the appropriateness of area selection. Following the findings of the Covid-19 impact assessment, beneficiary households were prioritized based on pre-selected vulnerability criteria. These criteria included income, poverty and the associated loss of jobs and income, no previous cash grants in response to the pandemic, and other commonly used socio-economic vulnerability criteria such as: women headed household, having elderly household members, pregnant woman in the family etc. Both qualitative (KIIs and FGDs) and quantitative (survey) information collection techniques were used to identify the beneficiaries along with the development needs.

The following table shows the cash distribution status:

Union	*Upazila*	*Support received HH*	*Date of distribution*
Erendabari	*Fulchari*	*700*	*19.10.2020*
Fazlupur	*Fulchari*	*600*	*19.10.2020*
Fulchari	*Fulchari*	*650*	*20.10.2020*
Gazaria	*Fulchari*	*550*	*20.10.2020*
Kanchipara	*Fulchari*	*100*	*22.10.2020*
Uria	*Fulchari*	*100*	*22.10.2020*
Udakhali	*Fulchari*	*100*	*22.10.2020*
Gidari	*Gaibandha Sadar*	*150*	*22.10.2020*
Ghagowa	*Gaibandha Sadar*	*150*	*22.10.2020*
Ghuridaha	*Saghata*	*400*	*22.10.2020*
10 Unions	*3 Upazilas*	*3500 Household*	

Table 14: Corona Response status, 2020

An exit survey following the distribution and a Post Distribution Monitoring (PDM) survey were conducted. For the latter through random sampling 360 (10%) HHs, were surveyed.

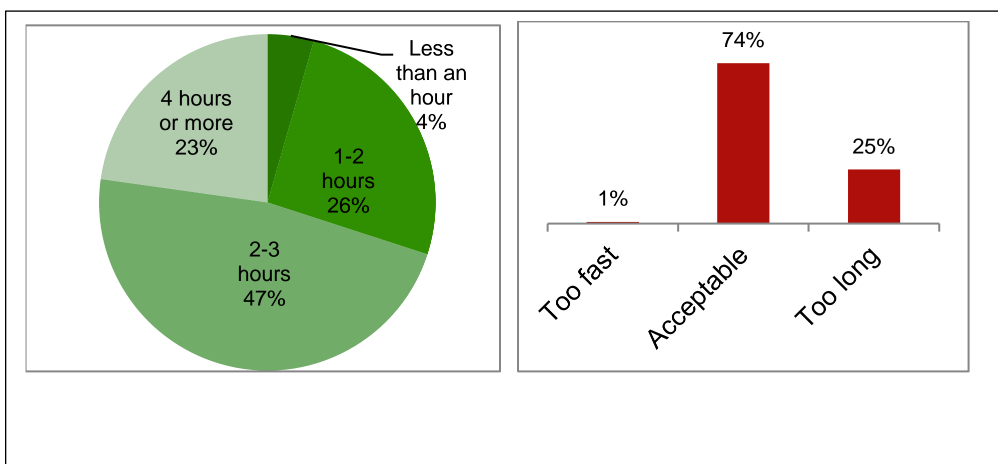


Figure 9: Waiting time at the distribution centre (at the left) and respondent evaluation regarding the waiting time (at right)

All of them mentioned that for being included in the beneficiary list, none of them has to pay or will have to pay any money or have to give a favour in return to anyone. The distribution of respondents can be seen in the following graph.

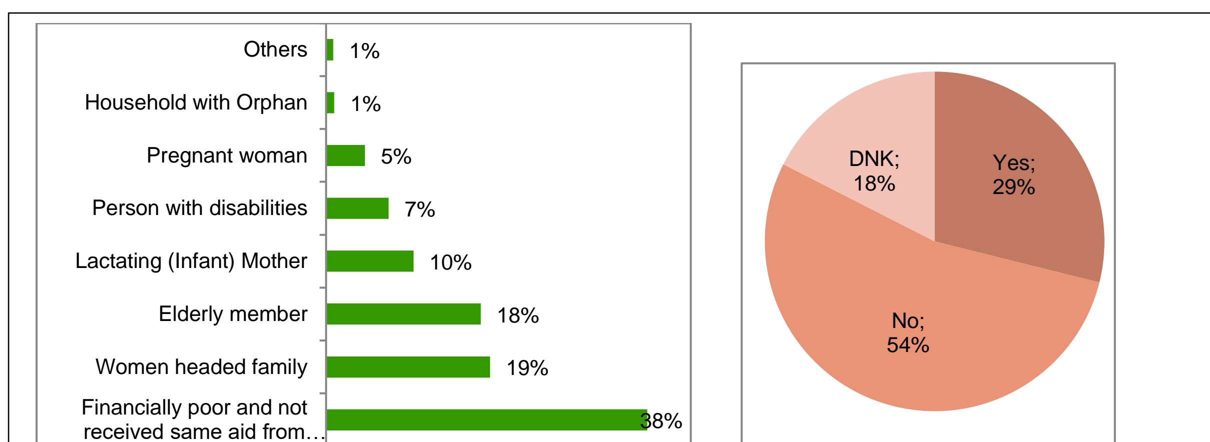


Figure 10: Respondents' vulnerability criteria (at left) and Respondents' perception about the coverage of cash grant (at right)

Financially poor families who have not received any aid from other sources was the main criteria for selection (38%), the rest of the criteria which are followed is portrayed in Figure 3. 54% of the respondents believe that not all the people in their community who were affected by the disaster (flood) /COVID-19 had been included in the beneficiary lists. This shows that a lot of people are still in need.

47% of respondents replied that they had to wait for 2-3 hours, and 23% said even more than four hours. Only 4% said they had to wait less than an hour and 26% said they had to wait less than two hours for receiving the cash (Figure 5). 74% of the respondents mentioned that the time required for receiving cash was acceptable and only 25% said it is too long to wait (Figure 6). In addition to this question, 5% reported feeling unsafe during their return trip from the cash distribution site. In addition, 5% respondent expressed that they are not satisfied with the environment of cash distribution centre (In terms of a safe environment, separate queue for male-female, priority for pregnant women, elderly and people with disability).

Food (34%) and medical expenses (22%) emerged as the main expenditure domains (Figure 7). Surprisingly, 46% of the respondent showed preference for receiving foods / in-kind items over cash grants. 49% are happy with the cash grant (Figure 8).

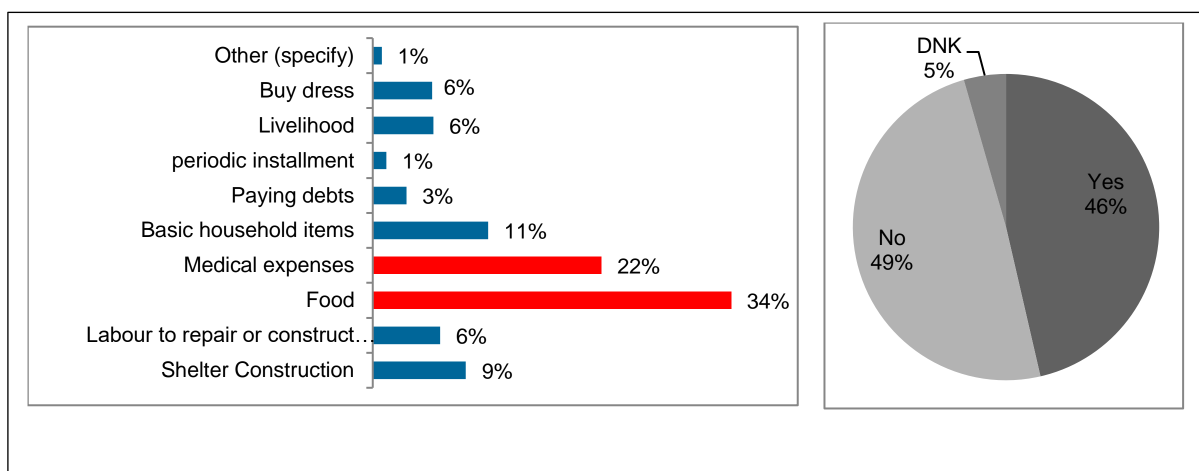


Figure 11: Utilization of cash (at left) and choice of cash/food (at right)

70% of the respondents knew how to report any complaints or suggestions to the Red Crescent about receiving cash, but 29% had little idea. (Figure 9). This is presumably because of 22% beneficiaries either cannot remember or did not receive any hotline/phone number or mail address to report any complaints or suggestions to the Bangladesh Red Crescent Society.

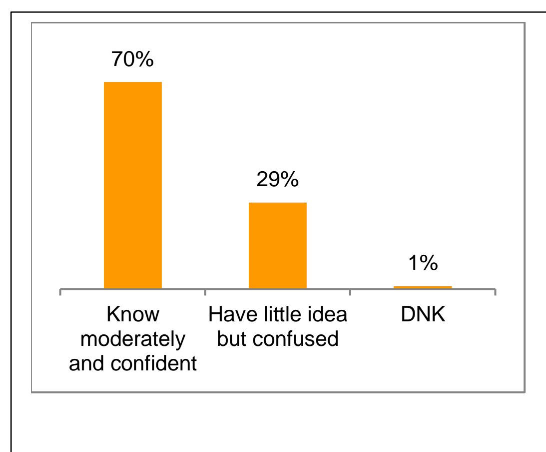


Figure 12: BenCom Mechanism

From this analysis, the following recommendations can be summed up, and would be considered for the cash SoP revision exercise which is planned by SRC-BDRCS with the support of SwS in coming year.:

- *The data shows the equity of female beneficiaries (67%) – that should be continued and increased for future response programming.*
- *The cash distribution process should be more efficient as the majority number of the respondent (70%) had to wait in the distribution centre for a long time.*
- *A small portion of the respondent (5%) expressed that they did not feel safe while returning with cash. This issue should not be avoided even if felt and reported by a small % of people.*

- *Beneficiaries should be given the option to receive cash or food/non-food items since a significant number of the respondent (46%) showed preference for receiving food / NFIs over cash grants and this can be determined during the beneficiary selection process.*
- *There is room for improvement in BenCom mechanism since more than one quarter of the respondents reported failure in recalling the phone /hotline number of BDRCS.*

*However, there were allegations of corruption / malpractices in cash assistance in one Union at Gaibandha: media reports, print and online, alleged integrity issues with cash assistance in one of the unions, Ghuridaha Union, where some of the beneficiaries reported that they were forced into paying half of their cash assistance (1'500 out of 3'000 BDT) to ex- UP members allegedly acting at the behest of District Council Chairman who is also the chairman of Gaibandha unit. Following its zero tolerance policy to fraud and corruption, BDRCS immediately instituted an inquiry with a clear ToR to be carried out by an investigation team comprising BDRCS, IFRC and SRC members. The inquiry could not unambiguously establish the involvement of the Chairman in extortion of cash from the beneficiaries but clearly brought forth the serious reputational risk and potential damage to BDRCS and RC/RC movement. It also highlighted the weaknesses of the CEA processes in the cash distribution and came forward with a set of recommendations to strengthen CEA in cash assistance. In its management response to the outcome of the inquiry, BDRCS stated that "**the allegation of extortion money from the Covid-19 (and flood) affected poor people of Gaibandha district who has received the cash support, is very disgraceful for the Gaibandha unit and the unit Chairman. As, this incident has hampered the image of Bangladesh Red Crescent Society, the unit Chairman may be called in the BDRCS headquarter personally to defend himself and share the grievance of the society. In addition to that, if such case repeats in future, then BDRCS will bound to inform the relevant Local Government Ministry and could take alternative measures for implementing response operations"***

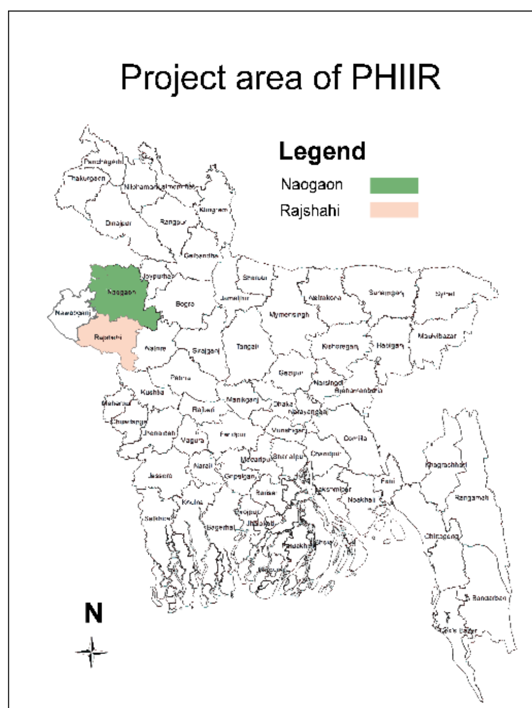
3.2 Long-term development projects implemented by DASCOH

3.2.1 440519, Public health improvement in Rajshahi (PHIIR) Phase III

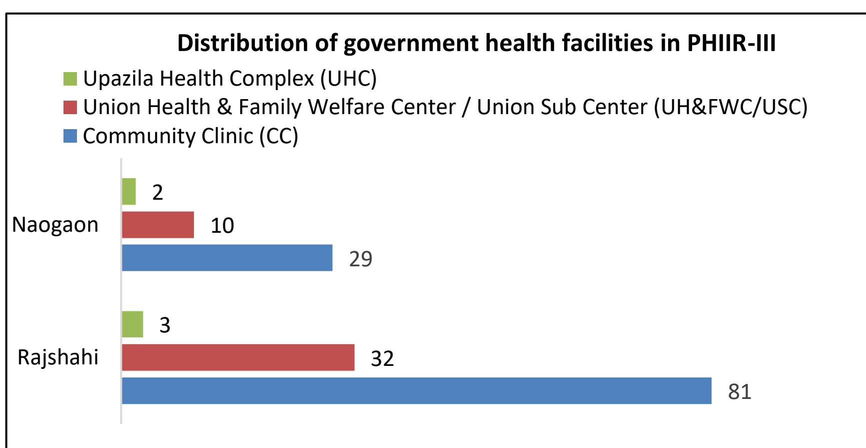
Public Health Improvement Initiative Rajshahi (PHIIR) Project, Phase III continues to build upon the successful practices of the previous phases I & II. This phase pays special emphasis on the following points: improving the quality of care across the PHC facilities in the project area, integration and streamlining of a structured referral system, partnership with private facilities to broaden the scope of CEmONC services, establishing social accountability systems to build bridges between communities, health service providers and local health authorities while improving people's behaviour in seeking care within the project area. Phase III of PHIIR project planned to cover all 157 government facilities (5 Upazila Health Complexes (UHC), 42 Union Health and Family Welfare Centres (UH&FWC), and 110 Community Clinics (CC)) in 5 Upazilas of Rajshahi and Naogaon district. Within the reporting period, the project activities were implemented as planned largely in the first and the fourth quarter while the second and third quarter witnessed serious disruptions of planned activities due to the containment measures activated by the government resulting in restrictions of travelling and social gathering. Besides adapting and engaging with Covid-19 preparedness and response activities, the project continues to support in delivering critical and essential health services following the rules of the GoB. Partnership with private facility actors is still under progress for effective referral linkages from the PHC facilities - especially for extending effective CEmONC services. This will add a new dimension to the whole referral system.

Whole Upazila Approach

From phase II learnings, phase III made design corrections seeking to implement the entire package of interventions in the whole of two selected Upazilas. Once this has been reasonably accomplished, the project will be expanded to cover the other three Upazilas and the intervention strategy will be better informed by the experiences and learnings acquired in the initial Upazilas. This is expected to make the replication and scaling up of programme interventions efficient and effective while allowing the project team to have a focussed approach that can be better managed. At the same time, while implementing the entire intervention package in two selected Upazilas, preparatory activities have been initiated even in the other Upazilas.



To initiate the "Whole Upazila Approach", apart from mapping all primary health care facilities to be covered, Sapahar Upazila in Naogaon and Baghmara Upazila in Rajshahi - were selected to pilot all the interventions. Key criteria for selecting these two for piloting was the presence of a supportive sub-district (Upazila) health administration, proactive LGIs with a track record of greater ownership and participation in phase II, pro-active management committees, and better placed health facilities in terms of staff, equipment, and logistics. The rationale was to initiate the whole package of interventions in areas with relatively fewer challenges to allow faster implementation and higher return on efforts, so that the results and experiences can be efficiently replicated in the remaining three Upazilas.



Starting from an intervention bundle in one Upazila to ensure that one model primary health care system would be created, the experiences and learnings gathered in establishing one model primary health care system in line with the "Essential Services Package" of the GoB will be gradually utilized and replicated in the other Upazilas with an incremental approach. The table below gives a status update on all the components of the intervention package in the selected upazilas.

Table 15: Status of activities within in the "Whole Upazila Approach" area

Activities	Status
MoU with private facilities for CEmONC	Repeated attempts have been undertaken to have local health authorities as signatories to the MoU with private health facilities. This involved bringing the matter to the attention of the present Director General of DGHS. However, the government officials are unwilling to sign the agreement, even after being oriented about the umbrella MoU with DGHS and DGFP which already seeks their co-operation in securing compliance of private sector heath

	facilities with the regulatory framework. DASCOH has decided to have bilateral MoUs which will be signed in early February 2021.
MoU with BDRCS for First Aid training of HSPs and project staff	This service agreement is completed and signed, preparatory works ongoing for rolling out the BFA training.
Renovation of facilities through co-financing by the FMC, UP & project	Assessment & cost-estimation done for 22 facilities and renovation completed in 5 facilities through co-financing
Equipment and logistic support for quality RMNCH services	Assessments were completed earlier last year, and after challenges in procurement delay due to pandemic, the distribution was completed by the end of the year.
Recruitment & co-financing HR for vacant positions through joint effort of FMC, UP & project	7 FWVs recruited and placed within Dec-2020, 5 at Baghmara and 2 at Sapahar
Provide hands on training for selected HSPs of public at the MCWC, Rajshahi and UHC Charghat to improve their skills and confidence	Hands on training provided to 6 FWVs from Baghmara and Sapahar.
Training on IP and waste management for HSPs at Union and Upazila level and private health facilities HSPs (SACMO, FWV, Aya & Private Facility)	1 batch with 24 participants were trained from the newly included facilities of Baghmara. Project provided similar training at Sapahar upazila in the phase II.
Basic Training of Community Volunteer (CV) member on MHCH and Nutrition	3 batches with 60 participants from Baghmara and Sapahar were trained
Basic training on ANC/PNC/FP/ Nutrition for HSPs in newly added facilities & private clinics	3 batches with 84 participants from Baghmara and Sapahar were trained.
Supervision and mentoring for capacity development	89 supervision and 88 mentorship visits were carried out at Baghmara and Sapahar Upazila.
Training of Facilities Management Committee (FMC) on their roles and responsibilities at UH&FWC	10 batches with 153 participants were trained in FMC's roles and responsibilities.
Capacity building for budgeting and fund raising with financial management for HSPs and FMC at CC and FWC level	2 batches with 55 participants from Baghmara FMCs and health facilities were trained.
Development of DRR plans for facilities vulnerable to hazards and implementation of safety measures	18 DRR plans developed out of the 22 identified as at-risk facilities at Baghmara and Sapahar Upazila, renovation work has been included in their annual development plans.
School Health program with orientation of adolescent girls and boys on hygiene, reproductive health, and early marriage	Though schools and participants for school health programme have been selected, this activity could not be initiated due to the closure of schools since March till December 2020.
Father's Club for sensitization and improve male engagement on MNCH issues	Clubs formed in each union, but further activities could not be undertaken due to Covid – 19 restrictions.
CG & CSG half yearly meeting with project support	Pandemic thwarted the planned ones, but this will be restarted in 2021 as per yearly operation plan
Improve social accountability and community engagement	Two open forum discussion at Baghmara and Sapahar Upazila and eight public hearings were conducted
Exchange visit at one completed upazila by stakeholders from other upazilas	Will be done once all components are completed in one upazila and is declared as a successful model to follow
Design and pilot a suitable regime of performance and result based financing	Not yet initiated.

Outcome 1: Sustainable access to MNCH services at government primary health care facilities (CC, UH&FWC, UHC) is ensured

Though the project has not achieved all the targeted outputs in this year, annual outcome survey done at the end of the reporting period shows progress in some of the indicators. We found a 20% increase - from 45% at baseline to 65% in the annual survey - in registration at the union level government health facilities (UH&FWC, USC) for MNCH related care seeking like ANC, PNC, etc. and normal deliveries among the surveyed women. This shows an increase in the care seeking pattern among the surveyed population, which is good reflection of our efforts especially during times of Covid – 19 when patient flow has been inconsistent and much lower compared to pre-Covid 19 and post – lockdown times. However, the number of deliveries at the same facilities has decreased from 22.9% to 20.5%. Apart from this, in the union level government facilities, registered pregnant women receiving PNC within 2 days increased by 9.2%, registered pregnant women accessing 4 or more ANC increased significantly by 33.5% despite pandemic induced restrictions, registered pregnant women delivering at a private facility increased by 3.8%. Also noteworthy is that immunization against measles among infant aged 1-2 years increased significantly by 18%. The referral system at the primary health care facilities was functional and improved significantly (13.5%) during the same period. In retrospect, though the initial lockdown measures may have contributed negatively, the project's consistent supportive engagement in keeping these facilities functional with all the Covid-19 adaptive measures made some significant improvements.

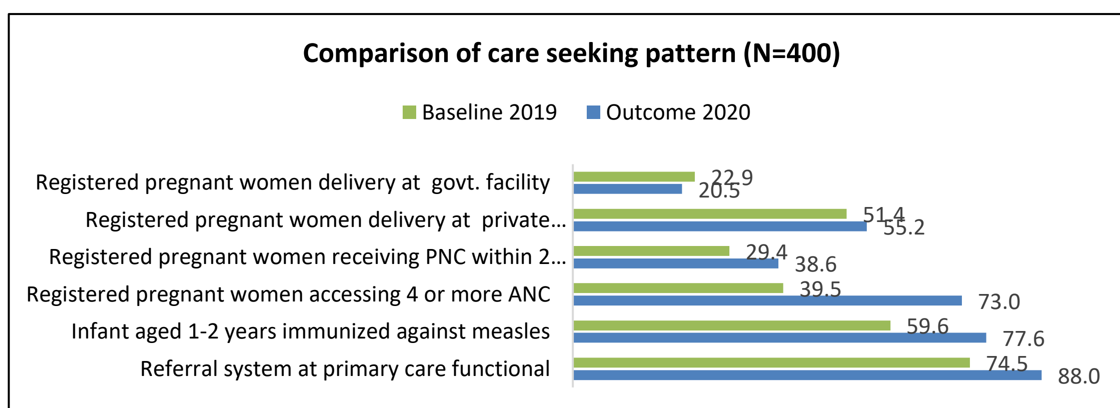


Figure 13: Comparison of care seeking pattern at the facilities.

The signing of a partnership MoU with private facilities in Rajshahi was under way when the pandemic struck. To create a sustainable option for the CEmONC services, the project drafted and finalised the MoU with private facilities in each of the five Upazilas in the project area. Due to covid-19 pandemic, the delay in renewal of valid operating licenses of the facilities and reluctance (rather refusal) of health and family planning authorities to sign a tripartite MoU for the reasons cited above, the project had to change plans. It is now aiming to complete the MoU bilaterally between DASCOH and the private facilities (without GoB being part of it). The signing is on hold as a quick functional status and eligibility assessment before signing found that all of them are awaiting approval for renewing their working license from the government authority. On the other hand, the low confidence of people in government health facilities especially due to risks of virus transmission has prompted them to turn towards the less crowded, apparently cleaner private sector for MNCH services in general and deliveries in particular. In places where the USC or UH&FWC is unable and / or is being perceived as unsafe, DASCOH has successfully referred many patients to the private sector clinics.

Institutional deliveries in this pandemic situation became a great concern for several reasons. Due to initial delays in mobilization of resources, the project was unable to fill up the required HR gaps at UH&FWCs and complete the planned renovation works before the pandemic started. Only 18 out of the 42 UH&FWCs had a full time FWV to continue 24/7 normal vaginal deliveries. Despite these visible HR gaps, a total of 2'112 NVDs were conducted in the entire reporting period within the project area (at FWC and UHC, see figure 2). Only one out of the five UHCs has a Gynaecologist and Anaesthesiologist to provide the mandated CEmONC services which include caesarean section deliveries. To mitigate the gap and provide an effective local solution, experienced nurses, midwives and surgeons at the UHCs are

also contributing to caesarean section delivery care. The successful mediation by DASCOH gets reflected in the higher spurt of normal deliveries being conducted at the private facilities where otherwise, for profit reasons, the number of caesarean section deliveries are disproportionately high. A positive outcome of the crisis has been the project developing a strong rapport with the private sector health facilities, which will be transitioned into a formal partnership in the coming months.

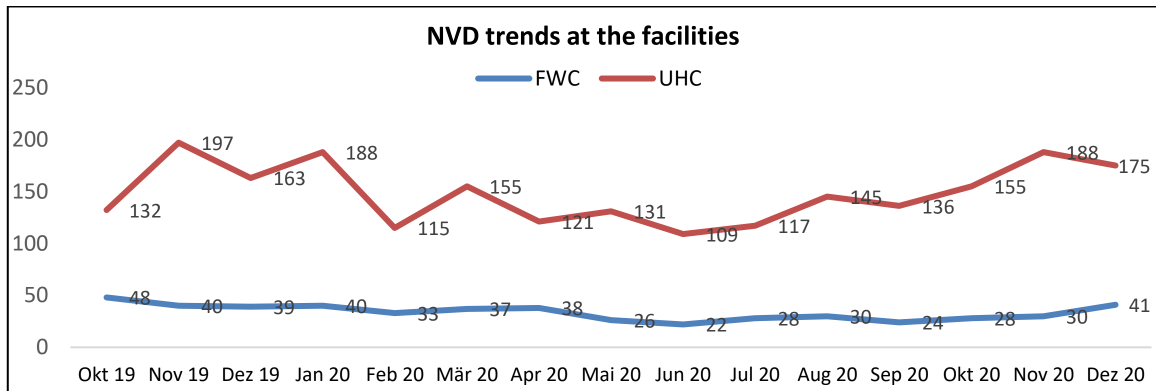


Figure 14: Trends in NVDs in the facilities

The lack of HR, specifically the gynaecologist-anaesthesiologist pair, but also the lack of skills to manage critical cases during delivery and subsequent referral and transfer delays to higher facilities like Rajshahi Medical College Hospital (RMCH) shows the failure of our health system to adopt appropriately to the crisis at hand. As long as the structured referral system is not institutionalized with a complete referral loop, properly trained HR (midwives) is not placed, and the bad practice of referring for profit remains, this adoption won't be completed. Through persistent advocacy on the issue on different platforms along with other stakeholders, the government has recently taken the initiative to restart the one-year basic Emergency Obstetric Care course for training anaesthesiologists to place them as the pair in the UHCs, to ensure CEmONC service availability throughout the PHC domain. One of the civil surgeons has even proposed to conduct elective caesarean cases at the UHC once in a week if the project can support with the fee for the anaesthetist.

In a very similar manner, through persistent advocacy, at nine of the UH&FWCs, the vacant key service provider FWV position has been filled in with skilled midwives, through a co-financing mechanism, involving the UP, FMC and DASCOH Foundation. Presently, the major portion (90%) is contributed from the project, but it is foreseen that in the upcoming period, through establishing a strong linkage with LGI, the FMC members will be able to gradually increase their financial contribution, which is likely to make the initiative sustainable.

Despite the pandemic, we found a good level of service utilization record during the reporting period. Even though the GoB initiated lockdowns and advised all to stay home, the health sector was specially advised to respond to the situation. By revising the original project and adding an additional budget line, DASCOH was able to complement and respond successfully by developing the IEC materials, providing training on PPE, supplying PPE along with cleaning and disinfection materials, installing hand washing stations, etc. to the HSPs at the health facilities within the project area, so that the health services could continue uninterrupted.

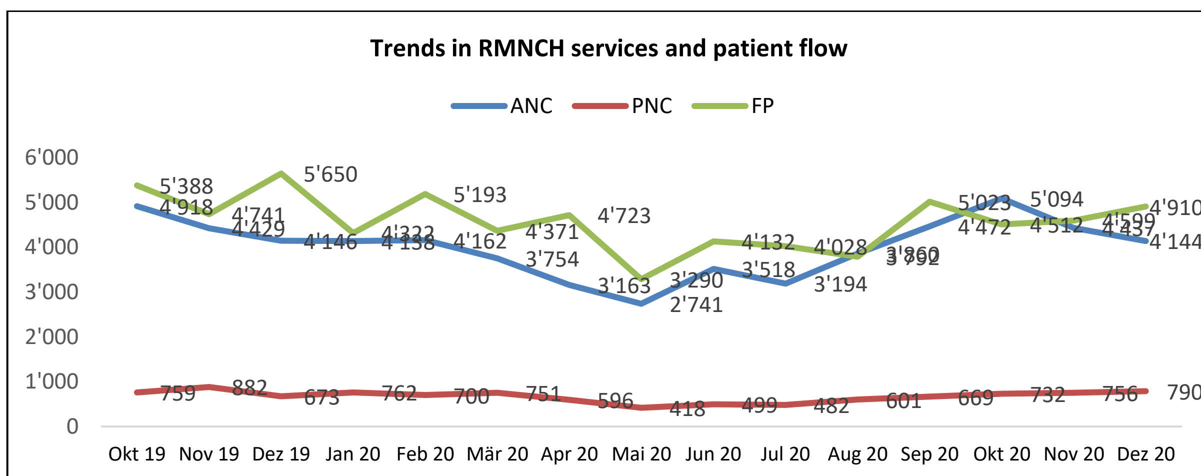


Figure 15: Trends in RMNCH services and patient flow

The above graph reveals that patients flow had a normative distribution, except from April to July, when the whole country was under strict lockdown. Care seeking for child health also shows a decline from March till September, after which it returns to the previous level. Throughout the year, PHIIR project staff have kept an open ear for any demands from the health service providers for IPC products like mask, sanitizers, etc. and has tried their best to supply them for safe continuation of all health services at the facility.

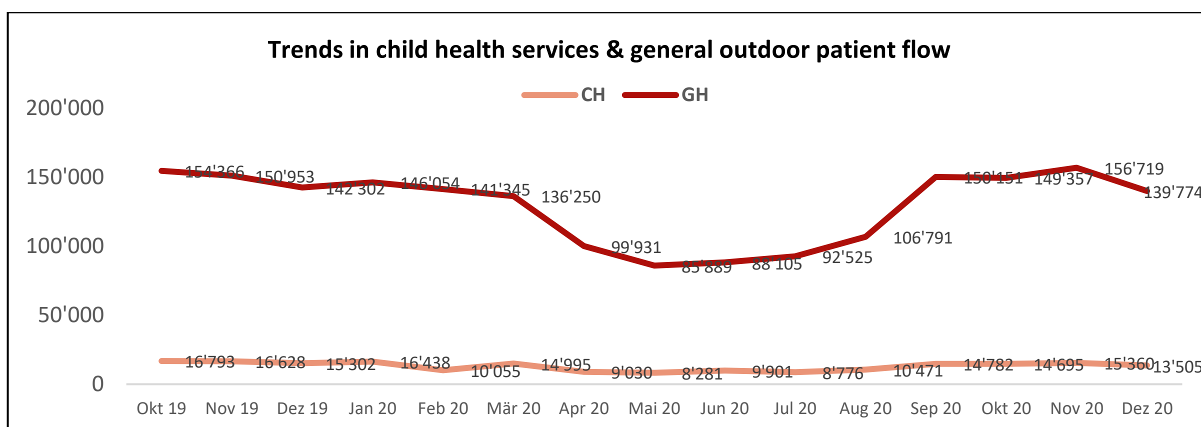


Figure 16: Trends in child health services & general outdoor patient flow

Orientation of HSPs and the community resource persons in updating referral registers at various health facilities was carried out before the pandemic. During the last quarter of 2020, an orientation on the structural referral guideline was given to HSP and FMC members at the newly added CCs and FWCs and private health facilities' HSPs, in order to realise the current referral practice by the HSPs and specific FMC of the facilities. In the reporting period, facility MIS shows all referrals were upwards, and out of the total referred, 75.6% cases were referred from CC, 20.8% were from UHC, and about 3.5% were from UH&FWC. Besides these, 116 pregnant women were referred by Community Volunteers (CV) also known as Community Resource Persons (CRP) for safe delivery services to appropriate health facilities. Program staffs also discussed about the referral system in the bi-monthly meetings of the CV and encouraged them to refer whenever identified.

A database for pregnant women has been developed and is being regularly updated & shared among the FWA/HP, FPI, CHCP and CRPs and also followed up by the project staff. High-risk pregnant women are identified from this database and are kept on a more frequent mode of communication for their ANCs, while appropriate guidance is given, for their self-care. To enable data driven decision making for programmatic purposes, a consultant firm is being deployed to develop a comprehensive relational database and integrated information management system to support effective processing, storage and sharing of information through their webserver. The server for this has been chosen where the consultancy firm will develop and deploy project databases, DASCOH's webpage, email server and HR Admin functionalities.

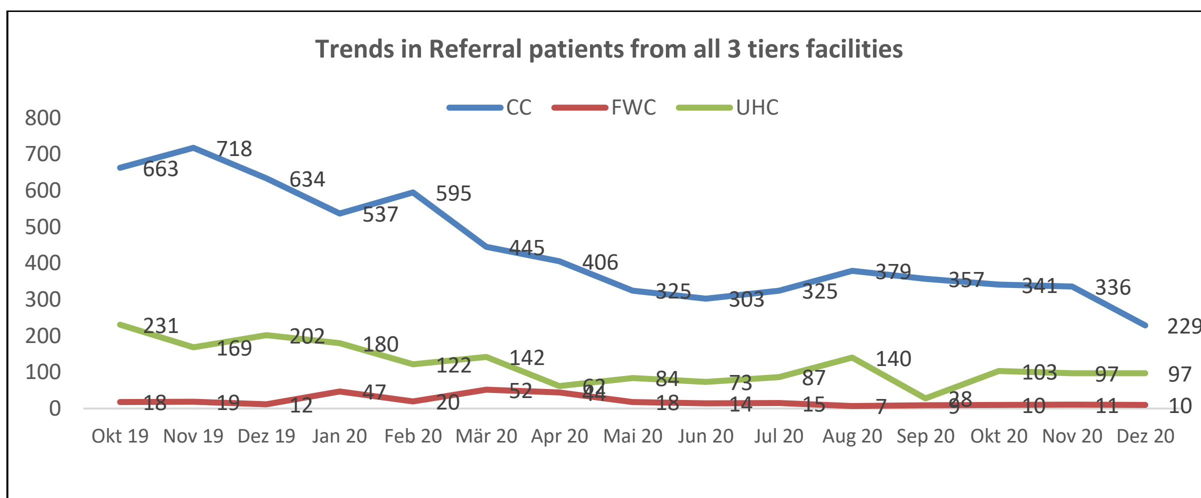


Figure 17: Trends in Referral patients from all 3 tiers facilities

This year, only six FWVs could be provided with the residential and hands-on training at the MCWC and Charghat UHC to improve their skills and confidence with safe delivery. The service agreement with BDRCS for the Basic First Aid training has been drafted and signed, and preparatory works are ongoing to roll out the training.

During the present phase, of the total 42 FWCs and 110 CCs, 15 FMC at Union level and 37 CG-CSGs at community level were formed, mentored and sensitised in local resource mobilisation for facility maintenance, mostly among the newly added facilities. Others were already completed in the previous phase. FMCs at the five UHCs were already present, and 4 of them were also reformed. In the reporting period, though the lockdown hampered the regularity of all types of meetings or public gatherings, program staffs communicated with the community elites, and were even able to organize some online meetings with FMC members of specific facilities (CC, UH&FWC, UHC) and volunteers to gear up the fund mobilization activities, as it was direly needed.

Within the reporting period, BDT 5,203,535 (approx. 54'000 CHF) was mobilized by the FMCs across the PHC system in Rajshahi and Naogaon. This includes funds collected through the FMCs and contributions from the LGIs. Most of these were in cash, along with contributions in-kind that include items like electrical fittings, solar panel, water tank, tubewell, submersible pump, boundary wall, nebulizer machine, etc. With annual plans completed in 29 of the 42 FWCs, FMCs will follow up with the UP to decide on the planned activities in the 2021 and whether more funds need to be leveraged or not.

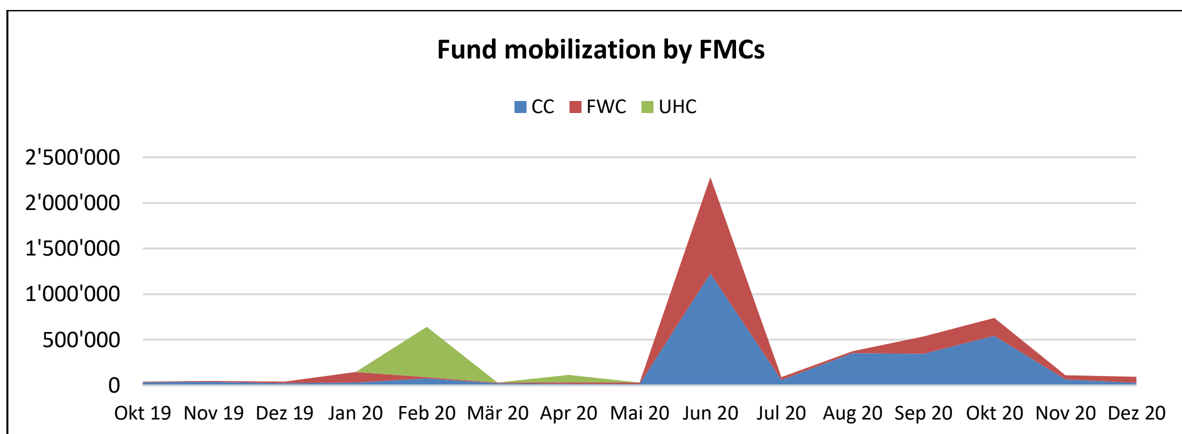


Figure 18: Trends in fund mobilization by FMCs at the facilities

HR mapping for all facilities shows gaps in positions that are crucial for MNCH services at various levels. The project also lays emphasis on recruiting these positions. The table below shows HR availability and gaps as identified through the mapping exercise.

Table 16: Availability of required HR at the facilities

Admin level	Facility type	Vital positions for MNCH services	Re-quired	Availa-ble	Gap
Upazila (5)	DGHS-UHC - 11 positions	Gynae. & Obs. (1)	5	1	80%
		Anesthesia (1)	5	0	100%
		Medical Officer (4)	20	20	0%
		Nurse (5)	25	25	0%
Union (42)	DGFP-UH&FWC (27) /DGHS-USC (15) - 2 posi-tions	SACMO - 1	42	33	21.4%
		FWV - 1	42	29	31%
Commu-nity (110)	CC - 3 positions	CHCP - 1	110	109	0.9%
		HA - 1	110	85	22.7%
		FWA - 1	110	80	27.3%

In summary, 53% (84/157) facilities have the required HR for optimal functionality and the rest does not. Though HR gaps are universal across the primary health care system in Bangladesh, the health system strengthening objectives cannot be achieved without having a sustainable solution for this omnipresent problem. Thus, in order to overcome HR constraints in the PHC domain, the project has developed a context-specific strategy for each PHC facility in consultation with the UPs and the FMC. Acknowledging that a “one size fits all” approach is not appropriate, the key principles underpinning the strategy are as follows:

a. All hiring to fulfil the gap in the FWV position will be done after due consultation and involvement of the government. The local health authorities, except for payment of salaries, will be involved at all stages of recruitment. The appointment letter will be jointly issued by the govt. and DASCOH.
b. The salary for each staff will be fixed in consultation with UP and FMC. It will not be a flat rate to be paid to all personnel recruited for a particular position. This has been decided following the request of UP as it is expected that during the project the UP-FMC contribution will gradually increase and that of the project will proportionately decrease so that eventually the entire salary is covered through UP and FMC resources.
c. The recruitments are being piloted in those facilities under those two Upazilas that have been prioritised under the “whole of Upazila approach.” The experience gathered thereby will inform the scaling up of the process to all other facilities.

Currently, at the UH&FWCs, out of 42 positions required for NVDs, only 29 HSPs are posted, while 13 posts are still vacant. DGFP has not approved the idea of engaging Community Skilled Birth Attendants (CSBA) instead, because they lack the necessary qualification and training. As an alternative, development partners and NGOs are encouraged to recruit FWVs or midwives. Through advocacy and a joint contribution mechanism, 10 positions have been filled with midwives as an interim solution (recruited jointly by DGFP, LGI and DASCOH). Following the strategic approach outlined above the rest of the positions will be filled up in the next quarter.

Within the Rajshahi region, monsoon flood is the key hazard in addition to recurrent drought due to failure of monsoon. Till now, 41 DRR plans has been developed among the 157 facilities. Implementing protective measures for the health facilities at risk was planned for this phase. 9 out of 10 UH&FWCs have already been assessed, estimated and renovated according to the plan, following small scale risk mitigation measures to protect facilities at risk of floods. A more systematic pursuit of enabling institutional preparedness for disaster management could not be realized in 2020.

Outcome 2: Quality of MNCH services at primary health care facilities is enhanced.

Survey results show that there has been a significant increase (28%) – from 8% to 36% - in the number of health personnel correctly following 80% of the standard treatment protocol. This can be directly attributed to the mentorship and supportive supervision efforts of the project. Mentoring visits were regularly undertaken by the POH and other technical staff. It is also reflected in the mild increase (3.2%) of mothers receiving appropriate advice within six weeks of PNC follow up. Community outreach activities by the community resource persons may have been able to address some of the heightened risk perceptions due to Covid–19 and have contributed to the increased number of facility visits for MNCH related care seeking. However, compared to baseline, there is an 8% decrease in the number of satisfied mothers receiving MNCH care services. We need to delve deeper to understand the factors behind this, probably the definition of satisfaction or expectation of services at a healthcare facility may have changed with the pandemic, of which we are not aware.

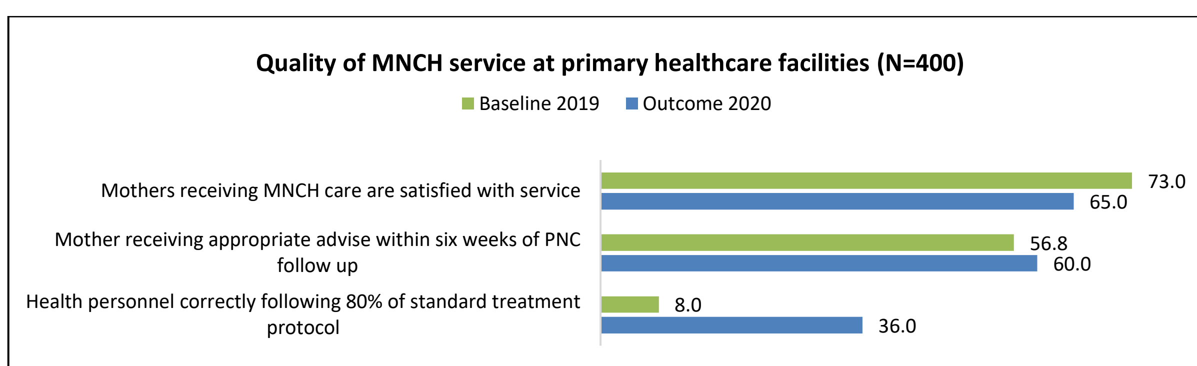


Figure 19: Quality of MNCH service at primary healthcare facilities

A range of capacity building trainings were developed and executed during the reporting period. Information on ANC, PNC, nutrition, IMCI, PPH and Eclampsia management, safe delivery, etc. were provided to the HSPs, community volunteers and private facility technical persons along with information on infection prevention and control and waste management at the health facilities. Due to the pandemic situation, most of the trainings have been reorganized into smaller batches, so that they can be completed under an adapted scenario. Furthermore, for the Covid-19 response, an orientation on COVID-19 Infection, prevention and control has also been developed following the government protocols, and was provided to the HSPs and the CRPs/CVs on the ground. In summary, 1,137 persons out of the targeted 1,202 were trained on 11 out of 11 planned training topics, described in the below table, by DASCOH experts.

Topic	# Facilities	# Participants	Area covered
Training of FMCs their roles and responsibilities at the UH&FWCs	CC - 10 UH&FWC-10	153 persons HSP- 35 (FWV, FPI, SACMO, AHI, HA, Pharmacist, FWA) FMC members-118 (Chairman, Members, cashiers)	Mostly from Baghmara upazila as priority, rest will be done in 2021
Orientation on develop and update a database of pregnant women register regularly	CC-55 UH&FWC-20 UHC-03	151 persons (FPI, FWA, CV, RHP, DDFP staff)	From Tanore, Charghat, and Porsha upazila. Trainings were completed in Baghmara and Sapahar in 2019.
Training of ANC, PNC & Nutrition for HSPs of CC and Private Health Facilities	CC – 44	84 persons (FWA, CHCP, SSN)	Baghmara and Sapahar upazila as priority, rest will be done in 2021
Hands on training for selected HSPs of public & private health facilities at the MCWC and FWVTI to improve their skill and confidence	UH&FWC-06	6 FWVs	6 new FWVs from Baghmara Sapahar and Tanore upazila

Training on TQM at UHC level	UHC - 01	36 persons (UH&FPO, MO, SSN, Midwife, MT-Lab, OA, SI, Statistician, MLSS, HA, Pharmacist, Support staff, Cleaner)	at Porsha UHC
Capacity building for budgeting and fund raising with financial management for HSPs and FMC at CC and FWC level	CC-10 UH&FWC-10	55 persons (Chairman and Secretary Cashier, CHCP, SACMO)	55 participants from the newly included facilities of Baghmara upazila, Tanore and Charghat will be done in 2021, whereas Porsha & Sapahar was done in 2019.
Orientation on structural referral guideline to the HSP and FMC at CC and FWC level and private health facilities	CC-10 UH&FWC-05 UHC-1	20 persons (SACMO, FWV, CHCP, SSN)	20 participants from the newly included facilities at Charghat upazila in 2020, Tanore will be covered in 2021, others provided in phase II.
Basic Training of Resource Pool /Community Volunteer (RP/CV) member on MHCH and nutrition	UH&FWC -42	117 RP/CV	117 community volunteers from Tanore, Charghat, Baghmara, Porsha and Sapahar upazila.
Training on IPC and waste management for HSPs at Union and upazila level and private health facilities	UH&FWC- 11	24 persons (SACMO, FWV, Aya,)	24 participants from Baghmara upazila, rest of the facilities will be covered in 2021.
Orientation on COVID-19 Infection Prevention and control for HSPs, CV & PVT.	CC – 110 UH&FWC-42 UHC-05	491 persons (SACMO, FWV, FPI, AHI FWA, CHCP, HA, SSN, Midwife, CV, Pharmacist)	From Baghmara, Sapahar, Porsha, Tanore, Charghat, upazila and private facilities
Virtual TOT for COVID-19 prevention	DASCOH Foundation's staff	19 persons (key selective staffs from all projects of DASCOH Foundation)	19 selected DASCOH staffs as a part of internal capacity building to combat on-going Covid-19

Mentorship and supervision have proven to be highly effective in improving real time capacity building at workplace of the HSPs, so that service quality following correct treatment protocols is consistently improved. The project invested quality time deploying technical experts in this respect. Though Covid-19 restrictions inhibited mentorship and supervision visits as planned for the year, 149 (60%) supervision and 148 (59%) mentorship visits were carried out of targeted 288 supervision and mentorship visits by project technical staff at both UH&FWC and UHC level during the reporting period. Deliveries happening at the facilities where there has been recent deployment of midwives are testament to this approach.

Picture 1: Mentor with newly deployed midwives with a new mom and her baby at Bashupara

The project had plans to include the government officials of DGHS & DGFP while carrying out mentorship and supervision visits, but official restrictions did not allow them to join the team during the whole year. Hopefully, through further advocacy and with adequate safety measures, they will join in 2021.

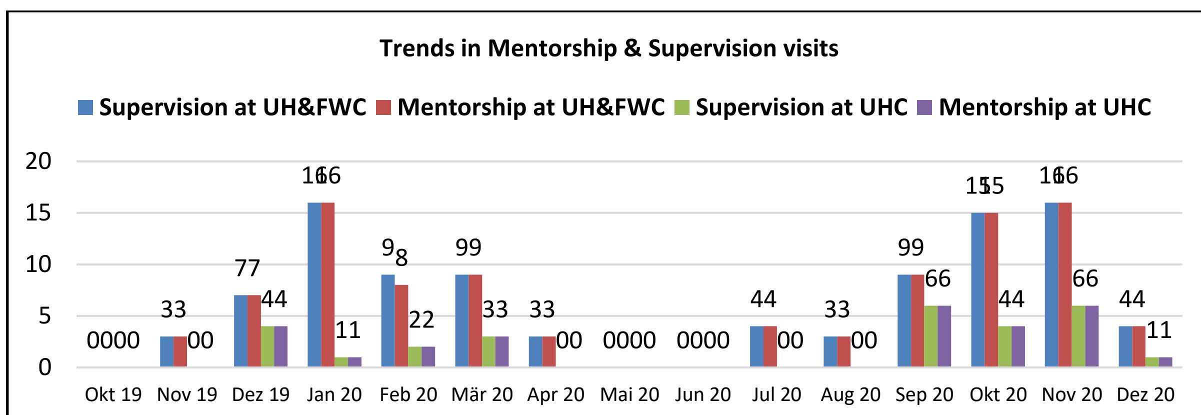


Figure 20: Trends in Mentorship and Supervision visits

To get an optimum quality of services at minimum cost through the constant motivation and participation of the entire staff of each facility, one of the first interventions of the project was to implement the 5S-Kaizen-CQI-TQM process. The 5S-Kaizen-CQI-TQM is an approach to improve hospital management with limited resources. The steps involve a) Application of 5S (Sort, Set, Shine, Standardize and Sustain) for improvement of working environment; b) Continuous Quality Improvement (CQI) or KAIZEN activities for evidence-based participatory problem solving at the workplace for continuous quality improvement; and c) TQM (total quality management) to make optimal use of capacity of the entire organization. The process is an innovative and well-acknowledged method across the world. Within the reporting period, a batch was trained at Porsha UHC with 36 health staffs. The participants were very enthusiastic in implementing the process. To ensure facility readiness, upgrading the facility infrastructure envisages not only improving the physical infrastructure but also ensuring equipment, logistics and essential supplies along with availability of job aids and education material. In order to sustain the improvements, adherence to TQM standards are necessary, otherwise facility readiness will be undermined.

The project carried out an assessment of structural repair and upgradation needs. The results were shared with govt. authorities and the UP, to leverage the former's approval for upgradation work and the latter's willingness to contribute financially. Subsequently, renovation activities were carried out at 9 FWC out of targeted 10. . TQM and other essential IEC-BCC material was printed and supplied at the field level. Alongside these, some of the other facilities have also initiated the process. However, these could not be completed before the onset of Covid-19. Capacity enhancement training for these activities will be carried out next year. The table below shows the status of implementation till now.

Picture 1: Sorting day at Porsha UHC, led by UH&FPO

Table 3: Implementation status of 5S-Kaizen-CQI-TQM

Facility level	Indicators for 5S change	Achievement till Dec'2020
Community Clinics	2S: sort, set in order	53/110 achieved 2S
Union level facilities	3S: sort, set in order, shine	22/42 achieved 3S
Upazila Health Complex	5S: sort, set in order, shine, standardise and sustain	3/5 achieved 5S

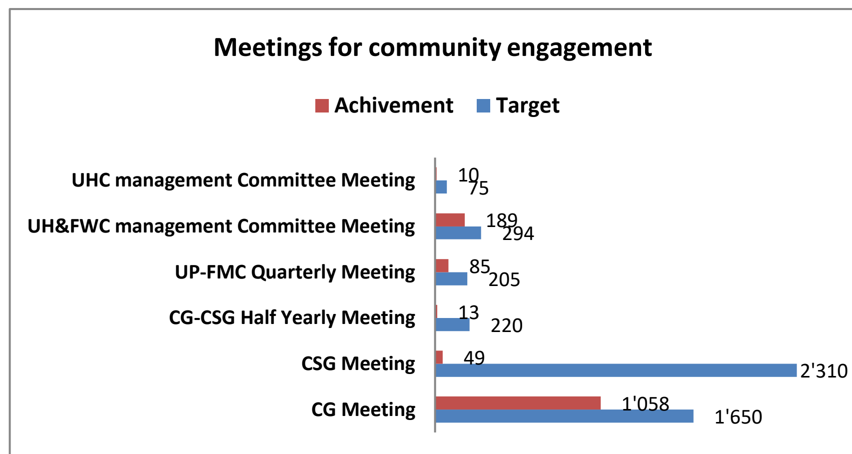
Most of the planned meetings with the LGIs and FMCs to raise their awareness regarding mutual functional assignment and the necessity to support each other for fostering accountability of HSPs could not happen this year. Two Open Forum Discussions were held in Baghmara and Sapahar Upazila, with the presence of the respective Upazila chairmen, Union chairmen (who are by default members of the Upazila Parishad), Union Parishad members (who are by default FMC member) along with govt. officials (like the UHFPO, UFPO and the UNO), and the service providers from the union level facilities in these Upazilas. These were very successful events, where all the bottlenecks (shortage in HR, logistics, repair/renovation necessity, etc.) of successful service delivery were presented by both the Union chairmen and the HSPs. In response, a couple of key decisions were publicly declared by the Upazila chairman himself, who was presiding over the program. Several decisions regarding HR and logistics were also given by the attending health and family planning officials. Even the UNO informed all present about the availability of some resources that might be leveraged for the upkeep and renovation of the facilities.

Picture 2: UNO addressing the Open Forum discussion at Baghmara

During the very last quarter of 2020, the UHC management committees were able to organise 11 meetings. In one of these, the local Member of Parliament also participated, and it was very well covered by the local media (http://www.bssnews.net/?p=506231). All management committee meetings witnessed good participation of women. Apart from these meetings, 26 simple service analysis visits were completed in accordance with the Union facility management guidelines at the UH&FWCs to provide guidance for improvement in the service quality. The main outcome from the analysis was the lack in HR hampering service provision at the facility.

Picture 3: Local MP addressing the UHC management committee

Within the reporting period, 1’404 (29%) meetings for community engagement took place out of the totally planned target of 4,754 meetings. 16’690 (19%) persons out of 86’318 of the FMC members participated in a M/F ratio of 58:42, which in itself is a testament of the team’s success in community engagement.



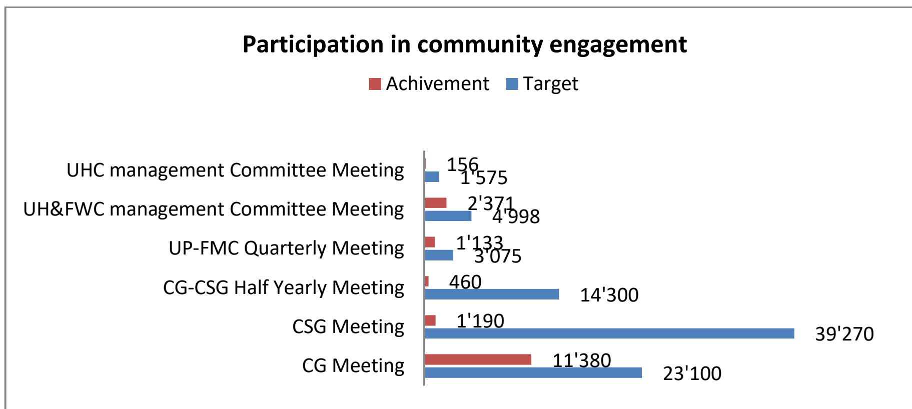
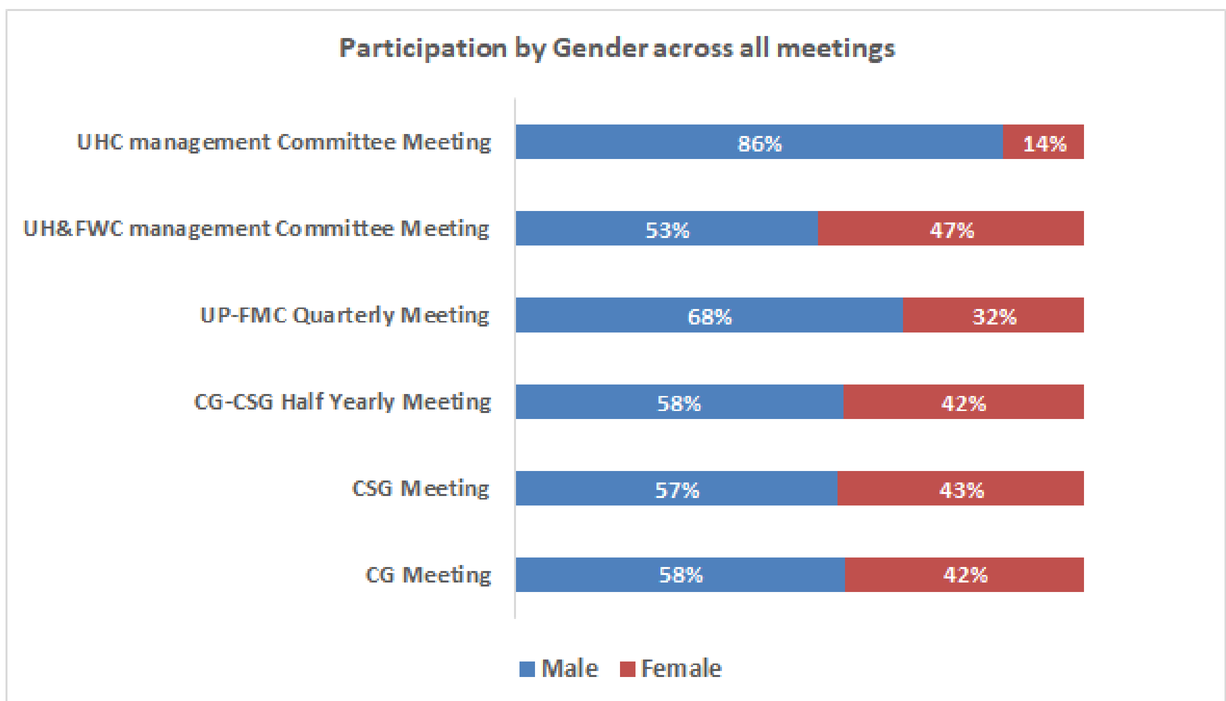


Figure 21: Participation in community engagement



Gender disaggregated data on the participants at various meetings is presented in the accompanying chart, which shows a M:F average of 63:37, which is promising. If the UHC is taken out of the equation, because of the presence of a higher cadre of service providers, this becomes even better, at 59:41.

Outcome 3: Improved health behaviour of community regarding MNCH

The Annual outcome survey results show that during the reporting period, the percentage of women knowing about neonatal danger signs increased from 63% in the baseline to 78% and the percentage of infants under 6 months of age having received only breast milk on the previous day has increased from 71.6% in the baseline to 84%. Both of these indicators show progress during the reporting period. This can be attributed to a few key interventions, some of which were implemented before the pandemic, like supply of IEC materials, posters, enhanced capacity of the HSPs through trainings, advocacy and awareness raising against Covid-19. For the pregnant mothers, such information was shared through phone calls during the pandemic.

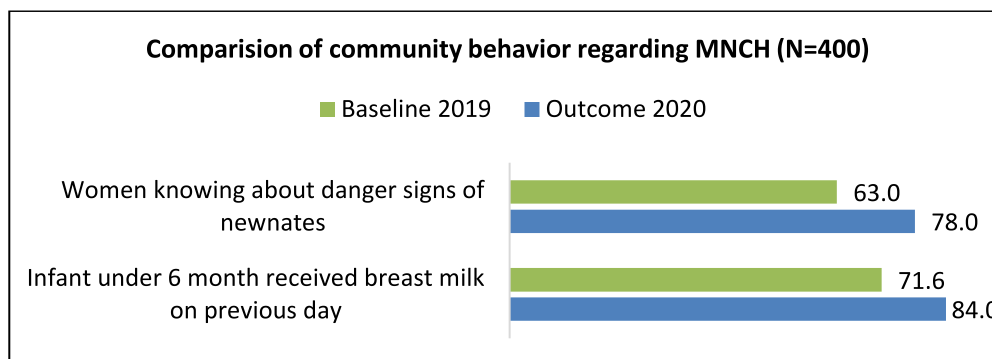


Figure 22: Comparison of community behaviour regarding MNCH

In addition to encouraging eligible women to seek ante/neo/post-natal care and supporting pregnant women in having a birth preparedness plan, the orientation involves enabling them to identify risky pregnancies followed by timely referral of complicated cases (eclampsia, PPH and abortion) to appropriate health facilities. During the reporting period, 203 health education sessions with 2'146 participants were conducted by 126 CRPs to sensitise and disseminate information on RMNCH and nutrition. These sessions follow the FWAs satellite sessions (courtyard session) with the mothers, where the CRPs or CVs communicate with the eligible women in the area, inform and invite them for the session. The FWA uses IEC materials like flipcharts and posters to orient, educate and promote different key health messages along with help of the CRP.

With the outbreak of Covid-19, the CRPs were also given an orientation in awareness generation and risk communication on Covid-19 (see also below). Presently, the CRPs are engaged in making pregnant mothers aware of Covid-19 prevention and protection measures through direct calls. Though the number of total ANC and PNC visits have increased, along with registrations, spouses are still not accompanying them to the facility. At baseline, this was around 49.5%, now it's even lower now with only 41% spouses accompanying pregnant women to the facilities, which might be attributed to the Covid scenario.

Activities planned under this output include targeted interventions for adolescents through School Health Program and fathers of adolescent girls through Father's club. Two concept notes were elaborated and shared for rolling out their engagement: one on School health and one on Father's clubs. For the school health component, in each of the 41 unions, 3 CRP or CV were selected through a rigorous process and were awaiting their orientation training when the pandemic struck. These interventions are being rolled out by the 126 CRPs. With the lockdown, everything was halted. For the school sessions, 123 high schools in 41 union (three schools per union) have been selected where through peer education modality under the guidance of three selected teachers adolescent girls will be oriented in relevant adolescent health topics once the schools reopen. 34 fathers' clubs were formed in the 41 Unions, to bring the traditional decision makers in our persistent patriarchal society into focus. In these clubs, the fathers are oriented on their supporting roles and responsibilities as both father and spouse: as a father to prevent early marriage, support their girls' education. As a spouse, how to act on the imperatives of having a birth preparedness plan, estimating the cost for delivery, arranging necessary finances, identifying a safe delivery facility, a focal medical person, identifying ways to reach the facility, arranging for transportation, etc.

To increase the project's impact through mass media dissemination and encourage more people to join our efforts, an arrangement has been made with Bangladesh Sangbad Sangstha (bssnews.net), the national news agency of Bangladesh, for publication of our intervention activities and success stories in both Bangla and English. Publication will be in the national and local electronic and daily newspaper regularly, which will influence the engagement of public servants like the Union and Upazila Chairman and even the local health authorities. Here are links to some of the recent activities, portrayed by the media; http://www.bssnews.net/?p=515326; http://www.bssnews.net/?p=512233; https://thebangladeshtoday.com/?p=28467. This media coverage is also shared through both DASCOH Foundation's Facebook page (https://www.facebook.com/DascohFoundation/) and a WhatsApp group, which is also very encouraging for all staff.

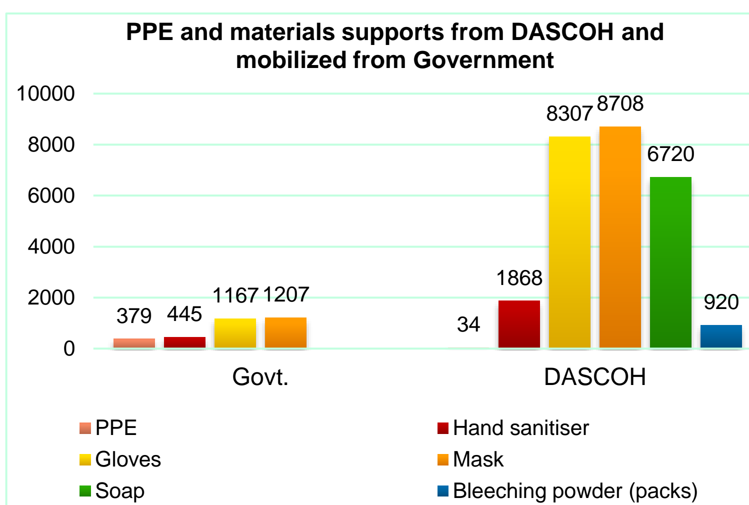
COVID-19 response activities

Outcome (4): The Covid-19 impact is minimised through addressing the health and subsistence needs of the target population

SRC-DASCOH's health programming is continuing its contribution to health system strengthening in five Upazilas of two districts. Thereby, at least in the program area, primary health care services are not de-prioritised in the wake of the pandemic and the risk communication strategies help people to prevent and protect themselves against Covid–19 and in overcoming the fear of infection while seeking health care services. Given the trust and credibility that the SRC-DASCOH partnership has acquired due to years of working together, the local health authorities and LGI (UP) expected SRC-DASCOH's support in addressing the particular health system challenges that have arisen following the outbreak of Covid-19. This has resulted in intensification of risk communication support on Covid-19 and ensuring that the primary health care centres in the project area emerge as key players with strong and targeted project support. It is of utmost importance that these centres are kept functional while exercising protection and safety (IPC) needed, for both the health service providers and the client population. The M&E team from DASCOH foundation contributed by sharing daily updates collated from all validated media sources and shared it during online meetings with local authorities during the routine online (skype/zoom) calls.

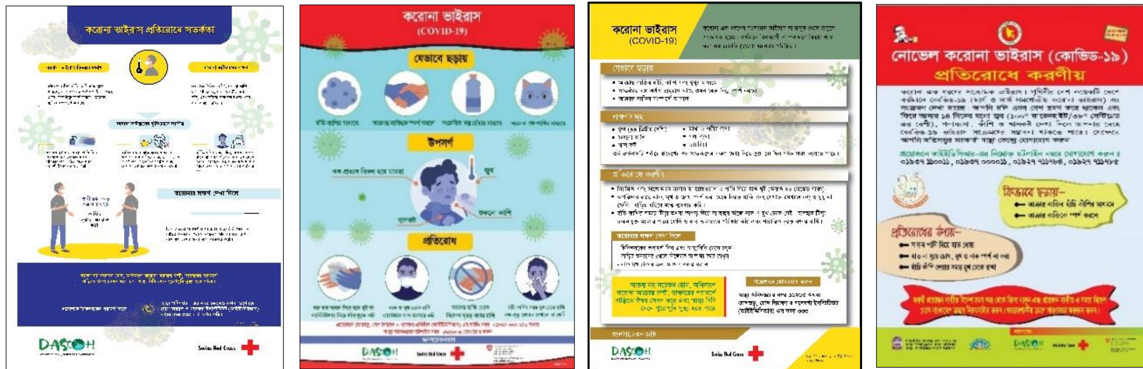
The PHIIR project has responded to government calls for support: besides ensuring basic services (water supply, hand washing station, orientation on Covid-19 IPC), protection from infection (through the use of PPEs) and disinfection at the health facilities, community volunteers engaged with the programme have been involved in raising community awareness on Covid-19 preparedness and prevention.

Following the first level of COVID response support, a more detailed Covid–19 response plan was developed and resources from the ongoing long-term PHIIR programme were redirected to implement the response plan. This included increased support of DASCOH in sensitising people on Covid-19 protection, prevention, symptoms, and treatment. All HSPs in the project facilities received an adequate number of PPEs and disinfection materials.
Efforts were made to increase compliance with Covid-19 protection measures at the health facility by motivating clients to wear masks and to maintain social distance. The social mobilisation approach was strengthened to create ownership where FMC members extended their support with essential preventive materials and setting up a permanent hand washing station at facility premises.



The program is already working on ensuring facility readiness. However, facility readiness plans had to be linked to ensuring safety and protection of HSPs and community people and mitigating the risks of widespread infections. Mass awareness on Covid–19 was undertaken through miking, the development and dissemination of BCC – IEC material on Covid–19, while capacities were built on infection, prevention and control. 491 people, comprising SACMO, FWV, FPI, FWA, CHCP, HA, SSN, Midwife and CV were oriented in IPC measures before being involved in raising community awareness on Covid-19 preparedness and prevention. The program distributed 330 posters and 15'200 leaflets for distribution in the community to deepen awareness. The entire project team was closely involved with Covid-19 preparedness and response activities at facility and community level. Some of the Covid-19 centred activities undertaken by the project are depicted below with some pictures/figures/illustrations.

a. *Development and dissemination of BCC-IEC materials like posters, leaflets*



b. *Need based and demand responsive provisioning of PPEs for the HSPs, CVs & community people.*

c. *Need assessment and installation of hand washing stations at all health facilities.*

d. *Dissemination of Covid-19 awareness and prevention messages amongst HSPs, Facility Management Committee members, and UP members through mobile SMS*

e. *Community sensitisation on Covid-19 risks, prevention, and awareness through community volunteers*

f. *Remote counselling of pregnant women over phone, especially those with approaching expected date of delivery (EDD). These were further advised on pregnancy care and birth preparedness plan keeping the Covid-19 challenges in mind*

g. *Mentoring of health service providers (HSPs) in appropriate Infection Prevention and Control (IPC) measures and its application to ensure continuance of MNCH services under Covid-19 conditions*

h. *Linkage building with private sector facilities for MNCH services especially for institutional deliveries while advocating for normal deliveries in all possible cases*

i. Ongoing monitoring of Covid-19 situation in the project area to guide response plan and actions

Table 4: Status of hand washing stations at the facilities

Health Facilities by type	*Target facility*	*Achievements*
Community Clinic (CC)	*110*	*102*
Union Health & Family Welfare Center / Union Sub centre (UH&FWC)	*42*	*40*
Upazila Health Complex (UHC)	*5*	*3*
Total	***157***	***145***

Initially 102 CC and 40 UH&FWCs got temporary hand washing devices and the 3 UHCs at Baghmara, Tanore and Charghat got 3 permanent hand washing stations in the instant response period. Later on, in the second stage, 60 permanent hand-washing stations have been set up at 36 CC & 24 UH&FWC/USC level, while 65 are under process of construction. The rest of the facilities did not need hand-washing facilities as they were already installed by LGI. Through these resource mobilization activities, community engagement for better facility maintenance and upkeep has improved. Compliance with Covid-19 protection measures is increasing, as health facility clients wear masks at all times, wash their hands while entering into the health facilities and maintain physical distance during receiving health advice from service providers.

3.2.2 440511, Integrated Water Resource Management (IWRM), Phase II

The IWRM project seeks to ensure equitable and adequate access of citizens to water resources in the High Barind area by implementing IWRM measures in compliance with the Bangladesh Water Act 2013 (BWA) and Bangladesh Water Rules (BWR). The realisation of outcome 1 involves fostering the LGI-Citizen dialogue leading to the design and implementation of relevant IWRM schemes following the 4R principles of reducing groundwater extraction, reusing water, recycling and restoring water safety. Steps were taken to institutionalize IWRM processes by encouraging LGIs to integrate 4R aligned water schemes into their annual planning and budgeting process. Additionally, at citizen and LGI level, the project intends to improve water management practices that are rule compliant and adhere to IWRM principles. Outcome 2 envisions the establishment of decentralized IWRM committees and their capacitation to fulfill their regulatory functions. Through WARPO, outcome 3 foresees necessary initiatives like groundwater modelling in Barind and PRA exercises to create a techno-social basis for understanding the challenges linked to water scarcity and potential measures to overcome them. The outcome also relies hugely on appropriate information flow to all levels of decision making, including the LGIs, IWRM committees, government ministries and line departments engaged with water sector, and other non-state actors so that the results of these exercises drive water management and water governance centred decision making.

In 2020, the project reported quite good progress against Outcome 1. A number of water schemes were planned, implemented, and co-financed by the project, users and LGIs – thus bridging the participatory engagement despite the constraints of the pandemic. Initiatives were taken to expand drinking water supply among the under-privileged communities to ensure access to safe drinking water, a fundamental right recognized by the BWA. Concerning Outcome 2, that hinges on enabling LGIs to take Bangladesh Water Rules compliant decisions on water governance and management and strengthening decentralized IWRM activities, the gains during the reporting period were limited: capacity building exercises, the key strategy to attain this outcome, were severely impacted due to Covid–19 restrictions on movement and collective gathering. However, although some critical progress was made towards the end of the year (last quarter), the overall progress continues to be quite unsatisfactory as it is critically dependent on WARPO's support and presence in the region. This could not be realized due to the impact of Covid–19 on government functioning. Nevertheless, foundations have been laid by WARPO during the reporting period to accelerate its engagement with the sub-national component.

In light of WARPO's approved TAPP and following SDC's acceptance of WARPO's request for SRC-DASCOH's monitoring and dissemination support in carrying out the PRA and hydrological investigation in the three districts Rajshahi, Chapai Nawabganj and Naogaon, the logical framework and action plan

was jointly reviewed by SRC-DASCOH and WARPO that led to following changes, which were approved by SDC in May 2020:

- Though Outcome 3 remains unchanged, the focus shifts to improving/ strengthening the information flow for the purpose of proper implementation of the BWR and the Union Parishad guidelines instead of seeking expert directives on improved information flow through a reformed set up of the NWRD. Thus, output 3.1 and 3.2 have been adapted accordingly while output 3.3 has become completely irrelevant.
- DASCOH and SRC will extend monitoring support to WARPO in conducting PRA and groundwater assessment. These assignments will be outsourced to expert organizations through a competitive bidding process. In addition, SRC-DASCOH with support from WARPO shall be responsible for disseminating the findings of the PRA and hydrological investigation with all relevant stakeholders in the Barind region. These are new activities that were not envisaged either in the Project Document or in the Budget.
- WARPO will conduct PRA and hydrological investigation in all 25 Upazilas of 3 districts while the sub-national component is operating in only 8 Upazilas of 3 districts. Therefore, the sub-national component will have to adapt its HR to extend facilitation and monitoring support for the assessment exercises.
- In few cases, outcome and output level indicators have been adapted to establish better alignment with the respective outcome and outputs.
- The changes in the Logical Framework inevitably required a review and adjustment of activities so that they are relevant and better aligned to respective outcome and outputs. This in turn had budgetary implications leading to re-allocation of resources to finance the modified outputs and activities. The addition of new activities – SRC-DASCOH's monitoring support for PRA and hydrological investigation followed by dissemination of results – further necessitated a budget review.
- Another issue that will require resolution is the varying timeline of the national and sub-national components. The modified duration of the national component covers the period from January 2020 to June 2023 (as per approved TAPP), while the project duration for the sub-national component remains that from July 2018 to June 2022.

To mitigate the impact of Covid-19 in the project area, SDC decided to review the plan of action and annual budget to ascertain the funds that could be potentially under-utilised given the suspension of project activities during the lockdown period so that these could be re-directed to support Covid-19 response. Thus, a Covid-19 response project was planned and completed during the first half of 2020. It entailed cash grants for the most disadvantaged people along with ensuring protection of staff, volunteers and LGIs. At the same time, a mass sensitisation strategy for Covid–19 was also developed that included wide dissemination of IEC materials.

Finally, a study on the citizen feedback system namely "community score cards (CSCs) study" was conducted – aiming at capturing community perception on the services by LGIs and IWRM project in the study area. The community score card rated services like IWRM schemes and their alignment with 4R principles, O&M of built water resource assets, gender sensitivity of LGIs, participation in ward and budget meetings, stakeholder communication, and the impact or its absence of project in augmenting livelihood opportunities leading to improved socio-economic conditions. The CSC study identified a few gaps in the water governance services and set strategies to minimize these gaps.

Outcome 1: Citizens' and LGIs effectively participate in IWRM processes to ensure increased availability of water

Achievements in 2020 were comparatively lower than what was planned for 2020, largely due to Covid–19 containment measures. During the reporting period, the project co-financed 171 water schemes aligned to the 4R principle (Table 1) and ensured the water rights of 33'289 citizens of which 26'307 (79%) are disadvantaged. Among them 16'845 are male and 16'444 are female. For drinking water supply, 40 schemes were implemented that involved extension of 2'973 metres of water pipeline that directly benefitted 8'368 disadvantaged; among them 4'158 are male and 4'210 are female. The co-financing of schemes involved 14% community contribution, 7% LGIs' annual budget contribution, and 79% project grants. The domestic water rights ensured to 284'410 beneficiary so far out of 405'000 disadvantaged

people (70%) as targeted. The percentage of UPs allocating funds increased in last 3 years to implement IWRM plans (62%, 72% and 92% UPs allocated fund in 2018, 2019 and 2020 respectively). The WRMC representation at the Union IWRM committees has largely increased in the last couple of years (90% and 97% in 2019 and 2020 respectively comparing to no representation in 2018).

To enhance the understanding and practising of the BWR, the project launched a sensitisation drive covering LGIs, government stakeholders, and the wider community. A total of 4'831 citizens were sensitized on BWR of which 3'009 were male and 1'822 female with an addition of 169 government stakeholders who are members of Union and Upazila IWRM committees. Community participation was ensured by representation in 97% Union IWRM committees which was 90% in the previous year. Last year 88% LGIs adopted WRMC's water resources plans which was 83% in previous year. The UPs addressed 169 reported compliance issues on water resources.in 2020.

Table 1: Direct beneficiaries of water interventions implemented during January to December 2020

Water Use	Water Intervention	Total Number	Direct beneficiary	Male	Female	Activity code	Remarks
Drinking water schemes (groundwater)	Submersible pump with overhead tank	24	3'499	1'716	1'783	1.2.5	
	Only submersible pump	7	969	496	473		
	Submersible pump with pipeline network	4	716	362	354		Overhead tank by LGI
	Only overhead tank	2	210	112	98		Submersible pump by LGI
	Only pipeline network	3	2'974	1'472	1'502		Length 2'973 m
Surface water schemes	Canal re-excavation with check dam	1	661	320	341	1.3.6	37.7 ha
	Check dam repair	1	579	285	294		39.4 ha
	Only stair case for pond	3	691	341	350		
	Pond re-excavation with stair case	59	16'382	8'410	7'972		6.0 ha
	Surface water irrigation schemes	4	5'406	2'722	2'684		52.1 ha
Improved irrigation and crop diversification	Alternate wetting and drying (AWD) irrigation schemes for rice	2	336	165	171		21.7 ha
	Incentives to fruit/vegetable gardening	9	290	139	151		1.6 ha
	Incentives to cotton cultivation in rice field	1	23	11	12		1.1 ha
Other interventions	Tube-well platform construction	44	553	294	259	1.2.6	
	Groundwater table monitoring well	7	0	0	0	1.2.2	4 new boring
All schemes		**171**	**33'289**	**16'845**	**16'444**		**159.6 ha**

Table 2: Indicators and criteria of evaluating community score card study

Indicators	Criteria of evaluation
WRMC's regular meeting	Hold regular meeting? Resolution of meetings? Presence and active participation of all members? Follow up of decisions? Active community volunteer? No conflict between members?
WRMC's planning	Participation of all members? Participation of women members? All participants informed about maps and plan? Women members' opinions valued? Are community's demand reflected? Prioritization of demand? Are all water sources are included in the map? Community well informed about the map? Regular updating of water sources in the map?
WRMC's 4R implementation	Schemes based on 4R principle? Implemented schemes from own funding? Implemented schemes from other source of funding? Implemented schemes from contribution of funding? Are all beneficiaries making the financial contribution? Are women's opinions considered? Community's demand met?
O&M of schemes	O&M by community? Repaired by community? O&M by both male and female? Trying to register as a cooperative society?

Indicators	Criteria of evaluation
	Transparent O&M? Do Bank account exists? Skilled operator/caretaker? All informed about income-expenditure of scheme? Planning for O&M?
Conflict resolution	No conflict between members? Are Women's opinion considered? Schemes are woman, child, handicap, and elderly-friendly? No discrimination? Immediately conflict resolution?
LGI's gender sensitivity	Women's participation in planning and implementation of schemes? Is Participation of wider of community ensured? Are women's opinion valued? Water schemes are women-friendly? No discriminations? Women's involvement in O&M of schemes?
Participation in budget and ward meetings	Participation of both male and female ensured Are demands for water services presented ? Women's opinion valued Community demand reflected
LGI's stakeholder coordination	Relation with stakeholders BMDA, DPHE, MP and NGOs Technical and financial support for schemes from stakeholders? Stakeholders informed about WRMCs? Communication through CV or other members of WRMCs?
Communication with LGI	Regular communication with LGIs? Expected response from LGI members? Are women's opinion valued? Community demand met by LGIs? Prioritization of schemes done?
Income generating activities	Income generation through schemes? Employment generation through schemes? Is food security ensured through schemes? No conflict? How schemes impact livelihoods of women headed family?

During the reporting period, a citizen feedback system has been initiated through a community score card (CSC) by conducting a perception study at all 1'272 WRMCs for assessment, planning, monitoring, and evaluation of water governance services by LGIs and WRMCs. In these sessions, non-WRMC members also participated to obtain a wider community perception on the various topics. The tool has been used to assess the functioning of LGIs and WRMCs and their acceptance by citizens using ten indicators, with detailed criteria as shown in Table 2. Each indicator was given a score between 1 (very bad) and 5 (very good). The CSC study revealed citizens' perception of the IWRM project and LGIs as service providers (Figure 2). Citizens' feedback clearly shows that there is scope for improvement in the practice / application of 4R principles, operation and maintenance of water schemes and assets, gender sensitivity of LGIs, participation in ward and budget meetings, and stakeholder communication. Of particular interest is that the contribution of water schemes in augmenting income generation opportunities and creating jobs was rated rather poorly with 50% of the WRMCs reporting negligible impact of IWRM schemes on job and income opportunities. A set of strategies have been taken into consideration to improve the situation.

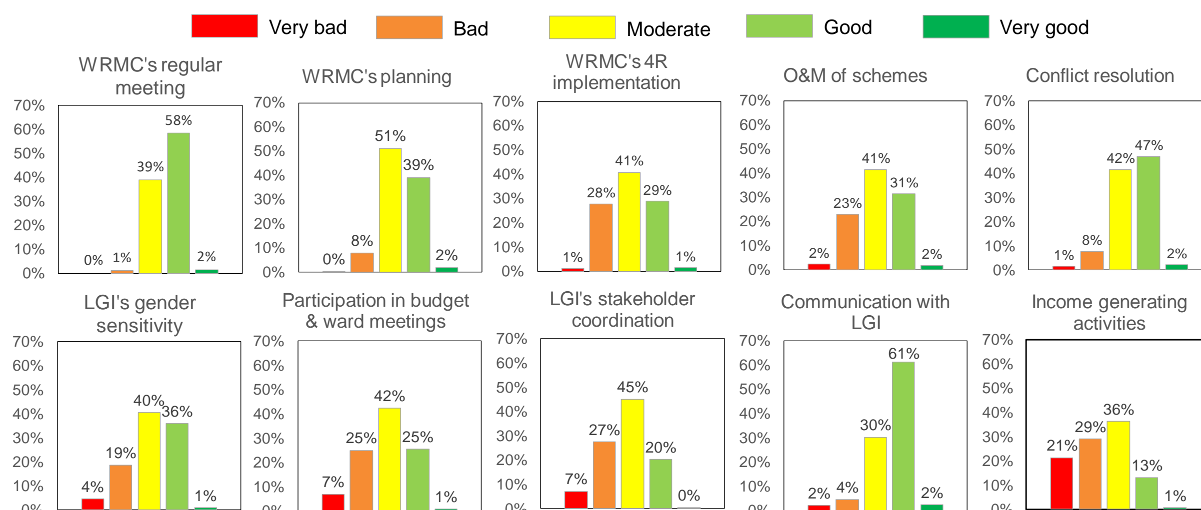


Figure 2: Community score card describing governance status of LGIs and WRMCs (*n* = 1'272 WRMCs)

To monitor the groundwater status of the project area, seven monitoring stations were modernized with automatic groundwater monitoring sensors during the reporting period. These sensors are logging hourly groundwater levels in the High Barind area where depleting ground water levels are a serious concern. In the MAR (Managed Aquifer Recharge) scoping report in Bangladesh, the IWRM project was documented as the only project piloting MAR in the Barind area. The MAR Scoping Report was prepared as per the initiative taken of the National Steering Board (NSB) of the Bangladesh Water Multi-Stakeholder Partnership (BWMSP) to develop a MAR strategy for sustainable management of water resources that is both safe and effective. SRC-DASCOH provided support for the preparation of the MAR scoping report including facilitation of community consultations. Other than in Barind area, MAR has been piloted in two other areas of Bangladesh: one in Dhaka City by Dhaka WASA, IWM, BUET, WaterAid and Dhaka University, the other in the coastal areas of Khulna by Dhaka University, DPHE and UNICEF. These pilots provide substantial evidence for both augmenting water quantity and enhancing water quality. Based on these pilots, the scoping report recommends that MAR should be adopted as a management tool where groundwater is either being depleted due to overexploitation or unsuitable for use due to poor quality.

Outcome 2: Functional decentralized IWRM committees address regional water resource issues

IWRM II aims at decentralizing WARPO offices in the field (at Rajshahi) to pilot the implementation of the BWR 2018 and promote physical IWRM interventions such as water saving, groundwater recharging and surface water irrigation through LGIs, concerned line departments and IWRM committees in the High Barind region. As part of the piloting, WARPO has just started formalities of establishing a district level office at the divisional headquarter in Rajshahi with necessary logistical support including office space, administrative support, and transportation with assistance of SRC-DASCOH. All the required bidding process has been completed. WARPO Rajshahi divisional office is planned to start in February 2021. The Ministry of Water Resources sent a formal letter to BWDB at all divisional headquarters to allocate space for WARPO office in their premises. The learnings and experiences of IWRM project in Barind area would be replicated in another 54 districts as per TAPP submitted by WARPO to Planning Commission of GoB.

IWRM Rajshahi district committee has started functioning based on the direction of the BWR, 2018. Two scheme proposals of water interventions (canal re-excavation and check dam construction for surface water retention) have been submitted to the district IWRM committee for approval by Mohonpur and Deopara Union Parishad as the budget of proposed schemes is more than 2 million BDT. The Member Secretary of the committee is reviewing the proposal and has scheduled a site visit as part of the review process. In the project area, all 39 Union IWRM Committees have been formed. All union IWRM committees have been oriented in their Terms of Reference as per BWR 2018. One or two meetings have been organised per committee. Major discussion points of the meetings include: (i) approval process of the schemes; (ii) role of the technical committees including how to conduct feasibility analysis before approving a scheme; and (iii) WARPO's engagement in the field to accelerate the implementation of IWRM principles and practices while ensuring adherence to regulatory requirements set in the BWR. One of the major challenges identified is that all government staff position is not available at the Union and

Upazila levels although the participation of government staff in the Union IWRM committees has increased from 53% in 2019 (target 25%) to 60% in 2020 (target 50%).

Outcome 3: Improved policy framework supports information flow and participatory water resource planning

BWR, 2018 and the IWRM Guidelines 2020 are in place. The LGIs at local level took various resolutions for implementing the schemes in adherence to the 4R principles. The Ministry of Water Resources is directly involved with the activities of WARPO for formulating policies, plans, strategies, guidelines, instructions and acts, rules, regulations, etc. relating to the development and management of water resources. LGIs have formulated their annual water management plans as per the feedback by the citizens (WRMC representatives) in their annual budget meetings. Following the singing of a tripartite agreement between SDC, WARPO, and SRC-DASCOH, the first tripartite meeting took place in November 2020 in Rajshahi. This meeting allowed all parties to discuss challenges and opportunities for cooperation in implementing BWR, 2018. The key decisions at the tripartite meeting included: (i) WARPO will issue a letter authorising SRC – DASCOH to form District and Upazila IWRM committees in the project area; (ii) WARPO will issue a letter to NILG to incorporate BWR and Guidelines in their training manual; and (iii) WARPO seeks support from SRC-DASCOH for office setup at Rajshahi. Discussions were held also to explore if SDC could further fund the implementation of the BWR Bangladesh Delta Plan 2100 in other districts of Bangladesh. The annual planning workshop held in December 2020 at Bandarban decided on collective involvement of all partners in the groundwater assessment process at the Barind areas from planning to implementation, monitoring and evaluation. The purpose of this annual planning workshop was to share learnings, experience, challenges, and opportunities of the sub-national component with SDC and WARPO and to solicit their expert advice on overcoming some of the challenges especially in the domain of IWRM committee formation and the absence of a harmonised policy in the water sector where some of the earlier policies were in conflict with the provisions of BWR. The workshop supported WARPO in developing a detailed annual action plan, which was then used to develop an integrated working plan for the national and sub-national component that can be used to coordinate the implementation of both components in 2021.

WARPO, on the other hand, has started all the necessary formalities of doing a PRA and a baseline study of the state of water resources in all 25 Upazilas of the three districts (Rajshahi, Chapai Nawabganj and Naogaon) of Barind area. The PRA exercise will establish the baseline of water resources in the study area, capture the present water use scenario, and map sectoral water demand up to Union/Mouza[15] level of the High Barind region. It will also identify the current location and status of observation/monitoring wells and irrigation borehole logs for each Mouza of the study area. The study will establish baseline conditions of demography, natural resources, land use and farming systems, agricultural practices and their constraints and opportunities, incorporate people's needs and demand for water availability, and water use in the study area through people's participation and associated consultation process at local level with PRA approach. The sub-national component will provide monitoring support to 25 Upazilas and support to validate the PRA report at Upazila level for each Upazila. WARPO has started working on the second component that will involve hydrological investigation and modelling of surface and groundwater resources. The investigation will collect hydrological, meteorological, hydro-geological, morphological, cross section of the major rivers and their tributaries/distributaries, elevation, groundwater level, water quality, aquifer properties and other necessary data as required. It will examine the present water use scenario; sectoral water demand and groundwater recharge mechanism in the study area based on the collected secondary data. In order to address data gaps, groundwater-monitoring wells will be installed wherever necessary and older wells will be restored.

The NILG training manual is used to train the local government representatives and officials in fulfilling their functional assignment. It elaborates on the Union Parishad Act, 2009 and the attendant rules which is used to train and orient LGI representatives in their overall mandate and attendant roles and responsibilities. It seeks to promote good governance by LGIs at all levels. NILG under the Ministry of Local Government is responsible for carrying out countrywide trainings based on their manual containing all essential information for the elected representatives of the local government to make full use of the information system. This manual includes a description of the system functions and capabilities, contingencies and alternate modes of operation, and systematic procedures for system access and use. The

[15] A mouza is a type of administrative district, corresponding to a specific land area within which there may be one or more settlements (source: Wikipedia)

IWRM project has an activity to include water scheme preparation process based on the direction of BWR, 2018 in the training manual of NILG. The inter-ministerial secretariat meeting has decided to incorporate BWR, 2018 in NILG training manual proposed by WARPO.

Covid-19 emergency support to disadvantaged people, staff, volunteers, and LGI functionaries

In addition to the three outcomes of the project, a Covid-19 response has been implemented during the reporting period. With the spread of Covid-19, the GoB announced containment measures that led to the complete suspension of project activities. While anticipating that suspension of project activities will lead to underspending of annual budget, SRC decided to re-direct these funds to support a Covid-19 response. Consequently, the annual plan of operation and budget was reviewed to identify annual budget funds that were likely to be unutilized in 2020. Based on the outcome of this exercise, a Covid-19 response proposal was submitted to SDC that eventually approved multipurpose cash grants to 3'900 families with each family receiving a one-time payment of BDT 2'000.
Following SDC's guidance on disadvantaged people, the project initiated a beneficiary selection process that resulted in the selection of 100 families in each of the 39 Unions. The beneficiary selection process was led by Community Volunteers. Thereafter, the project staff carried out a beneficiary validation exercise to check compliance with the agreed criteria of disadvantaged families. As a result of this, almost 40% of the families that were initially selected by the CVs were replaced by more deserving families in compliance with the agreed beneficiary selection criteria. The CVs found it difficult to resist the pressures of UP Chairman who for political reasons influenced the beneficiary selection process. However, this was corrected following a thorough due diligence by senior DASCOH and SRC staff. The beneficiaries received cash grants through the General Post Office and mobile cash transfers using Bkash.

Additionally, SRC-DASCOH mounted a widespread sensitisation campaign on Covid-19 preparedness, protection, and safety. A total of 175'310 citizens benefitted from the campaign; 41 permanent handwashing stations were installed at all LGI premises. All 39 UPs were provided with hygiene kits, hand sanitizers, and materials for disinfection. 11'200 reusable masks and 13'200 leaflets were distributed in the project area. Public information systems were strengthened by placing billboards, banners, and posters at Union and Upazila offices. These contained awareness and protection messages of the GoB and WHO. DASCOH, besides orienting community volunteers in Covid-19 preparedness and protection, supported UP in dissemination of awareness messages using mobile device. Guidelines were developed for facilitating interface between volunteers, the UP chairmen, and community members while respecting protection norms. A Covid-19 awareness video has been developed, shared, and posted on social media to which more than 100'000 views recorded.

3.3 Relief + Recovery projects implemented by BDRCS

3.3.1 440518, Primary and Environmental Health in Ukhiya

This project aims at improving the health status in five camps and one host community union in Cox's Bazar district. The aim is achieved through establishing and operating five Primary Healthcare Centers at camps (four are currently functioning) and two Solid Waste Management systems (one currently functioning), one in camps and one for the host population. These initiatives are interlinked with awareness raising initiatives on health and the environment in the working areas. Overall, the activities reach 101'676 persons in camps and 32'000 in the host population, either directly or indirectly.

When the COVID-19 pandemic started in 2020, the situation was initially highly volatile and uncertain with a sense of urgency for preparedness action. The first case in Bangladesh was recorded on 08 March 2020, in Cox's Bazar district on 23 March 2020 and in camp areas on 14 May 2020. In a first phase, until June 2020 and in camps until August 2020, case numbers increased, followed by stabilization and later a decrease in case numbers, while testing remained at rather low levels.[16] Overall, the primary health impact of the pandemic was less pronounced in camps and host communities than initially estimated. Especially in camps, this can be exemplified by low respiratory symptom prevalence, extremely low testing positivity rates and the general mortality rate not being beyond the average of the previous year. The secondary health impact is still difficult to estimate but is likely more strongly pronounced due to lower

[16] See details on COVID-19 in Bangladesh, host communities and camps her: WHO/Health Sector COVID-19 Dashboard

service seeking in the first months of the pandemic. In addition, the economic impact has been quite substantial in host and camp communities. 93% of households in host communities reported a diminished income due to the pandemic.[17] A separate COVID-19 preparedness and response project (440521) was implemented by BDRCS-SRC in the same area, of which the details can be found in a separate report. In the report at hand, we deliberately try not to elaborate on all the COVID-19 related details and the pandemic's impact on the project area and activities.

To contain the pandemic, the Government of Bangladesh (GoB) declared general holidays in June and July 2020. In camps, the Refugee Relief and Repatriation Commissioner (RRRC) only permitted essential and later critical services since April and May 2020, respectively. Although emergency services, such as the health and SWM activities planned under this project, continued to be permitted, the associated movement restrictions delayed and complicated procurements and construction works under this project. Furthermore, a 14-day quarantine policy upon entrance to Cox's Bazar district, imposed by the District Administration, complicated necessary movements as well as possibility of staff to go on leave outside the district. Overall, these restrictions had a negative impact on planning predictability and meeting implementation targets of BDRCS and SRC.

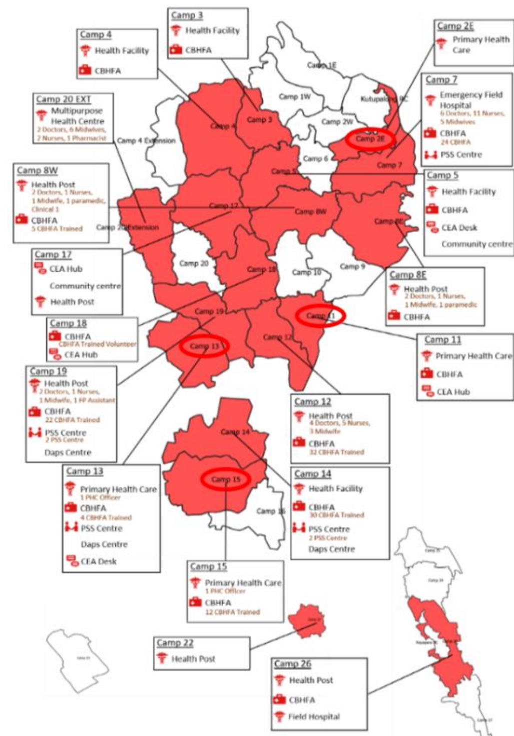
The COVID-19 initiatives by BDRCS and IFRC Population Movement Operation (PMO) used most of the HR capacities of the teams. Under the Country Plan of Action (CPoA) for Bangladesh, IFRC decided to open two Isolation and Treatment Centers (ITCs), one being co-financed by the SRC (under project 440521). The task of setting up and operationalizing these centers utilized all capacities within the BDRCS health team and SRC hence decided to prioritize the respective COVID-19 initiatives.

During this period, SRC decided to continue running health, Solid Waste Management (SWM) and outreach components under this project at pre-COVID-19 levels, i.e. neither expanding to new areas nor starting new activities. The PHCs in camps 11, 13 and 15 continued their operations, the fourth center in camp 2E was transitioned into an Isolation & Treatment Center (ITC) under the separate COVID-19 project (440521), whereas the construction works for the fifth facility was postponed due to the restrictions. SWM in camp areas was not expanded as had been planned. The SWM initiative in Palongkhali Union, of which the planning process had started in March 2020, together with the UNDP and their implementing partners, was halted until July 2020. In August 2020 the discussions on SWM in Palongkhali were taken up again and an expansion in camps was undertaken. The camp 2E facility was transitioned back into a PHC in October 2020 due to less than expected need and the land selection and technical assessment process for the fifth PHC facility commenced. Overall, the period since August 2020 can be marked as a phase where BDRCS-SRC continued launching and scaling new activities at pre-crisis levels.

Regardless of COVID-19, the Cox's Bazar context remains volatile. Different government initiatives, such as fencing around the camp areas (officially for security reasons) and relocation to the Bhasan Char remained salient issues with unclear future outcomes. Since October 2020, the parameter fencing disabled access to our SWM facility (Material Recovery Facility, MRF) in camp 15 and we are cooperating with BRAC to use their waste facility nearby. The road access to the PHC in camp 11 was disabled, which is making emergency referrals from the facility challenging. On top of that, the tension between guest and host communities have intensified. As several studies show, the pandemic had a more severe negative economic impact on the host population than the camp population.[18] Separate cash distribution initiatives for the host population are underway to mitigate the economic impact.

Please find the BDRCS-SRC working areas marked with red circles hereafter:

[17] The 2020 UN Joint Multi-Sector Needs Assessment (J-MSNA) exemplifies this, for example.
[18] The 2020 UN Joint Multi-Sector Needs Assessment (J-MSNA) exemplifies this, for example.



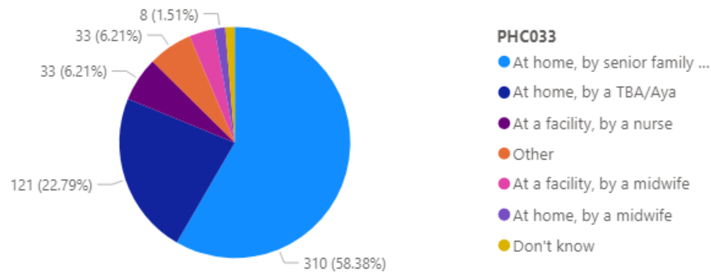
Outcome 1: Improved access of guest and host community to health and protection services

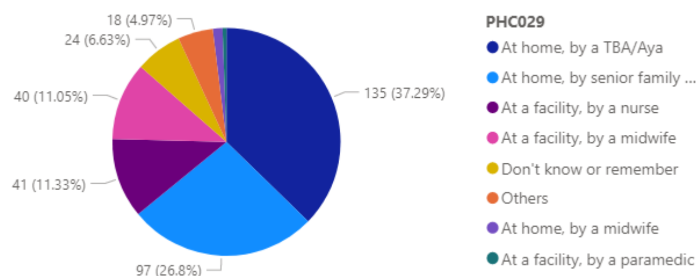
During the reporting period, the access to health and protection services in camps 11, 13 and 15 has increased. 24% of births were attended by skilled personnel (by a nurse or midwife), out of which 22% were conducted at health facilities and 2% at home.[19] This is an increase from 13% of births attended by skilled personnel. A strong emphasis of the BDRCS and Hope Foundation outreach teams on safe motherhood contributed to this increase, as communities were informed about the advantages of conducting births at a health facility. This was complemented by activities of other community health workers in a vein to increase safe deliveries. Further, 64% of women of reproductive age or their partner are currently using contraceptives, an increase from 42%, reaching the project's target. 64% of survey respondents reported they had been referred within the PHC already in the past (at least once). On the other hand, the PHC MIS shows that 48% of registered patients use multiple services, and hence were referred internally. It also shows that only 2% of patients at the BDRCS-SRC PHCs were referred to a higher facility. However, when survey responders were asked if they had been referred to a higher facility before, 6% of survey respondents said yes. The cause for this discrepancy may be not all referrals being adequately captured by the PHC MIS or a low number of referrals during the period August – December 2020, which was used for calculating the % of external referrals according to the MIS.[20]

The following graphs show the place of delivery and who attended deliveries. More graphs on the outcome indicators can be found in the annex.

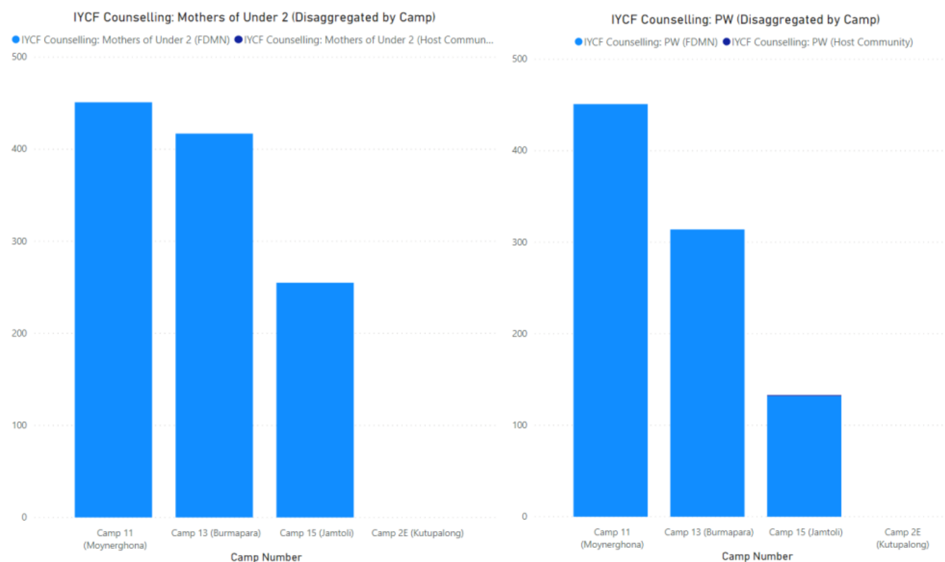
[19] Nurse: BSc in Nursing, 4 years bachelor's course, with on-the-job training continuation at district hospital, covering all health facility wards or thematic areas. / Midwife: Diploma in Midwifery, 3 years diploma course, done in midwifery institutes, led by midwives, who might have had similar training like the SSN, but later their career was mostly in the OBGN wards, thus becoming specialist midwives. / TBA: Traditional Birth Attendants have no formal training or affiliation with any institutes, mostly comprised of elderly women, who have learned some of the skills necessary for conducting delivery at home, and whom the government has tried to bring into the mainstream through promoting them as helpers for the midwives in the lower-level health facilities. / Aya: Ayas are maids without any formal training supporting the delivery process.

[20] In the previous PHC MIS (up to July 2020) not sufficient data was available to calculate the % of external referrals.





Since the beginning of this project, the PHCs at camps 11, 13 and 15 served on average 111 patients per opening day. The average was slightly reduced from 117 in the last half yearly report. The planned initiatives to increase patient flow and bring it closer to the targeted 200 patients per operating day could not be achieved due to the pandemic, which had a negative effect on patient flow. Since the beginning of the project, on average 7.7 NVDs were conducted per PHC per month. Close coordination with IOM, which is responsible for most medicine and consumable supplies, led to no stock-out at the centres during the reporting period.



Graph XX: achievements by RTM-I since starting their services in October 2020

The PHCs in camps 11, 13 and 15 continued to deliver a variety of services during 2020. While palliative care services were piloted by IOM and Fasiuddin Khan Research Foundation (FKRF), they were stopped due to funding constraints of the IOM. Research, Training and Management International (RTM-I) initiated Infant and Young Child Feeding (IYCF) services. The focus is IYCF and breastfeeding counselling for pregnant and lactating mothers or caregivers of under 2 children. Counselling is mostly done for women attending an ANC or PNC service. Hence, RTM-I closely collaborates with Hope

Foundation. The counselling is complemented by single and group demonstration sessions. In the previous graph the achievements by RTM-I since starting their services in October 2020 can be seen.

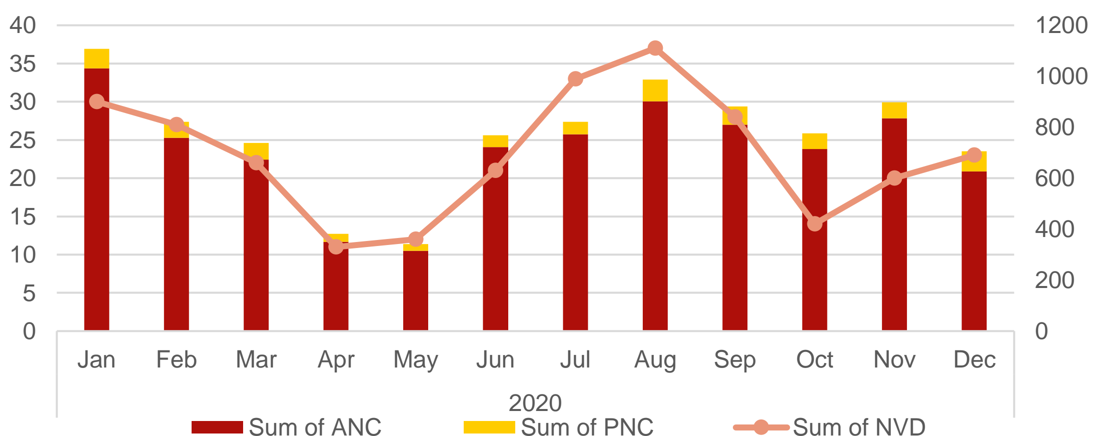
Furthermore, negotiations with Fred Hollows Foundation to extend eye care from PHCs in camps 11 and 13 to PHCs in camps 15 and 2E (and later 6) were almost concluded at the time of writing this report. More on partnerships can be found in the partnership chapter.

The PHC in camp 2E was completed in April 2020 and operated as a COVID-19 Isolation & Treatment Center (ITC) up to September 2020 (see separate report on project 440521). From October 2020, it was transitioned back into a PHC with a COVID-19 component consisting of screening at entrance and at a flu corner, short-term isolation, sample collection and referral to other ITCs. The 2E facility will not only be equipped with a 24/7 maternal health department, but also a 24/7 In-Patient Department (IPD), thus ensuring the centre is in line with the "Minimum Package of Essential Health Services for Primary Healthcare Facilities in the FDMN/Refugee Camps, Cox's Bazar, February 2020" (MPEHS) by the Health Sector and the MoHFW. Discussions with UNFPA concluded that it would be best to work directly with the International Rescue Committee (IRC) at the 2E facility. A formal partnership agreement, based on the MoU with the UNFPA, is being drafted and will be signed in January 2021. The IRC will operate the SRH department, while BDRCS and IRC will jointly operate the IPD. Eye health will be provided by Fred Hollows, Nutrition by ACF and the OPD by IOM and MoHFW.

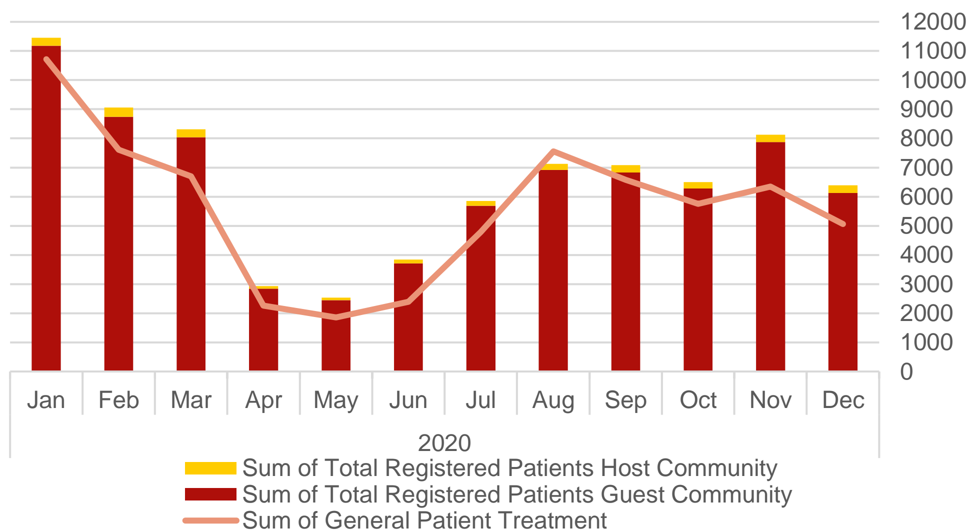
In the third quarter 2020, the need for a 5th PHC was thoroughly assessed through key informant interviews, the Health Sector gap assessment and facility visits and interviews to evaluate the occupancy rates and patient flow at existing 24/7 facilities. The assessment concluded that the need for an additional PHC was still given if it be equipped with a 24/7 IPD. The need in camp 6 was the highest, and hence this camp was selected for PHC construction. At the end of 2020, the procurement process was in its final stage and construction should start in February 2021. UNFPA partners, Fred Hollows Foundation and ACF committed to start providing services from April 2021. Unfortunately, the MoHFW through the IOM will not be able to support. However, first discussions with the IRC have shown they are interested in supporting the OPD and IPD as well as the SRH department. For the latter, a decision will be taken together with the UNFPA, as SRH falls under their domain.

While the COVID-19 pandemic initially had a negative effect on service seeking behaviour – as rumours spread about disappearance and forced isolation of patients with COVID-19 symptoms at health facilities – extensive COVID-19 outreach work was able to mitigate this and increase patient flow back to pre-COVID-19 levels. While Normal Vaginal Deliveries (NVDs), Ante- and Post Natal Care (ANC and PNC) services reached normal levels already in June 2020, total registered patients and services provided at the Out-patient Department (OPD) are stabilizing at a slightly lower level. It will be important in 2021 to continue with the regular outreach work while continuing with COVID-19 messaging. This should help in increasing patient numbers again.

Normal Vaginal Deliveries (left axis); Post-Natal Care Services and Ante-Natal Care Services (right axis) at PHCs in Camps 11, 13 and 15; Source: PHC MIS.



General Patient Treatment/OPD (right axis); Total Registered Patients Guest Community and Total Registered Patients Host Community (left axis) at PHCs in Camps 11, 13, 15; Source: PHC MIS.



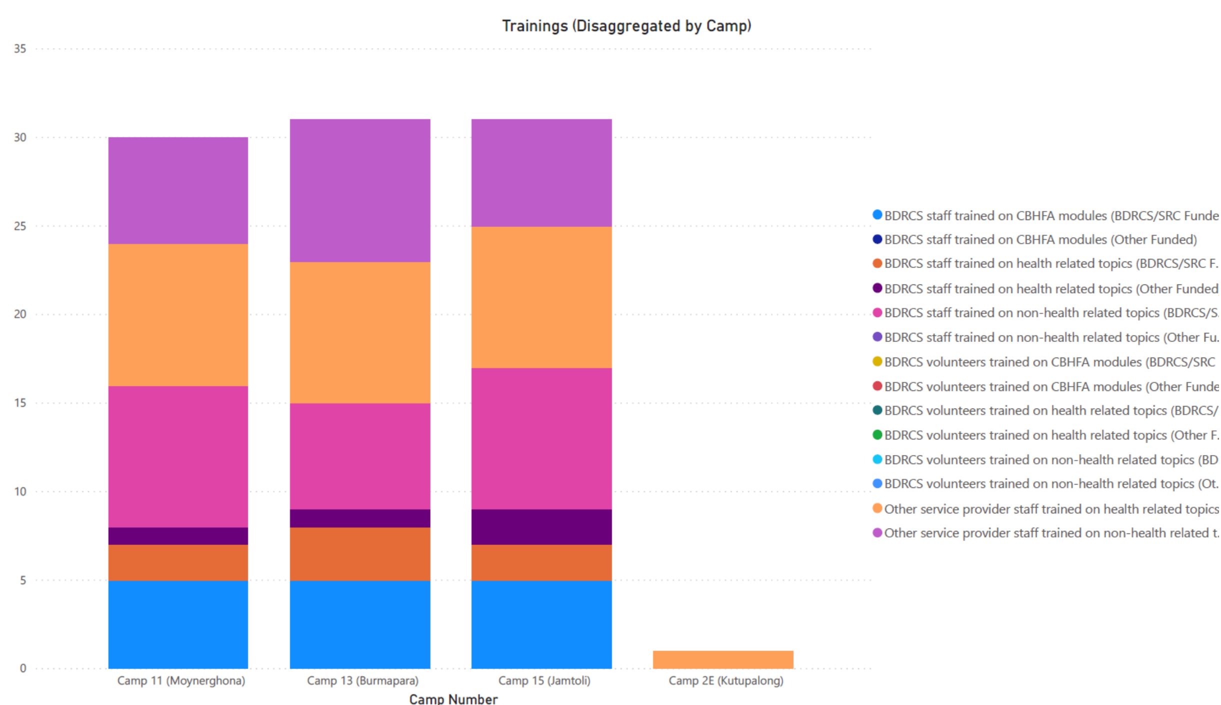
During the reporting period the Monitoring & Information System (MIS) was revised. The revision included a higher level of detail and disaggregation (e.g. age disaggregated patient data was added, referrals were differentiated in more categories, more details on nutrition services etc.) and reporting on indicators previously not covered (e.g. reporting on IYCF, outreach, meetings, trainings etc.). Since August 2020, weekly facility level data is submitted through Kobo and analysed with Power BI. Weekly reports that track the achievements are circulated internally and externally and support evidence-based decision making at all levels. While data accuracy is not given throughout, the reporting system will be continuously optimized as we proceed into 2021. Please find the report up to week 53/2020 as an annex, while some selected graphs are shown throughout this report. The annexed report contains graphs along all available service data at the PHCs.

In the first half of 2020, several Inspection Prevention and Control (IPC) trainings were undertaken by WHO accredited master facilitators (as reported under project 440521). Additional trainings in the first half of 2020 were not undertaken due to the COVID-19 pandemic. However, in the second half of 2020, the following trainings were implemented while upholding relevant COVID-19 guidelines:

- A training on EWARS, the reporting tool used by actors in the health sector in Cox's Bazar and DHIS-2 reporting, the District Health Information System used to collect nationwide health data (September 2020, 1 day). The training targeted all BDRCS PMO staff form various health facilities responsible for reporting and included the following:
    - Overview of existing reporting system- DHIS-2, EWARDS, 4W-Health
    - Reporting process
    - Review- different types of EWARDS report
    - Demonstration
- The training on CEA and Protection, Gender and Inclusion (PGI) (in October 2020, 3 days) targeted health facility staff, both BDRCS and from other service providers, from the 3 SRC-BDRCS health facilities:
    - Complaints and feedback mechanism at BDRCS PMO
    - SBCC (Social & Behavioural Change Communication) and general communication skills
    - Rumours in community
    - Beneficiary accountability and RCRC code of conduct
    - Next steps to integrate CEA in programming
    - PGI (Protection, Gender, Inclusion)
    - DAPS approach
    - SGBV (Sexual and Gender-based violence)
    - PSEA (Protection from Sexual Exploitation and Abuse) and child protection
    - Referral pathway at camps

- Nutrition Identification, Prevention, Management and Referral Practices (in November, 2 days) targeted health facility staff, both BDRCS and from other service providers, from the 3 SRC-BDRCS health facilities:
    - Basic concept on food and nutrition
    - Definition, type, cause and consequence of malnutrition
    - Community-based management of acute malnutrition
    - Management of SAM and MAM and treatment protocol
    - IYCF (Infant and Young Child Feeding) interventions
    - COVID-19 health precaution and prevention

In addition, a CBHFA refresher training was conducted. Further details of this training are listed under output 3.1 below. All trainings were conducted for BDRCS and non-BDRCS staff working at the PHCs, while some Cox's Bazar level staff of BDRCS and SRC participated too. Training attendance since August 2020 for PHC level staff can be seen in the graph hereafter:



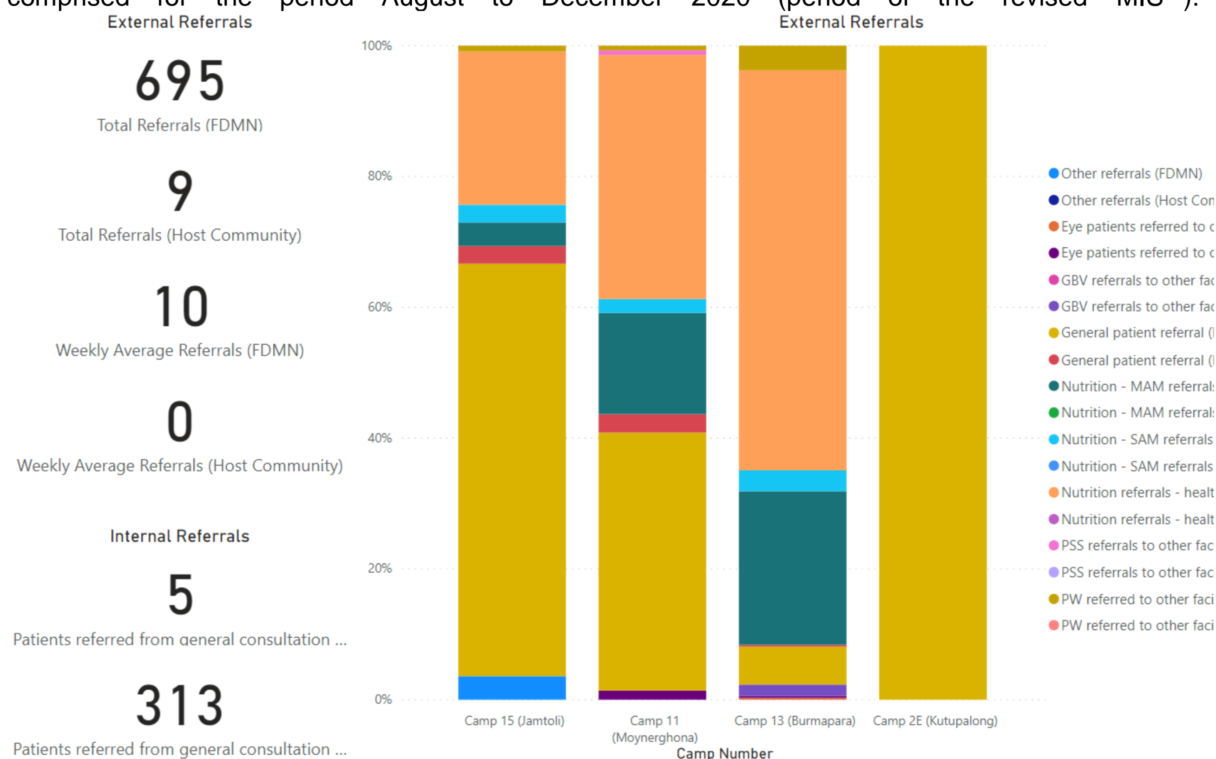
The graph shows that since August 2020[21], 92 BDRCS and non-BDRCS staff or volunteers were trained. Opening many trainings to attendance of non-BDRCS staff showed to be effective and appreciated by the partners. Since April 2019, 151 healthcare staff were trained (cumulative figure without Volunteers), thus being only 49 short of the set goal of 200 staff trained.

All pregnant women were referred safely and in due time (88). Around 12,3% of deliveries, which might have led to a complication, were referred to a secondary facility.[22] 447 eye patients were referred to Baitush Sharaf Hospital for further inspection since the beginning of this project. While on average 7 severely malnourished children per month were referred to a therapeutic feeding centre (total 146), the figure is below the target of 10 malnourished children being referred to feeding centres. On average, 8.5 persons use PHC transportation, which is still slightly below the target of 10.

[21] Most of the graphs in this report are shown for the period August until December 2020. The reasons are that the MIS was completely revised and amended with additional information, and hence it was not possible to combine most indicators of the old with the new MIS. Furthermore, many activities were halted in the first half of 2020 and the main achievements were made in the second half. Hence, the graphs still give a rather good overview over what was achieved. Whenever there were noteworthy achievements in the first half of 2020, this is specified in the text. The logframe reports includes achievements over the complete project period.

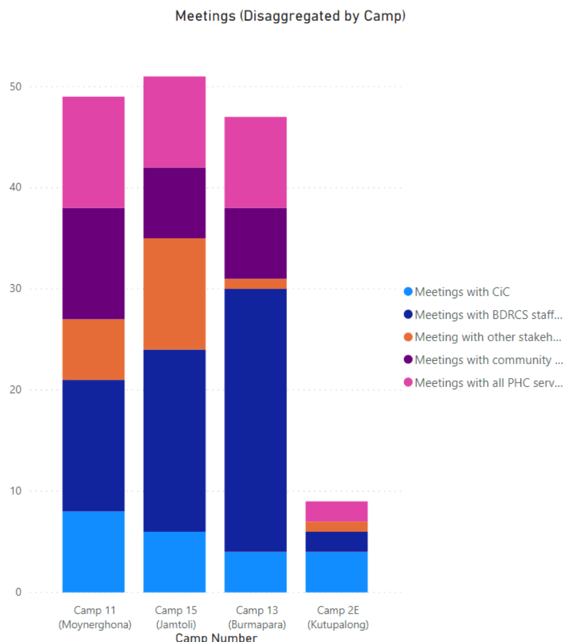
[22] In the period of August to December 2020 – the period of the revised MIS – 122 deliveries were conducted at PHCs and 15 pregnant women referred to a higher facility due to complications.

As outcome indicators show, referral practices have slightly improved. However, the PHCs still lack a systematic referral system. Currently the referral practices are very partner-centered. Most partners use their own referral systems incl. transportation and destination. Unfortunately, COVID-19 shifted priorities, so the planned workshop on establishing a holistic system could not be undertaken. Referrals are currently managed by an ambulance and motorised auto-rickshaw provided by Hope Foundation. In 2021, the BDRCS will contribute two additional 24/7 ambulances to the referral pool of currently 4 PHCs. In 2021, a round of workshops shall map the current referral practices at PHCs and determine the existing gaps and synergies. The following graphs shows how internal and external referrals are comprised for the period August to December 2020 (period of the revised MIS[23]):



Out of 704 referrals conducted since August 2020, the vast majority were general patient referrals from the OPD and Nutrition referrals to Nutrition centres and Therapeutic Feeding centres. The % of referrals per category differ per camp. While the PHC in camp 13 generally conducts more nutrition-related external referrals, the PHC in camp 15 conducts more general referrals.

[23] Most of the graphs in this report are shown for the period August until December 2020. The reasons are that the MIS was completely revised and amended with additional information, and hence it was not possible to combine most indicators of the old with the new MIS. Furthermore, many activities were halted in the first half of 2020 and the main achievements were made in the second half. Hence, the graphs still give a rather good overview over what was achieved. Whenever there were noteworthy achievements in the first half of 2020, this is specified in the text. The logframe reports includes achievements over the complete project period.



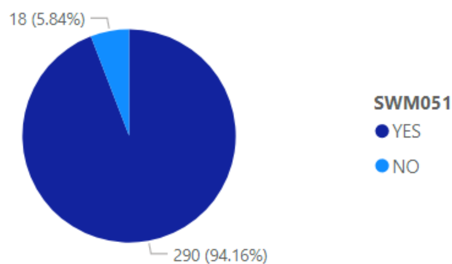
During the reporting period, three steering committees were held. One was held in January 2020, immediately after a fire incident at the PHC in camp 11. In July, a remote meeting was held on different management topics and in September 2020, the meeting focussed on the results of the SRC Health Manager's quality assessment. While the January meeting achieved a cost sharing between UNFPA, IOM and SRC to cover the damage of around BDT 600'000, the meeting in September 2020 was able to start a discussion on quality improvement and strengthening synergies between partners. Tangible results to date are an optimisation of the pharmacy management, rationalization and increased efficiency at patient registration and better room placement (delivery and post-delivery rooms are placed closer to each other). The graph to the left shows meeting numbers per PHC since August 2020[24]. The second half of 2020 also marked a shift in community engagement. It is now frequent practice at the PHCs to invite Majhis and Imams to the centres and convince them about the importance of regular health service seeking.

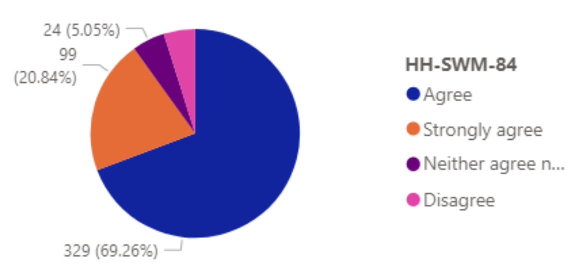
The PHC officers continued to conduct monthly meetings in the second part of 2020, after meetings were discontinued due to COVID-19 for some months. The PHC officers enjoyed a crucial role in supporting all health service providers with PPE provided through BDRS-SRC, as well as by ensuring that IPC standards stipulated in the COVID-19 Guidance Note (see report 440521) were upheld.

Outcome 2: Improved access to functional 2 solid waste management services for the population in camp 15 and two host community wards in Palongkhali Union

The access to SWM in camps and host communities has increased during the reporting period. While only G block under camp 15 was covered in 2019, in 2020 we expanded to blocks A, F and H in camp 15 and to Palongkhali Union. In Camp 15, block G, the % of inhabitants using community bins increased from 14% (in 2019) to 76%, a result of the continuous awareness raising work. While the % of persons agreeing that SWM improved living conditions decreased slightly from 94% (only block G) to 90% (blocks A, F, H and G), this can be attributed to the working area extension, where the SWM is rather new. 85% of the collected waste was used, processed or sold, while 15% was disposed safely.

The following graphs show the self-perception regarding improved living conditions of households in the working areas. More graphs on the outcome indicators can be found in the annex.

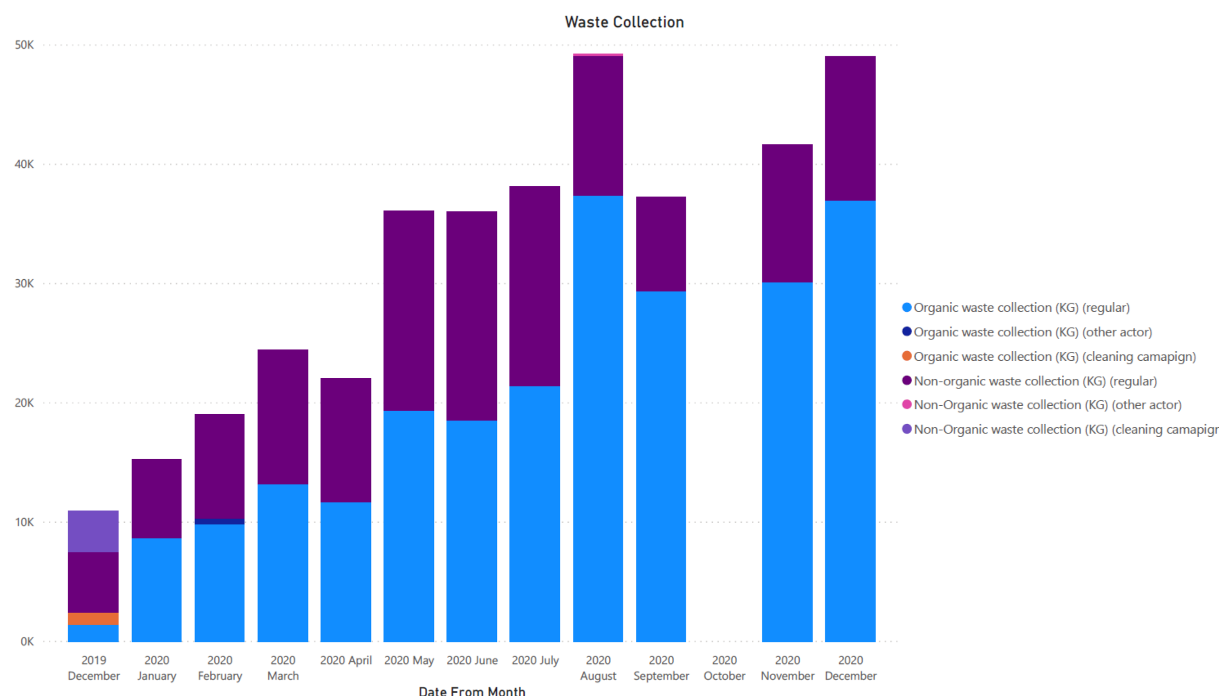




[24] Most of the graphs in this report are shown for the period August until December 2020. The reasons are that the MIS was completely revised and amended with additional information, and hence it was not possible to combine most indicators of the old with the new MIS. Furthermore, many activities were halted in the first half of 2020 and the main achievements were made in the second half. Hence, the graphs still give a rather good overview over what was achieved. Whenever there were noteworthy achievements in the first half of 2020, this is specified in the text. The logframe reports includes achievements over the complete project period.

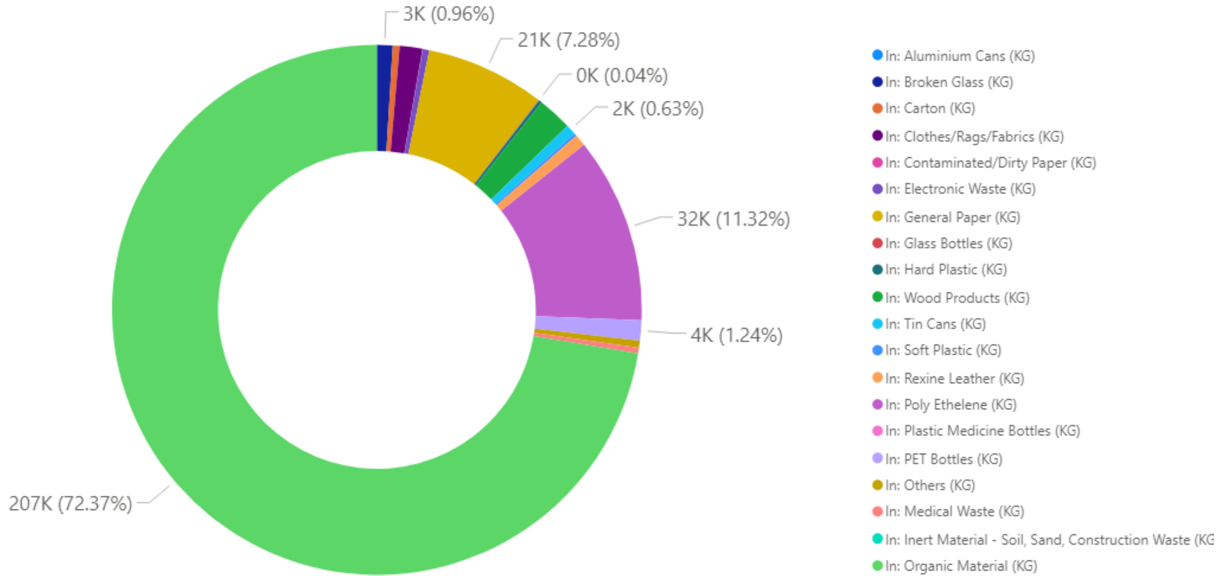
While the Material Recovery Facility (MRF) at camp 15 continued operating until September 2020, the camp boundary fencing which completely blocked access to the MRF led to an interruption in October 2020. Since November 2020, a BRAC waste management plant is used for processing organic waste, and open spaces are used for sorting the non-organic waste and selling it to waste dealers. The BDRCS have advocated for a pocket gate construction to ensure access to the MRF intensely with the CiCs, RRRC and the Army. Three formal requests were submitted to the latter – one in March, September and October 2020– which all remained unanswered. The WASH Sector, after visiting the MRF, supported in advocacy efforts as well. If access cannot be restored in the first quarter of 2021, a re-locating and re-construction may have to be considered. We had first discussions with HEKS to acquire land next to their distribution centre in camp 15. A thorough assessment will follow in February 2021.

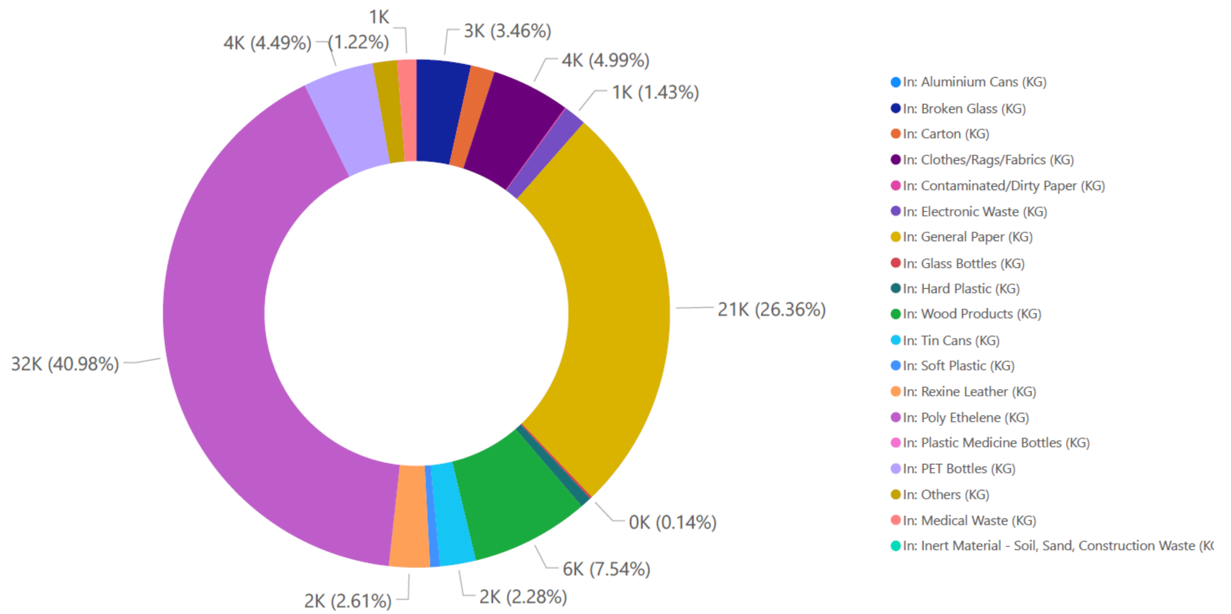
The coverage was extended from Camp 15 block G to blocks A, F and H, and hence now covering 5,835 households or 52% of camp 15. In 2019, 2’784 (1,392 pairs) household bins and 20 (10 pairs) community bins had been distributed in block G. In 2020, 5,236 (2,618 pairs) were distributed to blocks H and A. Block F will receive bins in January. The outcome survey shows that the vast majority of inhabitants are happy with the services and self-report improved living conditions. The scaling to new working areas can be exemplified by the total waste collected in the following graph:



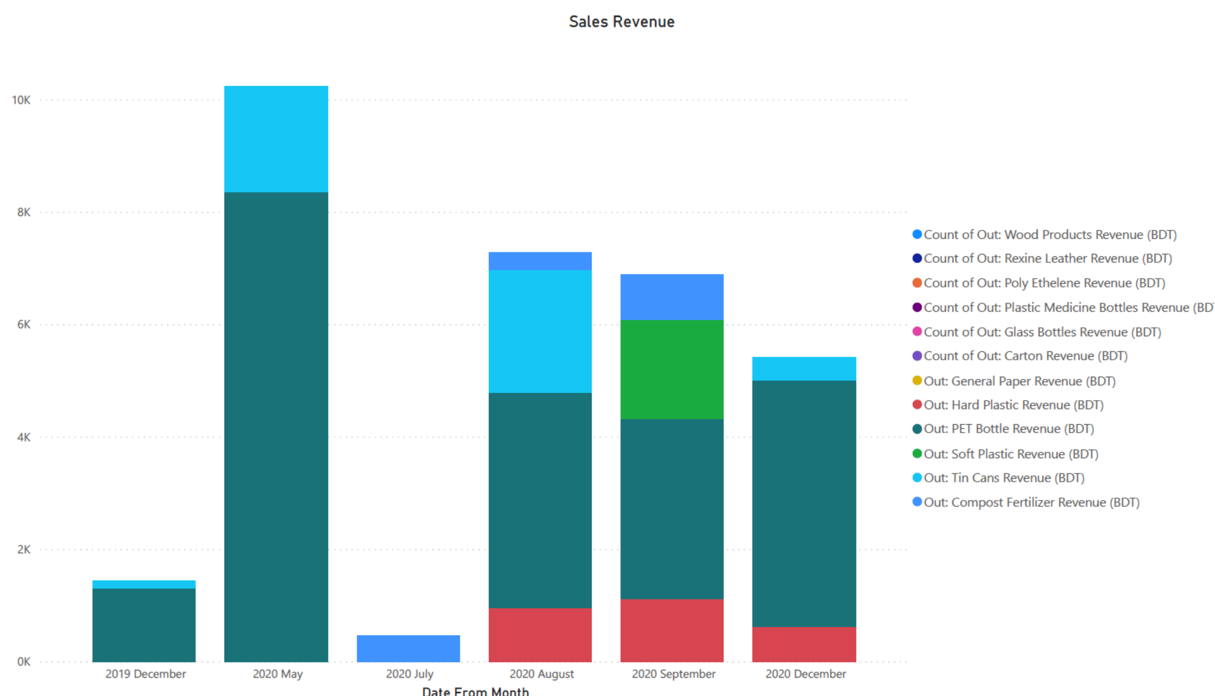
To date, 379’158 kg of waste was collected. The discrepancy between total waste collected and total waste sorted (277,122 kg) cannot be explained completely. The reasons may be extracted water between collection and sorting or measurement mistakes. In a vein to continuously optimize and increase the accuracy of data in the MIS, we will investigate the matter in early 2021. The following graph shows that waste (a total of 277,122 kg) is sorted in a very detailed manner at the centre. On average, 85% of waste is processed, sold or given away free. Inert waste in camps is mostly not collected, as it is used for construction and collected directly at source from construction agencies. To date, 13,093 kg of compost fertilizer was produced, while 9,779 kg is still in process. The conversion rate approximately amounts to 9.5% (total organic fertilizer in process[25] or finished, i.e., 22,872 kg divided by total organic waste collected, i.e. 239,649 kg). There is scope to improving the conversion rate to 20% according to our SWM consultant, which the project teams are working on. Since October 2020, composting data is not captured, as composting is being done at the BRAC facility.

[25] This value may still reduce during the process.





The graph hereafter shows waste sales. Since the beginning of SWM activities, BDT 31’758 in revenues were generated. The project has well-established linkages to different waste buyers eager to procure materials from the MRF.



The process to start SWM activities in Palongkhali Union, which started with a range of planning workshops with UNDP and its partners in March 2020, was halted at the outset of the pandemic. BDRCS-SRC decided to focus on the running activities and the separate COVID-19 response project. In August 2020, the planning process continued and led to devising a detailed implementation strategy together with the Union Parishad, UNDP, BRAC and Practical Action.

Waste collection started in August 2020, on market areas at open spaces only (under the COVID-19 project) and was transitioned into this project by the end of the year. In January 2021, 800 (400 pairs) shop bins will be distributed in a first phase and waste will be collected from shops and households at three market areas (Palongkhali Union, Telkhola Bazar, Palongkhali Bazar and Batolli Bazar) in Wards 6, 7 and 8:

Sl. No.	***Palongkhali***	***Partner responsible for collection***	***HH***	***Stores***
1	Palong Khali Market - Ward-01 & Partial ward no. 02	BRAC	79	197
2	Thaingkhai Bazar - Ward-02 & Partial ward no. 4, 5	BRAC	37	335
3	Palong Khali Bazar - ward 7	BDRCS	108	649
4	Telkhola Bazar ward- 6	BDRCS	64	52
5	Battoli Bazar - ward – 8 and partial 9	BDRCS	31	58
	TOTAL		**319**	**1,291**

The procurement process for the second MRF – constructed together with UNDP – which will include a temporary sanitary landfill, will start in February 2021 and should be completed in March 2021. Until then, the SWM system is using dumping areas assigned by the Union Parishad. A first SWM Steering Committee meeting is planned in January 2021, where issues such as service fee collection will be discussed.

The SWM consultant visited in March 2020 to advise on the implementation strategy, while a remote mission commenced in December 2020, where he supports elaboration of an awareness raising strategy in Palongkhali and the process to come up with SWM Steering Committee ToRs, among others.

43 regular waste workers (Camp Volunteers) and one night guard are engaged in camp 15 and serving blocks A, F, G and H. On average, 1 waste worker serves 136 households. The waste workers also

engage in awareness raising activities during their daily interactions with the households in their working areas. Waste workers are selected to come from the very working areas they serve. The team is overseen by two Waste Supervisors at the camp level.

Even though the number of trainings were reduced due to COVID-19, the following sessions were held while following COVID-19 guidelines:

- Training for 29 waste workers in May 2020. They were trained through discussions and demonstrations on waste collection, waste segregation, organic composting, teamwork, personal protection and usage of PPE.
- Training for 44 waste workers in October 2020. They were trained on community awareness raising, using PPE, time management, different waste types, van route mapping, and COVID-19 message dissemination.

In Palongkhali Union, eight waste workers (Host Community Volunteers) are collecting waste from open spaces at markets. As the SWM system becomes fully operational, further waste workers will be hired. The MRF Officer for Palongkhali was employed in December 2020 and is currently undertaking preparatory activities for the next phase recruitment.

During the reporting period, an agreement with HEKS was signed. BDRCS-SRC commit to hand over 81 tons of compost fertilizer to HEKS until the project end. HEKS will serve the communities in camp 15 with a vegetable gardening project. This cooperation will enhance the awareness of the communities of the circularity of the environment. In turn, HEKS will improve roads and access in camp 15 for smooth functioning of waste collection. Further, they will support the MRF with construction of addition composting pits.

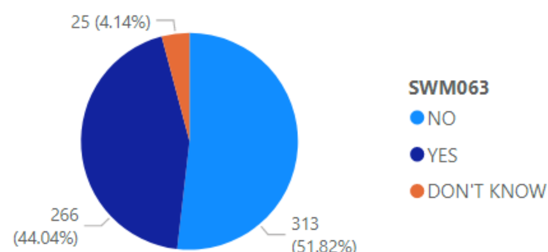
The main achievement for the SWM activities in Palongkhali was the completion of a detailed Cooperation Agreement between the Union Parishad in Palongkhali, Practical Action, BRAC and BDRCS. The agreement will be signed by UNDP and SRC as witnesses. The partnership has the objective to establish a financially sustainable SWM system owned by the local community and led by Palongkhali Union Parishad.

Outcome 3: *Improved behaviour of the host and the guest community in terms of personal and environmental health.*

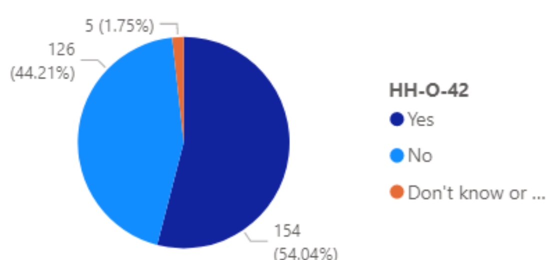
The activities in the reporting period where able to contribute to an improved health behaviour. While 81% of children under 6 months were breastfed exclusively on the day before their mothers were surveyed in March 2020, 93% received breastmilk in January 2021, hence overachieving the target. Outreach work further ensured that 83% of women knew where to turn to for SRH needs. 83% of women reported they availed SRH services at a PHC. This marks a slight increase from 78%. While less children sought regular check-ups (decrease from 72% to 68%), more children attended growth monitoring (increase from 44% to 54%). Please refer to the Outcome Measurement annex for further details.

The following graphs show growth monitoring of children between 0 and 59 months. Growth monitoring is not conducted at BDRCS-SRC PHCs, but children are referred frequently to nearby Nutrition centres where they are monitored. More graphs on outcome indicators can be found in the annex.

Do you take your under 5 children to the primary health centres for growth monitoring? (PHC 11, 13 and 15 - March 2020 - N=604 - Children 0-59 months)



Do you take your under 5 children to the primary health centres for growth monitoring? (PHC 11, 13 and 15 - January 2021 - N=285 - Children 0-59 months)



During the reporting period, the outreach teams were equipped with COVID-19 knowledge and mainly delivered COVID-19 and personal hygiene related messages. All details on the COVID-19 outreach work carried out by the Volunteers can be found in the report of project 440521.

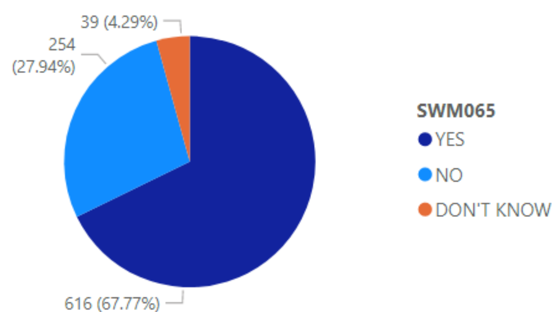
Regular sharing and coaching sessions (85 since the beginning of the project) helped the Volunteers and CHFs to improve their work. 19 Outreach Volunteers were recruited and trained on their tasks since the beginning of this project. 4 for the PHCs in camps 11, 13 and 15 and 7 for the PHC in camp 2E since inception of this project. During the reporting period, the outreach work was assessed. PHCs 11, 13 and 15 are currently staffed with 4 Outreach Volunteers and 4 Community Health Facilitators (CHFs). They visit households and conduct community sessions in pairs consisting of one CHF and one Volunteer. The CHFs cannot communicate and connect with the communities, so they usually solely technically guide the Volunteers. The Volunteers' work of engaging with the households is more time consuming than the support they need from CHFs. Hence, it was decided to staff each PHC with only 2 CHF supported by 12 Outreach Volunteers. That will allow the CHFs to focus solely on guiding, training and monitoring the outreach work, where the Volunteers disseminate messages at the door-step and in sessions. The process to implement the necessary changes have been initiated in December 2020 and will be finalized in January 2021. As soon as all staff are on board, they will be trained and given their area-wise outreach targets.

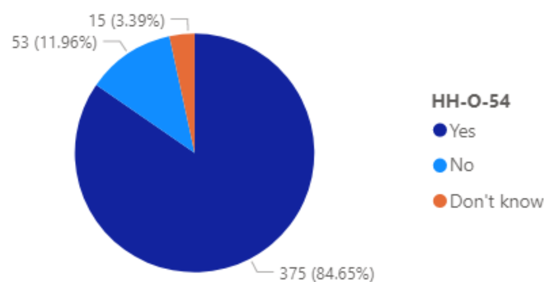
A CBHFA refreshers training was conducted (September 2020, 1 day) aiming at bringing PHC Officers and CHFs up to date again. The included the following contents:-

- Minimum requirements of CBHFA
- Health Promotion
- Environmental Health, WASH & SWN
- Safe motherhood, safe delivery and danger signs
- New-born came, danger signs and nutrition
- SRH, adolescent health, family planning
- Outreach interventions: CEA & PGI, Reporting
- Community mobilization in emergencies
- Public health in emergencies: preventing and responding to epidemics
- COVID Guidance Note at PHCs

The health outreach work conducted in the context of COVID-19 can be considered to have successfully supported improving patient flow as described in detail in the 440521 report. Since the beginning of this project, 25,546 households were visited, and 127,730 persons reached directly or indirectly. Community sessions were conducted until February 2020. Since April 2020 only household visits were undertaken due to COVID-19 guidelines by WHO and GoB. Between January and March 2020, 1,115 community sessions had been conducted.

The following graphs show that outreach teams have become more active. While 68% of households reported they had been visited last week in March 2020, 85% reported so in January 2021. A vast majority of households (95%) reported to be either strongly satisfied or satisfied with the volunteers' work.





3.3.2 440521, COVID-19 Preparedness and Response, Cox's Bazar

This project was implemented between 15 May 2020 and 31 December 2020. It contributed to increasing preparedness on the one hand, and reducing morbidity, mortality and social impacts of the COVID-19 outbreak on the other.

When the COVID-19 pandemic started in 2020, the situation was initially highly volatile and uncertain with a sense of urgency for preparedness action. The first positive tested case in Bangladesh was recorded on 08 March 2020, in Cox's Bazar district on 23 March 2020 and in camp areas on 14 May 2020. In a first phase, until June 2020 and in camps until August 2020, case numbers increased, followed by stabilization and later a decrease in case numbers, while testing remained at rather low levels.[26]

When COVID-19 reached the country, it was seen as another health burden that would add to the misery of poor health to those living in the camp and would have the potential for quickly overburdening the health services. There was an urgent need to prevent and stop any COVID-19 transmission at the point of entry. Health promotion, early detection, screening and tracing, and managing individual cases through isolation were considered the most important needs at that time. There was a common understanding that due to the conditions within the camp, the WHO recommendations on isolation, social distancing, hand washing, as prevention measures would not be sufficient to stop the spread of COVID-19.

SRC thus proposed to equip and remodel its existing PHCs into facilities that continue dispensing essential primary health care services. They were to be protected from cross infection and transmission risks and equipped to conduct triage and short term isolation that is safe followed by referral of suspect cases to appropriate levels of testing and treatment. At the same time, the newly built primary health care facility at camp 2E was to be repurposed to temporarily serve as a dedicated COVID-19 isolation and treatment centre. This is in response to the government's request to expand camp capacity for localised management of COVID-19 cases.

After all and so far, the primary health impact of the pandemic was less pronounced in camps and host communities than initially estimated. Especially in camps, this can be exemplified by low respiratory symptom prevalence, extremely low testing positivity rates and the general mortality rate not being beyond the average of the previous year. The secondary health impact is still difficult to estimate but is likely more strongly pronounced due to lower service seeking in the first months of the pandemic. In addition, the economic impact has been quite substantial in host and camp communities. 93% of households in host communities reported a diminished income due to the pandemic.[27] As a result of the nation-wide lockdown which was decided in order to contain the spread of the pandemic in the first second quarter of 2020, limited movement, delayed procurements and complicated construction works were obstacles, which hampered part of the project implementation.

In the second half of the project period, many difficulties eased, especially with lifting of most lockdown measures from August 2020. Furthermore, the number of officially positive tested cases overall Cox's Bazar started stabilizing, while even declining towards the end of this year. While this may be due to lower testing and inadequate epidemiological oversight in the rest of the country, the surveillance system in camps is rather sophisticated. Mortality rates did not increase compared to the previous year.[28] Overall, the need for COVID-19 treatment in the camps showed to be lower than initially projected by the World Health Organization (WHO). On the other hand, first data showed that the secondary economic impact in host communities was immense. This led to the adaptation of the Isolation & Treatment component of this project (outcome 2) and inclusion of a Multi-Purpose Cash Grant component (outcome 4).

Under outcome 1, the project achieved most goals. The outreach work proved to be effective in stabilizing patient flows, even though the average monthly flow of 2019 last year was not achieved. The centers were adapted to WHO and Cox's Bazar Health Sector[29] guidelines and equipped with Personal Protective Equipment (PPE). All staff were trained on Infection Prevention and Control (IPC) while guidelines were set in place at the centers. This ensured that the centers functioned in a safe manner through the pandemic.

Under outcome 2, the SRC/BDRCS operationalized an Isolation & Treatment Center (ITC) in camp 2E under the guidance of IFRC. As a result of the lower pressure on isolation and treatment facilities and lower than expected bed occupancy at the ITC, it was decided to close the 2E facility while focusing

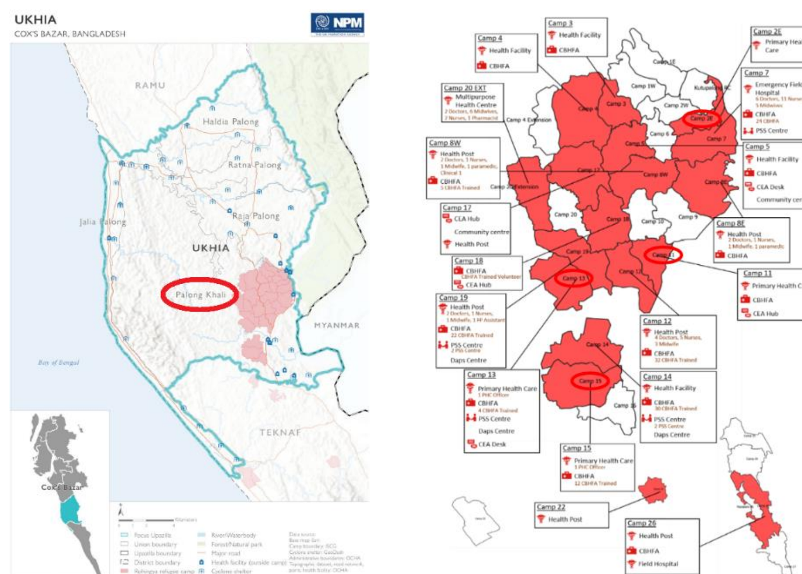
efforts on the second RCRC ITC facility at Rubber Garden (near camp 7). The 2E facility was henceforth transitioned into a PHC with a COVID-19 component (screening, triage, and referrals to higher facilities) towards the end of this year.

Under outcome 3, the local government (Union Parishad) at one host community Union (Palongkhali) and five health facilities were supported and strengthened to cope with the pandemic. The Chairman of the Union contributed to steering of this outcome, thus ensuring that activities are owned by the local government. The outreach work covering the full union, various trainings to Union Parishad staff and volunteers as well as health workers equipped the Union to cope with the pandemic. PPE, equipment support and infrastructure improvements at health facilities were able to fill existing gaps and enhance operational capacity of the facilities.

Under outcome 4 (which was added in November 2020), 1,177 households of Ward 6 or 7 of Palongkhali Union received a cash grant of BDT 5,500. This allowed them to cover subsistence needs during one month, and thereby contributing to ease the income loss resulting from COVID-19 containment measures.

Introduction

The project was successfully implemented in four camps (11, 13, 15 and 2E) and host community areas (Palongkhali Union, all Wards) in Cox's Bazar. 145'000 Displaced People from Rakhine benefitted from access to continued services from three Primary Healthcare Centres (PHCs) as well as COVID-19 messaging and outreach work in camps 11, 13 and 15[30]. The inhabitants of camp 2E (36'495 persons) had direct access to COVID-19 testing, isolation and treatment services thanks to the ITC (and as of October 2020 PHC with COVID-19 services). Furthermore, the population of Palongkhali Union (32'843 persons) benefitted from continued and safe services from Union-level health facilities as well as COVID-19 messaging and outreach work. Please find the working areas marked with red circles hereafter.



Since the first COVID-19 positive case occurred in Cox's Bazar (host communities) on 23 March 2020, 5'407 COVID-19 cases were detected among both host and displaced communities as of 03.01.2021. Out of those, 18 cases in the host population are currently in isolation, whereas 5'316 have recovered

[26] See details on COVID-19 in Bangladesh, host communities and camps her: WHO/Health Sector COVID-19 Dashboard

[27] The 2020 UN Joint Multi-Sector Needs Assessment (J-MSNA) exemplifies this, for example.

[28] WHO Bangladesh COVID-19 Morbidity and Mortality Weekly Update (**MMWU**) **27** December 2020/Vol. No **44** (https://cdn.who.int/media/docs/default-source/searo/bangladesh/covid-19-who-bangladesh-situation-reports/who_covid-19-update_44_20201227.pdf?sfvrsn=bffee8db_7); CxB_Epidemiological_summary_Week52.pdf (https://ln2.sync.com/dl/f33b85a60/99r3nuhb-zebna3tg-kun4acy3-mvyxqv56/view/default/1106809606006)

29 The Cox's Bazar Health Sector is a coordination centre staffed by WHO, who technically guides and coordinates health actors together with the GoB.

30 145'000 constitutes the population of camps 11, 13 and 15 together. All these persons, in one way or another, have access to the services of the PHCs and to the services under outcome 1 of this project. The figure does not differentiate if they have used services or not.

and 73 died. Among the Displaced People from Rakhine, one person is in isolation, 356 recovered and 10 died.

COVID-19 update among Displaced People from Rakhine and Host Communities (as of 03 January 2021):

Number of tests conducted (last 24 hours):	72,784 (269)	Host Population (last 24 hours)	FDMN/Rohingya Refugees (last 24 hours)
Number of confirmed cases (last 24 hours):	5,774 (8)		
Number of tests conducted		49,386 (184)	23,398 (85)
Number of confirmed cases		**5,407 (8)**	**367 (0)**
Cases in Isolation		18 (8)	1 (0)
Cases recovered		5,316 (6)	356 (0)
Deaths		**73 (0)**	**10 (0)**
Quarantine (Home)		213 (32)	0

The WHO/Health Sector COVID-19 Dashboard gives a detailed overview of the conducted testing, detected positive cases, community symptoms, mortality monitoring and the status across 17 Isolation & Treatment Centres (ITCs). Overall, daily new cases declined in both host communities and camps and stabilized at a low level. Testing declined as well - in host communities from 2'896 in week 25 to 1'457 in week 52 and in camps from 1'556 in week 39 to 454 in week 52. The average positivity rates in both camps (1.5%) and host communities (10.8%) remained below the national average rate of 15.6%. The strikingly low rate in camps can partially be explained by the sentinel testing approach (testing being less targeted) and the high number of samples collected from children. The database also reveals that mortality rates due to respiratory illnesses are not significantly higher than in the previous year.

A survey jointly conducted by the Institute of Epidemiology Disease Control and Research (IEDCR), WHO, MSF and the Bangladesh Red Crescent Society (BDRCS), extracting and testing blood samples on COVID-19 anti-body prevalence among Displaced People from Rakhine is ongoing. At the time of writing this report, the sample collection was finalized. First results may be expected in late January or February 2021. The results of the survey will reveal if and how many camp inhabitants have already been infected by COVID-19, and hence allow us to understand where we stand in the pandemic. Overall, the data at hand points towards a lower negative impact of COVID-19 in camps and host communities than predicted by the Johns Hopkins University in March 2020[31].

When developing and initiating this project, the situation in Cox's Bazar was highly uncertain and volatile. The Government of Bangladesh (GoB) implemented a lockdown and declared public holidays from mid-May 2020 until early August. On top of that, the Cox's Bazar district administration practiced a strict 14-day quarantine regime for persons entering the district. In addition, movement and access restrictions in Cox's Bazar city and into the camps complicated operations. Although critical services, such as the health activities implemented under this project, remained permitted by local authorities, the mentioned restrictions limited movement, delayed procurements and complicated construction works. Since mid-August 2020, thanks to absence of a large-scale outbreak, the situation stabilized substantially.

Due to the lower need, the Isolation and Treatment Center (ITC) funded from this project was closed by 02 October 2020, whereas the second ITC, operated by the International Federation of Red

[31] http://hopkinshumanitarianhealth.org/assets/documents/COVID-19__Rohinya_Refugees__Beyond_-_Summary_FINAL_March_25_2020.pdf

Cross/Red Crescent Societies (IFRC) and the BDRCS, will continue operating until March 2021. Consequently, this project was modified with a multi-purpose cash grant component for host communities after the approval of the Swiss Development Cooperation (SDC). CHF 87’000 from COVID-19 isolation and treatment (outcome 2) activities have been re-allocated to COVID-19 recovery through multi-purpose cash grant distribution (outcome 4). This is in line with this trend and tries to address some of the newly emerged needs in the host communities (according to the UN Joint Multi-Sector Needs Assessment (J-MSNA), 93% of households in host communities reported a diminished income due to COVID-19).

Results achieved during the reporting period

The activities aimed at mitigating the primary health effect of COVID-19 reduced morbidity in general. By isolating the patients, we were able to contribute to reducing the transmission of COVID-19 to family and community members, and hence reducing morbidity, as well. By strengthening and adapting existing PHCs and Union-level health facilities, we ensured that camp inhabitants and host communities had continued access to basic health care and thus contributed to reduce secondary health impacts of COVID-19. The numerous outreach activities in camps and host communities had a preventive effect on COVID-19 related morbidity. The health response under this project was duly aligned with the strategy of the WHO, Cox’s Bazar Health Sector and Ministry of Health and Family Welfare (MOHFW) for Cox’s Bazar, thus ensuring synergies with other actors. Luckily, mortality rates in both camps and host communities are rather low. Under this project no cases were treated which were life threatening due to the direct health impact of the virus..

The secondary social impacts of COVID-19 in Cox’s Bazar are immense. They are present in camps, due to less distribution of relief goods and cash-for-work programming, and to a larger extent in host communities, due to loss of income and livelihoods. By distributing multi-purpose cash grants at the approximate value of a household’s monthly consumption (BDT 5,500 = approx.. 56.75 CHF), we were able to contribute to a mitigation of these severe consequences while ensuring that decision making power on how the cash is utilized rests with the beneficiaries.

Outcome 1: Facility readiness of PHCs is ensured to deliver essential primary health care services including health promotion, outpatient and PSS services while mitigating risks of cross infection and ensuring referral of at-risk patients to designated isolation and treatment facilities.

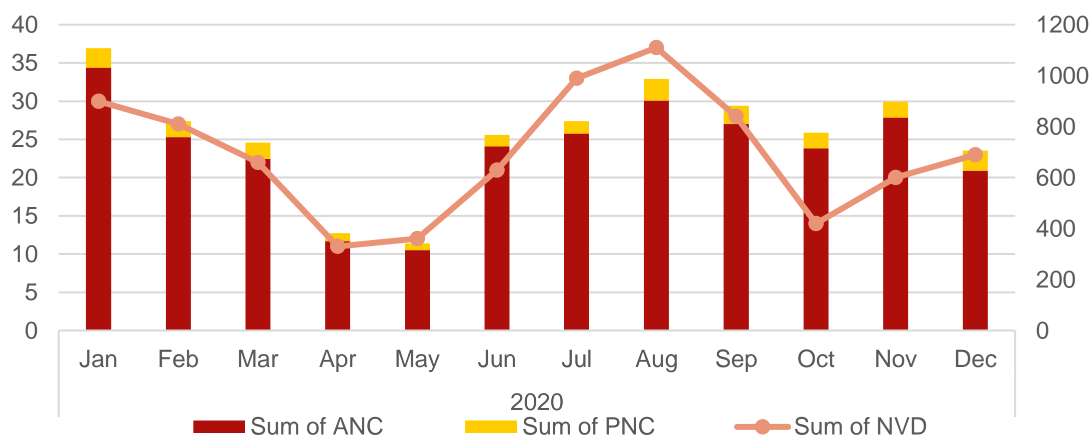
Thanks to activities under the project, the pre-COVID patient flow of 2’685 patients per PHC on average in March 2020 (10,7% of catchment area) was reached in December 2020 again (2’626 or 10.5% of catchment area). However, the project goal of 14.8% (corresponding to the average value between April 2019 and February 2020) could not be achieved. This is in line with the sector wide trend. In large measure, this could be achieved due to successful risk communication and community engagement (RCCE) activities while improving facility readiness to minimise the perceived and actual risks of virus transmission.

Output 1.1: *The 3 already operational PHCs are equipped and remodelled for safe triage and short-term isolation of at-risk patients with suspected COVID-19 symptoms and have the necessary medical supplies to operate during times of increased stress on health facilities.*

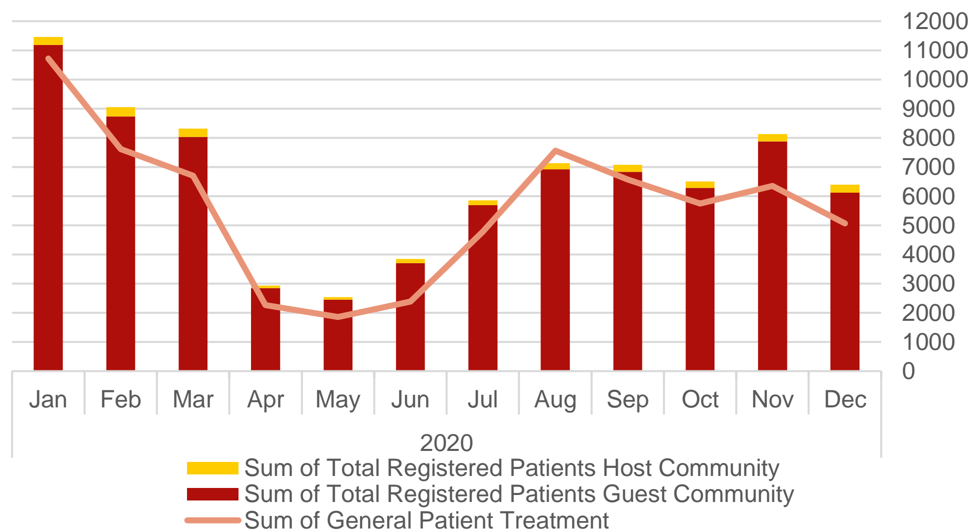
At the onset of the outbreak, misinformation and fear about a new disease spread rampantly in the camps. Consequently, camp inhabitants began becoming afraid of seeking regular health services. The Cox’s Bazar Health Sector reported a reduction in patient flow in all health facilities. Noting that this may lead to secondary, negative health impacts, the BDRCS and SRC acted very fast and started COVID-19 and WASH messaging by the end of March 2020, well before the first case in camps (May 2020) was reported. In fact, through the long-term primary and environment health project, the outreach activities were adjusted to include messaging on Covid – 19 prevention and protection. After an initial reduction in patient flow at the BDRCS-SRC Primary Healthcare Centres (PHCs) from March 2020, the downward trend reached a low in May 2020. In June 2020 patient numbers and services increased again. Under Sexual and Reproductive Health (SRH) services, Ante-Natal Care (ANC), Post-Natal Care (PNC) and Normal Vaginal Deliveries (NVDs) increased back to the pre-COVID levels of March 2020 (graph 1) in June 2020. Similarly, general medical consultations as part of the Out-Patient Department (OPD) and total registered patients almost increased back to pre-COVID (graph 2). The COVID-19

outreach activities have reached all families in the catchment areas more than once. The camp inhabitants learned that the rumours and misinformation around COVID-19, which initially led to reduced service seeking, were largely unfounded. Beyond the project period, BDRCS and SRC will continue with COVID-19 messaging as part of the outreach work whilst modifying it with regular health messaging in line with the Community Based Health and First Aid (CBHFA) modules.

Graph 1: Normal Vaginal Deliveries (left axis); Post-Natal Care Services and Ante-Natal Care Services (right axis) at PHCs in Camps 11, 13 and 15; Source: PHC MIS.



Graph 2: General Patient Treatment/OPD (right axis); Total Registered Patients Guest Community and Total Registered Patients Host Community (left axis) at PHCs in Camps 11, 13, 15; Source: PHC MIS.



The PHCs were remodelled to meet COVID-19 WHO and Cox's Bazar Health Sector guidelines. An external waiting area with hand-washing points before entry was setup. The patients were screened at the entry. 79 patients were screened as suspected COVID-19 patients. Furthermore, each of the three centres was equipped with an isolation holding area for patients meeting the definition of a suspected case. 37 out of the 79 suspected COVID-19 patients waited in the designated rooms until they were referred to a COVID-19 Isolation Unit or Isolation and Treatment Center (ITC), while others were referred immediately (by ambulance or on foot) or were unwilling to fulfil the advisories and left. In addition, the three centres are equipped with a second room to be used for emergency obstetric care services for suspected COVID-19 cases. Pregnant mothers presenting to a PHC and requiring emergency support, while at the same time fulfilling the case definition of a suspected COVID-19 patient, are treated in this room. The second room was constructed at the request of the United Nations Fund for Population Assistance (UNFPA). However, due to fewer cases than initially envisaged, only 2 patients having obstetric complications while being a suspected COVID-19 case presented to a PHC. Once the pandemic

is over, both the constructed rooms will be used by health service providers and contribute to solving the pre-COVID space limitations at the PHCs.

The outreach work in camps comprised COVID-19 messaging and awareness raising for adequate hygiene practices. Camp inhabitants were informed about COVID-19 symptoms, isolation and treatment options, prevention measures and personal hygiene. Hand washing demonstrations were integral part of the household visits. 28,128 households were visited, while 48,678 individuals attended each visit (per household 1-2 persons were informed). Thereof, 4,323 were pregnant and lactating women, 4,911 elderly and 826 persons with disabilities. Directly and indirectly, including all household members, 140,640 individuals were reached.

Output 1.2: *The health service providers, project staff and volunteers are continuously provisioned with protective equipment for their personal safety and follow the guidance for safe delivery of health services at the PHCs.*

123 health workers and 31 volunteers at three PHCs were equipped with sufficient Personal Protective Equipment (PPE), such as face shields, aprons, gowns, face masks and gloves.[32] Furthermore, the centres were equipped with thermal scanners, liquid and bar soap, and hand rub and sanitizer. To ensure adequate cleaning and disinfecting, the PHCs were supplied with liquid chlorine, spraying machines, gum boots, heavy duty gloves, and napkin rolls.

With close support of the SRC Health Manager, a PHC COVID-19 Guidance Note was developed by BDRCS and SRC. The guidance note regulates procedures and practices, including Infection Prevention & Control (IPC), at the PHCs in times of the pandemic. It contains everything from the entry and screening procedure, maximum number of patients allowed in the facility at a time, roles and responsibilities for IPC, requirements for staff and the referral procedure for suspected and confirmed COVID-19 patients. As the pandemic further developed and new guidelines by GoB, Health Sector and WHO were enacted, BDRCS and SRC updated the note, respectively. 154 health workers and volunteers were trained on the guidance note. Through regular monitoring by the SRC Health Manager guidance note compliance by 154 PHC staff was ensured. Selected PHC staff were trained in more detail on IPC by WHO accredited master trainers at early stages of the pandemic. The trainings and guidance allowed to safely continue delivering primary healthcare services at the three centres.

Outcome 2: The new health facility in camp 2E is transitioned into a 30-bed centre for management of COVID-19 cases.

The to-be PHC at camp 2E was successfully transitioned into a COVID-19 isolation and treatment centre. However, due to a lower need, the centre only reached 37% occupancy (including contacts 77% occupancy), via the target of 90%. Subsequently, it was remodelled back into a PHC with a COVID-19 component that included COVID-19 sample collection, and hence this project continued to contribute to the overall COVID-19 response in Cox's Bazar. Until 9th January 2021, 53 samples could be collected from patients.

Output 2.1: *The camp 2E facility is equipped and adequately staffed to function as an isolation and treatment centre for mild and moderate COVID-19 cases following WHO guidelines.*

The Severe Acute Respiratory Infection (SARI) ITC in camp 2E was established in close collaboration with IFRC and the newly recruited BDRCS ITC team. Around 100 clinical and support staff were employed to operate the 30 SARI ITC beds in camp 2E as well as the integrated support services at the second ITC at Rubber Garden (near camp 7). From the funds of this project, 10 Nurses and 5 Medical Officers were financed. After initial delays mainly due to international procurements of high-quality PPE conducted by the IFRC, the ITC was ready to admit patients on 21st July 2020.

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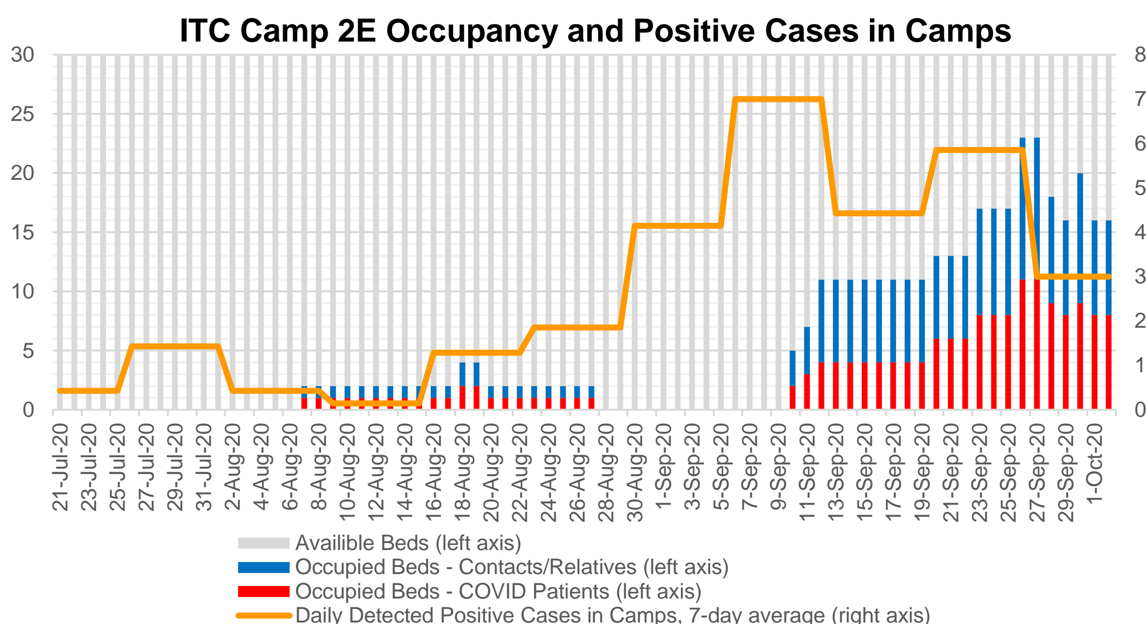
[32] Until 31.12.2020 the following PPEs/hygiene materials were supplied: 60 face shields, 60 clinical aprons, 12'200 non-sterile gloves, 3'700 sterile exam gloves, 45 heavy duty gloves, 15 gum boots, 3 non-touch thermal scanners, 810 bottles hand rub (250mL), 80 bottles hand sanitizer (200mL) 600 bottles handwashing liquid (200mL), 48 bottle chlorine solution (4L), 1'280 napkin rolls, 300 soap bars, 20'600 face masks, 9 sprayer bottles, 3 hand sprayers (2L).

SRC implemented several construction works to transform the planned PHC facility in camp 2E into an ITC. Inside the facility, electrification; installation of ceiling fans for proper ventilation; completion of roof over one washroom; finalization of washroom for persons with disabilities; and completion of kitchen, among others, were done. Outside the facility, a large drainage between the facility and the Camp-in-Charge building was constructed as a result of the flooding that happened in March 2020. Land levelling in front and on the side of the facility was undertaken and two tents for screening/triaging and for a staff resting area were set up. The construction of small retention walls to ensure water does not enter into tents during heavy rainfall was undertaken; the construction of a waiting area was done; and the frontside bamboo fencing, backside concrete fencing, submersible pump and an overhead water tanks structure with the high capacity required for an ITC were constructed. All these works ensured a proper infrastructure, in line with WHO and GoB SARI ITC guidelines, to establish an ITC.

The SRC supported the 30-bedded ITC at camp 2E with a medicine procurement sufficient for three months. Furthermore, part of the required PPE was supplied for the same period. The remaining PPEs were supplied by the IFRC. The medical equipment for ITC 2E was procured by IFRC as well. The SRC Health Manager played an instrumental role in defining specifications for several BDRCS, SRC and IFRC procurements and in setting up the oxygen system at the ITC. Further, both the SRC Head of Sub-Delegation and the SRC Health Manager played a prominent role in developing the Clinical Management & Operational Guidelines for ITC staff - Furthermore, the SRC Health Manager led several Infection Prevention and Control (IPC) trainings for the ITC staff after being accredited by WHO as a master facilitator.

In total, 14 positive tested cases were being treated and recovered at the ITC in camp 2E. The occupancy rate of positive COVID-19 cases , all of which were mild to moderate patients not requiring oxygen supply, reached 37% at its peak (11 out of 30 beds occupied on 26/27 September 2020). In addition, contacts to the positive cases were admitted according to advice of WHO. Including contacts, the occupancy rate peaked at 77% (23 out of 30 beds occupied).



Graph 3: ITC 2E occupancy rate and weekly avg. positive cases in camps, Source: ITC MIS / WHO.

The Health Sector and WHO in Cox's Bazar lowered the requirements for ITC admission over time. Initially, only severe and confirmed cases were to be admitted, while at the time of opening the ITC in camp 2E also mild and suspected cases as well as contacts were to be admitted. Contacts were family members and dependants of admitted patients. In some cases, patients refused to be admitted unless their dependants were admitted as well. After encountering this situation, guidance by the WHO was sought. WHO recommended to admit those contacts as well. They usually stayed in the facility until the admitted positive patient they stayed with was discharged. While this increased occupancy rates across

the 17 ITCs and Isolation Units for camps in Cox's Bazar (bed capacity of 561), the current overall occupancy rate stands at only 9% (ref. WHO/Health Sector COVID-19 Dashboard).

In the context of the assumed low COVID-19 symptom prevalence and low number of positive tests, the investments being made in the ITCs, especially in human resources, were assumed to be disproportionate in relation to the need. Consequently, the BDRCS, SRC's implementing partner, formed a fact-finding team that recommended HR rationalisation. To cut costs and have readiness in providing COVID-19 services, it was decided to close one of the ITCs. After deliberation on security, access/location, and capacity, it was decided to close camp 2E ITC on 02 October 2020, while operating the ITC at Rubber Garden (near camp 7) from 03 October 2020. The better security conditions, central location, easy access, and higher capacity (readiness in the eventuality that cases spike) informed the decision to continue with this ITC. This decision allowed the reduction of HR costs by approximately 50%. On the day of closure, the 8 positive cases and 8 contacts at ITC in camp 2E were transferred to the ITC at Rubber Garden (near camp 7).
From mid-October 2020, the facility in camp 2E started operating as a PHC. General medical consultations with minor family planning and SRH components are carried out until January 2021. From February 2021, the 24/7 In-patient department (IPD) and fully-fledged SRH department will be operational. In March 2021, nutrition and eye health services are expected to start operating. The PHC is financed from outcome 1 of the SDC-supported Primary & Environmental Health project (7F-10058.02.01). The PHC was amended with a COVID-19 component conducting screening/triaging, short-term isolation of suspected cases, referrals to ITC at Rubber Garden (near camp 7) and COVID-19 sample collection. The former services started in November, while sample collection commenced in December 2020. Up to 9th January 2021, 53 samples were collected, while 2 patients were detected as positive. For those, the referral and admission to ITC at Rubber Garden (near camp 7) was arranged. The COVID-19 component was funded from this project up to December 2020. From January until March 2021, it will be covered form the Primary & Environmental Health project. In case, services add value beyond March 2021, a further extension is thinkable. A decision will be taken in February 2021.

Output 2.2: *Referral of severe and critical COVID-19 cases is ensured to higher facilities designated to treat them.*

Under this component, the IOM Dispatch and Referral Unit (DRU) for COVID-19 patients was supported with a level-2 ambulance (for severe cases with oxygen support) up to December 2020. The ambulance ensured applicable IPC standards according to WHO guidelines and the drivers were trained by the DRU. The DRU is operated by IOM and functions as a centralized coordination body for all COVID-19 related referrals.

Outcome 3: Risks of COVID-19 are mitigated for host communities through strengthened engagement of Palongkhali Union Parishad with COVID-19 preparedness and response initiatives.

92% of the Union population was reached, while 58% were reached directly and 34% indirectly. A Memorandum of Understanding (MoU) with and trainings to the local government ensured that elected and administrative officials were taken on board through the process and carry on with the activities post-project. 3 health facilities were intensely supported while 2 were partially supported in order to operate in a safe manner, meeting COVID-19 guidelines by WHO and GoB throughout the pandemic.

Output 3.1: *Institutional preparedness of Palongkhali UP is strengthened for COVID-19 preparedness and response.*

After preparatory tasks were carried out and the community, health facility staff and local government were oriented about the planned activities, a MoU between the BDRCS and the Union Parishad (Union Government) was drafted and signed by the parties. The agreement governs the activities, roles and responsibilities under this outcome. The Union Parishad, mostly through its Chairman, has been involved in all major decisions and activities.

13 elected representatives and 14 administrative staff of the Union Parishad were oriented and trained on GoB's COVID-19 guidelines by project staff. 13 elected Union Parishad representatives, 14 Union

Parishad staff, 10 Union Parishad volunteers and 9 BDRCS volunteers received regular PPE supplies to continue their works in a safe manner.

9 Outreach Volunteers were working in all 9 Wards of Palongkhali Union under the guidance of a Community Mobilizer. Through both community sessions and household visits 18,952 persons were reached directly. 30,325 persons were reached either directly or indirectly. All visited households (6,065) received two reusable cloth masks and were oriented on how to use and wash the masks.

In the Union, 20 hand-washing points were established and maintained by the community with support of the Union Government. 1 billboard, 75 festoons and 3,000 posters were setup as well. In addition, 9,000 leaflets, 5,750 soap bars and 300 T-shirts with COVID-19 messages were distributed during awareness campaigns and sessions in Palongkhali Union.

8 waste workers collected waste from 3 Union markets. Waste from approximately 800 shops and 200 households surrounding market areas was collected on a regular basis. The collected waste was stored temporarily at a designated dumping site and will be transported to the Material Recovery Facility (MRF), which will be constructed in February 2021 under outcome 2 of the SDC-supported Primary & Environmental Health project. The Solid Waste Management (SWM) activities were a request by the Union Parishad Chairman. He was convinced that SWM should be part of the activities. SWM supported in making the Union environment more hygienic, and hence limiting transmission of communicable diseases. From BDRCS' and SRC's programming perspective, it seemed to make sense to start with waste collection under this project. BDRCS and SRC were able to include SWM into the COVID-19 agreement with the Union Parishad, while in parallel negotiating a more holistic SWM agreement with UNDP partners, BDRCS and the Union Parishad Chairman under the Primary & Environmental Health project were ongoing. The SWM component was transitioned into the regular programming of SRC in Cox's Bazar.

Output 3.2: *The government health facilities at the Union level are supported to deliver their mandated services while being equipped to mitigate risks of COVID-19 transmission and refer at-risk patients to appropriate case management facilities.*

Three primary healthcare facilities in the Union were equipped with adequate PPE and cleaning material for a period of six months – the Nolbuniya Community Clinic, the Palongkhali Union Sub-Center and the Palongkhali Union Health & Family Welfare Center (UH&FWC). Overall, 90 health workers received regular PPE supplies. During the reporting period, 32 cases were screened as suspected COVID-19 patients at the three mentioned facilities and referred to the Ukhia Health Complex for further investigation or isolation.

Furthermore, the setup and infrastructure at the Community Clinic was improved by constructing an external drain to reduce flooding and a roof over the patient waiting area. The facility was fenced to increase security and improve patient flows. At the UH&FWC, boundary fencing construction that increases security and improves patient flow is still ongoing and will be completed in the first week of February 2021. After BDRCS faced procurement issues, the SRC exceptionally decided to procure the fencing in a rapid procedure. Public tendering was waived, and the request for quotation (RFQ) procedure was adopted following SRC's procurement policy which requires prior approval of SRC HQ for launching RFQ in exceptional cases. Responding to RFQ, 16 vendors were invited and submitted quotations. The work order amount was charged to the project as a payable, and hence is reported in the finance report as expenditure.

Whereas the three health facilities recorded 3,707 patients from the host community in March 2020, the number decreased by around one-third to 2,479 patients in December 2020. The lower patient flow is most likely due to a fear of the host population to become infected at the health facilities during the pandemic.

Additionally, 2 health facilities were partially supported under this project – a newly constructed Community Clinic in Palongkhali and the Ukhia Health Complex. The Community Clinic is being equipped with a boundary fencing and access road. The construction is ongoing, and hence the work order amount was charged to the project as payable as well. The Ukhia Health Complex – being the main

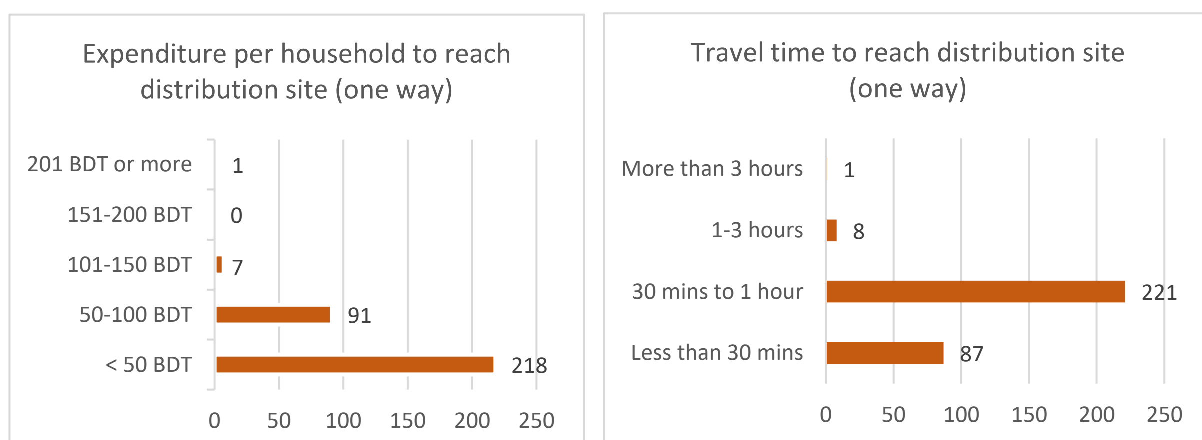
health facility in the Ukhia Sub-District and having a COVID-19 treatment department - was supported with 70 sets of mattresses, 140 pillows, 140 pillow covers and 20 saline stands.

The health facility staff were trained on GoB COVID-19 guidelines in a two-day training. All interventions at host community health-facilities were coordinated with the Upazila Health & Family Planning Officer, the focal person for the facilities in the Sub-District.

Outcome 4: 1'200 most vulnerable HHs in Palongkhali Union are able to meet their subsistence needs through the support of multi-purpose cash grants.

Cash grants of BDT 5,500[33] were distributed to 1,177 households of wards 6 and 7 in Palongkhali Union. In early 2021, a post-distribution monitoring (PDM) survey was carried out among a sample of 317 out of 1,177 beneficiary households, to collect feedback on the distribution process as well as regarding the use of the funding distributed. Out of 317 interviewees, 186 or 58.7% were female and among all households in the PDM sample, 27.8% reported to have female heads of household. The average household size among the sample is 5.7 members, with household size ranging from 2 to 12 members.

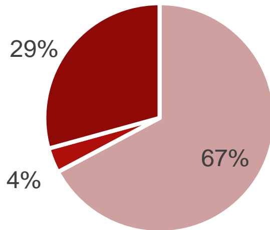
The large majority, total 96.8%, travelled to the distribution site by Tomtom, an electric motorized three-wheeler. Average expenditure to reach the distribution site was under 50 BDT for one way, which is equivalent to approximately 0.50 CHF, and most people (97.2%) spent between 30 minutes to 1 hour for one way of the trip.



During the interview, 77.3% of respondents indicated that they were aware why their household was selected as beneficiary, while the remaining 22.7% stated that they were not aware of the reasons for being selected. In relation to the beneficiary selection process and information dissemination regarding the distribution, a majority learned from BDRCS or IFRC staff/volunteers in person: 67% of households were informed about their selection by BDRCS or IFRC staff / volunteers in person, 29% received a phone call from BDRCS or IFRC staff / volunteers and 4% were informed by other actors such as UP members. Practical information related to distribution processes and related beneficiary cards were received by 54% in person from BDRCS or IFRC staff / volunteers, and by 40% through a phone call.

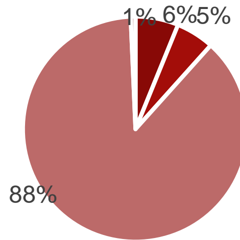
[33] In accordance with the MPCG cash operational guideline developed by the Cash Working Group.

Who informed you that you had been selected for this cash transfer program?



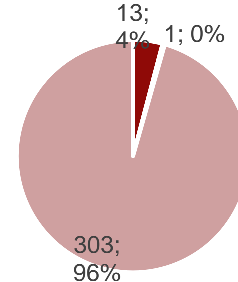
- BDRCS/IFRC staffs/volunteers
- Others (specify….)
- Phone call from BDRCS

Who informed you about the beneficiary card distribution and procedure?



- Local volunteers
- Others (specify….)
- Phone call from BDRCS
- Union parishad representatives

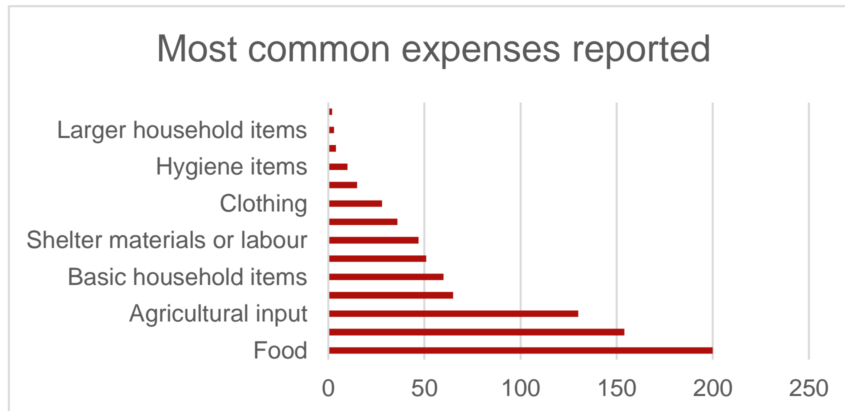
Did you or the person who went to the distribution for you feel safe at the venue for the distribution?



- Don't know
- Not at all
- Yes – completely

In 82% of the cases, the interviewee him- or herself was the person to collect the cash at the distribution site, in 14% the spouse of the interviewee collected the cash, and in 4% it was either a parent or another relative. 96% of beneficiaries felt completely safe at the distribution site. Only one person reported to feel unsafe during the distribution, but did not provide any further information.

Out of all beneficiaries, 91% had spent the entire amount of 5,500 BDT by the time the PDM survey took place, and only 2% of respondents had spent under 3,000 BDT. In the following, interviewees were asked around the use of the funds received. Only 15% of respondents spent the entire amount on items from one expense category, such as food, medical expenses or household items. Of the respondents who only reported one type of expense, this was most commonly agricultural input or livestock. A majority of 82% of respondents purchased items of between 2-4 different categories. The most common combination there was purchasing food, medical items and basic household items. The purchases listed under 'other' expenses reported by 65 interviewees were most commonly livestock, such as goats or chicken. Only a minimal number of cases paid back debt (15), saved money (4) or gave money to relatives and friends (2). Only 14 respondents needed items that were not available in the immediate area, such as specific medicine or food.



Overall, 32% of interviewees reported that the assistance had strongly improved their lives and 64% reported it had improved their lives. Only 8 respondents felt that the assistance had neither improved nor worsened their lives, and one respondent reported that it had worsened. When asked if respondents

preferred in-kind assistance over cash for future interventions, 68% said no, 29% said yes and 2% were undecided. 70% also reported that in their household, the use of the cash assistance was discussed and decided jointly. 90% of respondents stated that the assistance had not caused any conflict or disagreement in their household.

Output 4.1: *1'200 most vulnerable households are selected and provided with multipurpose cash assistance (MCA) of BDT 5,500.*

Together with the Upazila and Union government, the Wards 6 and 7 were selected for the multi-purpose cash grant distribution in Palongkhali. These Wards are amongst the core working area of this project and poorer compared to the other Wards. Volunteers from the area and Red Crescent Youths (RCYs) were employed to conduct the various activities leading up to the distribution. They were guided by National Disaster Response Team (NDRT) consisting of 4 members. The NDRT are cash experts that were deputed to Cox's Bazar for this distribution. A Junior and Senior Cash Officer from the BDRCS Population Movement Operation (PMO) trained the NDRT, 6 RCYs and 9 local Volunteers on the different aspects of the cash programming. They were also trained by the Community Engagement and Accountability (CEA) team.

The first step for the distribution was to conduct Focus Group Discussions. The 4 FGDs carried out in the two Wards generated community-defined beneficiary inclusion and exclusion criteria. Following this, the household assessment questionnaire was piloted. The NDRT/RCYs and local Volunteer visited households in pairs to gather respective data through Kobo Toolbox running on one tablet per team. After piloting, the questionnaire was finalized and almost all the households in the two Wards[34] were surveyed by the teams. Some households did not want to participate, others where not present after continued visiting, while other households looked affluent (e.g. large farms, houses etc.). These households were skipped, and hence, only 1'929 out of 2,574 households were surveyed. After every day, the data was transmitted from the devices to the Kobo cloud.

After completion of all surveys, the inclusion criteria were applied by the means of a weight as defined in the community consultation. If a household fulfilled certain criteria, he received a score of 1 that was multiplied with the weight. The sum of the weighted score was used to rank all the households. The 1'200 households with the highest score were then checked based on the exclusion criteria and removed in case they met one. The number of households excluded were then included again (the ones with the next higher score) until the beneficiary list reached 1,200.

Please find the inclusion and exclusion criteria defined through the community consultation hereafter:

Step I. - Inclusion Criteria		**Step II. - Exclusion Criteria**
(1,200 HH with highest score included)		*(If one fulfilled, HH is excluded, not weighted)*
Criteria description	*Weight*	
Disability and with chronic illness (1 HH member)	17.4	Part of Vulnerable Group Feeding Program by GoB (receiving 20/30kg Rice)
Widow (1 HH member)	16.5	Receiving/received cash assistance from other organization
Elderly (60+) (1 HH member)	13.8	One family member is a GoB service holder
Day labourer (1 HH member)	11.9	Internally migrated to this area (unregistered but living in Palongkhali, from other parts of Bangladesh)
Landless	5.5	Displaced People from Rakhine (Migrated and started to living along with the host community)
Women Headed	5.5	Receiving Old Age Allowance
Low Income (less than 5,000)	5.5	Receiving Widow Allowance
Big Family (6+ member)	4.1	
Income source affected by COVID-19	3.2	
Divorced	2.8	
Unemployed (1 HH member)	2.8	

[34] Population of Ward 6: 1,268; population of Ward 7: 1,306.

4+ women in a family	2.8	
Micro Business	2.3	
Landless Farmers	2.3	
Child Headed	1.4	
Mud house/shanty	1.4	

After finalization of the beneficiary list, 10% of beneficiaries were revisited to verify the information. This led to minor changes. Thereafter, the beneficiary list was published at offices of the local government in accordance with the Cash SOP of BDRCS. This was accompanied by a CEA process. Individuals were able to look at the list and file complaints through a complaint box. Community sessions where the population was informed about the CEA process were undertaken. A phone number where community inhabitants could call was also widely disseminated. After all complaints were addressed, the beneficiary list was finalized and shared with the Bangladesh Post Office (BPO). In parallel, the funds of BDT 5,500 * 2,000 were transferred to the BPO. All beneficiaries received a SMS from the BPO with place and date of the distribution. Two distribution points were setup ensuring adequate IPC. On 23 and 24 December 2020, the days of distribution, 1,169 households picked up the cash grant. Subsequently, the team communicated with the 31 beneficiaries who did not pick up the cash amount. They were informed by SMS by BPO again to attend a third distribution, which was combined with another distribution by BDRCS PMO later in December. During that day, 8 addition persons picked up their cash amount. Hence, 1,177 beneficiaries received the multi-purpose cash grant of BDT 5,500. No additional following-up will be done with the remaining 23 households.

Local partners

To implement this emergency preparedness and response project, SRC and its national partner, the BDRCS, defined a joint budget and procurement plan. For regular programming, SRC usually only undertakes steering, monitoring and technical advisory tasks, while implementation is done by the BDRCS. However, for this emergency project, around one-third of activities were implemented by SRC especially those related to ensuring facility readiness and health system strengthening initiatives in the host community. This was due to BDRCS's intense engagement in implementing IFRC's Country Plan of Action (supported by all movement partners) and, in anticipation, the distribution of roles and responsibilities between SRC and BDRCS were pre-agreed.

The Deputy Director of the BDRCS Population Movement Operation (PMO), working under the guidance of the BDRCS Head of Operation, played a key role in decision-making. He met every other week with the SRC Head of Sub-Delegation and SRC Programme Manager to review activities and take major decisions. The PMO is a joint outfit of BDRCS and RCRC movement partners to coordinate and implement humanitarian activities in Cox's Bazar in a spirit of shared leadership. Operationally, the project was managed by the BDRCS Health & Environment Coordinator who worked closely with the SRC Programme Manager. The BDRCS Finance & Admin Officer played a crucial role in coordinating procurements, the rented vehicles for safe movement, financial reporting and bookkeeping, as well as further administrative matters.

Outcome 1 of this project is closely linked to outcome 1 of the Primary & Environmental Health project (SDC 7F-10058.02.01) and is supported by the same staff structure. Furthermore, outcome 2 was implemented in close coordination with IFRC and newly recruited BDRCS ITC team, out of which 15 staff were funded from this project. The BDRCS SWM Operations Manager, working under the leadership of the Health & Environment Coordinator, was assigned to support outcome 3 of this project. He is guided by the SRC SWM Officer. Outcome 4 was supported BDRCS PMO Cash team through a Senior and Junior Cash Officer, the deployed NDRT, recruited RCYs and local Volunteers, as well as the CEA team.

For implementation of outcome 2, a close collaboration with IFRC and BDRCS was established. SRC and IFRC had taken up the function to co-coordinate the establishment of the SARI ITCs in camp 2E and at Rubber Garden near camp 7. Both organizations represented the movement in operational and technical meetings.

Under outcome 3, a formal agreement with the Union Parishad was signed. The Union Parishad, through elected officials, administrative staff and volunteers supported the project endeavour in awareness raising, selecting locations for posters and billboards, setting up and maintaining hand-washing points, and in linking the project to health facilities in the Union. The Chairman attended all relevant public events and ensured the project activities were backed by the community.

All health facility support activities were planned and jointly conducted with the Upazila Health & Family Planning Officer and the relevant the Facility-in-Charges were consulted for all activities. The COVID-19 training was chaired and co-facilitated by the Upazila Health & Family Planning Officer.

Monitoring & evaluation SRC
For the activities implemented by BDRCS, SRC extended supportive supervision. All field visits and activities were jointly conducted or facilitated by SRC and BDRCS staff. The joint procurement process defined involvement of SRC staff in BDRCS procurements and vice versa. SRC joined the weekly operational meetings. Every second week a meeting to review and plan activities was undertaken. During this meeting, all major decisions were taken jointly by BDRCS and SRC.

To maintain a healthy and safety of the SRC Sub-Delegation team in Cox's Bazar followed a stringent split office and movement policy until October 2020. Furthermore, office presence, field movements and meetings were reduced, leading to more working from home. This has altered productivity of SRC staff making interactions with BDRCS more difficult and reducing informal interactions within the SRC team. In November 2020, the SRC team went back to pre-COVID working modalities. Furthermore, SRC developed a medical evacuation plan that would ensure a safe transfer to a Dhaka hospital with ICU capacities in case a staff member has suspected or confirmed COVID.

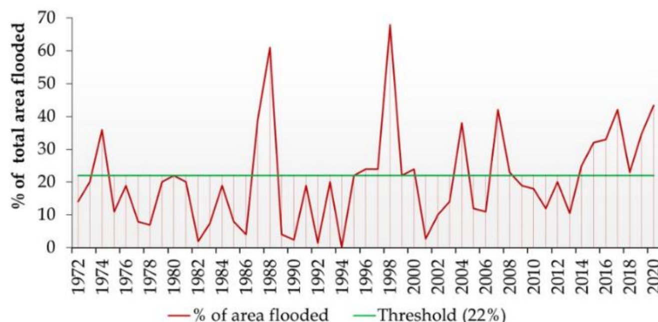
No evaluation will be undertaken for this project, as it is an emergency endeavour.

Conclusions and outlook
While some construction works under outcome 3 are continuing in January 2021, all other activities were successfully implemented as planned. The inherent linkage of this response project with the long-term programming of the SRC in Cox's Bazar ensures sustainability of the interventions. The outreach volunteers onboarded under outcome 3 will now be used for the SWM endeavour, for example. Furthermore, the waste collection initiated at the request of the Union Parishad Chairman is being phased into the regular SWM programming as well. The outreach facilitators and volunteers working in camps 11, 13 and 15 on COVID-19 messaging (outcome 1) were already working under the Primary & Environmental Health project before COVID reached Bangladesh - they already knew their communities and thanks to this project were equipped with new knowledge on WASH and COVID-19. The COVID-19 sample collection, short-term isolation and referral support to ITCs at the camp 2E PHC (outcome 2) is being continued well into 2021, most likely until March 2021. The cash component (outcome 4) is likely to be scaled with support from Swiss Solidarity in host communities to another Union that is relatively underserviced while a pilot in camps is planned. The learnings under this project will be instrumental in carrying out more cash interventions in a COVID-19 recovery manner.

3.3.3 440495, Monsoon Flood Response 2020 (Final project report)

In Bangladesh, floods occur regularly both due to in-country monsoon rains and due to upstream rainfall that passes through the numerous rivers in Bangladesh to drain in the Bay of Bengal. The monsoon floods in July and August 2020 belong to the worst in recent history, especially on account of its early onset and prolonged inundation of affected areas, and they occurred at the peak of the Covid-19 pandemic in Bangladesh. This double-disaster situation led to enormous humanitarian needs in affected districts. Taking flood data from Bangladesh Water Development Board (BWDB) and other sources, the research group from Bangladesh Rice Research Institute (BRRI) shows that land areas above the threshold level (According to BRRI it is expected that 22% of the land will be inundated with the monsoon rainfall and if it goes above that then they call it severe flood) have been submerged in the past six years consecutively – in 2015, 2016, 2017, 2018, 2019 and 2020.

In 2020, it was the second-longest flood since 1998, when the water level was 63 days above the danger level. However, such types of prolonged floods in the Brahmaputra-Jamuna river basin never started so early in the past (Source: HCTT report, published on 4 August 2020). The report of the National Disaster Response Coordination Center (NDRCC) issued on 2 August informs that 5.4 million people were affected and, that 1,059,295 households were inundated. The DPHE informs in its report that 92,860 tube-wells and 100,223 latrines were damaged. The Ministry of Agriculture (MoA) reported inundation of around 83,000 hectares of paddy fields.

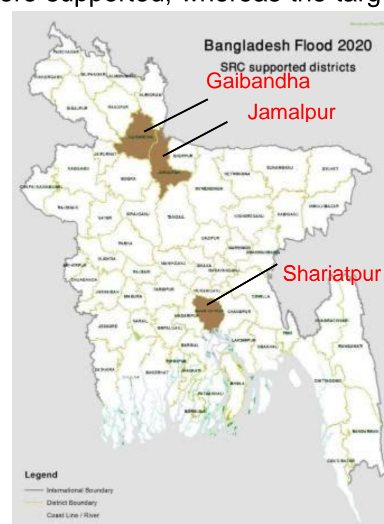


Jamalpur, Shariatpur and Gaibandha districts were amongst the seven worst impacted districts[35]. In Gaibandha, where SRC is present through its long-term disaster risk management programme, BDRCS-SRC supported families worst impacted by Covid-19 with multi-purpose cash grants (through project 440514), a timely measure that also aided people during the monsoon floods. In order to support flood- affected people in other parts of the country, SRC extended the cash grant support (for the amount of BDT 4,500) to 2,000 impacted HHs in Jamalpur and Shariatpur district while extending limited support (WASH & shelter repair) to affected families in Gaibandha.

In response to the floods and at BDRCS' request, the International Federation of Red Cross (IFRC) launched an Emergency Appeal in July 2020. IFRC through BDRCS allocated CHF 577,496 from the Disaster Relief Emergency Fund (DREF) to respond to the flood. A total number of 960 Red Crescent Youth (RCY) Volunteers worked in all affected branches for emergency response activities. At the initial stage, BDRCS National Headquarter allocated BDT 2 million for 12 worst affected districts to purchase dry food items, which was distributed by July 2020, but the demand was much more than that, as all those targeted districts were facing prolonged and repeated flood.

Overview of relief aid provided by SRC

Through this bilateral emergency relief project, a total of 3'037 HH were supported, whereas the target was to cover 3'200 HH.



Besides granting limited support (WASH and shelter repair) to affected families in the project areas of *Gaibandha* District, SRC extended its support to vulnerable families in two additional districts: *Shariatpur* District, one of the most vulnerable districts to floods and flood erosion, and *Jamalpur* district, the most heavily flood-affected district in 2020 and generally one of the top flood-prone districts of the country.
Based on the market assessment carried out flood affected districts that included Gaibandha and Jamalpur, the markets were found to be still functional and accessible even in remote regions. Therefore, the cash transfers were chosen as the preferred mode of response support.

[35] Priority Geographic areas are ranked by index based calculation of three major dimensions e.g. hazard impacts, vulnerability and response capacity. For every dimension composite indicators are indexed as per the Global INFORM risk index. The index is valued from 0 to 10 where 0 refers no impacts / severity and 10 refers highest impact / severity. Further these three composite dimension are compiled as (*hazard impacts × vulnerability) / response* capacity to rank the geographic priority.

The implementation of the project was supported by National Disaster Response Teams (NDRT) and Red Crescent Youth (RCY) of Bangladesh with the following number of staff:

- Gaibandha: 1 NDRT person (4d), 34 RCY (4d)
- Jamalpur: 2 NDRT persons (15d), 15 RCY (10d)
- Shariatpur : 7 NDRT persons (10d), 15 RCY (10d)

In addition, SRC's DRM manager was deployed and SRC's finance officer based in Gaibandha contributed at different stages of the response under the overall guidance of SRC's local Cash Advisor (DHoD). The project team of Gaibandha was responsible for the restoration part in Gaibandha and the BDRCS cash focal was leading the process in Jamalpur and Shariatpur under the guidance of the DR department of BDRCS. The DHoD also provided technical support to the DR department for facilitating the process on the ground as well as NHQ level.

Beyond the bilateral support to flood-affected districts, SRC also contributed with 200'000 CHF to the above-mentioned IFRC Emergency Appeal (50% non-earmarked, 50% earmarked to livelihoods support and NSD). This appeal was launched to meet the most urgent needs arising from the floods, with a focus on the provision of food, cash, safe drinking water, sanitation, shelter, and health support.

Outcome 1 2'000 HHs receive cash transfers enabling them to meet their subsistence needs

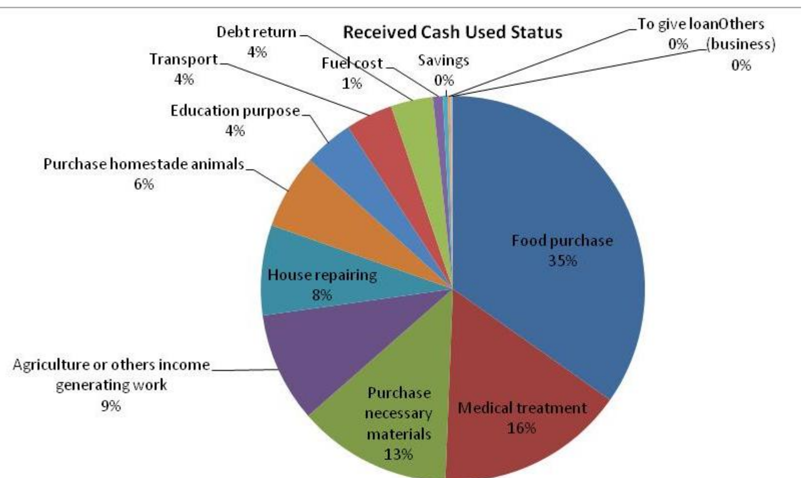
In Shariatpur and Jamalpur, BDRCS provided Multi-Purpose Cash Grants (MPCG) to affected families to meet their basic needs for one month. This support was granted just after the flood receded and people were able to return to their homestead. Given the magnitude and multiplicity of crises, the capacity of BDRCS' DR department was overstretched, hence PCU pro-actively brought in the desired level of support. In both Jamalpur and Shariatpur, BDRCS followed the cash SOP where they maintained the following key steps:

- Area selection: At first, government D-forms were collected to determine the most affected areas. Physical verification of the severity of damage was also observed by the local key informants, LGI members and BDRCS branch leaders. In both districts, focus groups discussions and key informant interviews were organized to determine the exact Subdistricts and Unions where the project would intervene. As Shariatpur Branch was in a reformation process, a detail reconnaissance survey team, comprised by BDRCS and SRC personnel, physically met the local government administration (DRRO, UNO, PIO), locally elected representatives and NGOs to get their suggestions, related information and to build a rapport. After triangulating all the feedback and information from all the relevant stakeholders (GoB, NGO, Branch and community), the areas (subdistricts and unions) were selected with D-form data.

- Beneficiary selection, CEA and complaint response: NDRTs were oriented on the CEA process and the overall response operation at the NHQ before their deployment in both the places. The DR and CEA Department and Data Management Team of BDRCS led the process with the support of SRC. Community consultation sessions were organized to orient the community on CEA and to sensitize them about the BDRCS mandate, targeting criteria, distribution process etc. The volunteers (RCYs) were also oriented on CEA and the process of organizing the sessions. CEA Department of BDRCS facilitated this process. Realizing the lessons from the Covid-19 response under project 440514, a separate card containing the BDRCS Hotline Number was provided to all the project participants along with the final beneficiary card. Several suggestion Boxes were established in public places of the selected communities, in line with the suggestion coming from the CEA process. Beneficiary list was also hanged in common places so that if there was any complaint about any beneficiary it could be verified and addressed.

- Verification of Beneficiary: To control the quality of collected data, a separate group of data collectors randomly verified the information from at least 10% of the selected beneficiaries. The final beneficiary lists were shared with the respective District Administration, LGIs, and local NGOs to avoid duplication.

- Distribution of MPCG: The transfer value of BDT 4,500/HH was decided based on the recommendation of the Cash Working Group. The final beneficiary list was handed over to the Post Office for distributing the cash grants. Accordingly, the distribution plan, including place and time, was developed, and shared with the beneficiaries. While sharing that information, the beneficiaries were also requested to bring their National ID card and relevant sim cards so that their identity could be verified. After that, the post office distributed money where BDRCS and SRC staff along with the Unit representatives were present.



- Exit Survey after Emergency Cash Support: After the cash distributions in Shariatpur and Jamalpur, a mobile-based quick exit survey was carried out by RCY volunteers at the distribution points to get immediate results from the distribution process. In Shariatpur, 110 people were surveyed and in Jamalpur 330, who had all received cash grants under the project. The results showed high levels of satisfaction among the targeted families.

- Post Distribution Monitoring (PDM): A PDM was carried out following the cash distributions both in Jamalpur and Shariatpur in December 2020. Trained RCY volunteers collected the data from 210 recipients of the cash grants (roughly 10% of the total number of targeted people), 47% of the respondents were from Jamalpur and the remaining 53% respondents were from Shariatpur. The information was collected through the KOBO toolbox. Among the respondents in Jamalpur, 81% were women and 19% were men while in Shariatpur 66% were women and 34% man. 98% of the total respondents were highly satisfied with the cash distribution process, while 2% were satisfied partially. On the other hand, 99% woman are highly satisfied with the cash distribution where 94% man are partially satisfied.
  The PDM showed that in most cases, the cash receivers used the grants for purchasing food and other necessities. Moreover, it is interesting to note that 16% of the respondents spent a significant amount of the cash for medical treatment, and 9% for agriculture and income generating work. The distribution points were within their walking distance (within 5km for 80% beneficiaries) and beneficiaries did not feel any pressure or security threat from any corner. Strengthening the CEA process had an impact on the beneficiary complaint response mechanism as 90% of beneficiaries were able to describe the complaint response process where during Covid-19 response this percentage was below 70%.

Outcome 2 1’200 HHs are supported to restore damaged WASH and Shelter facilities

Sanitation Repairing Support: Due to the devastating nature of the floods in 2020, many HH level latrines were damaged. Because the universal sanitation coverage is an important objective of the DRM programme in Gaibandha, 837 HHs in the four project unions of Fulchari Upazila received support to repair their hygienic latrines. Given that the existing DRM Programme in the area is working hard on ensuring hygienic sanitation at HH level, the project staff carried out a quick survey to identify the number of damaged latrines. Out of the 1000 flood damaged latrines, 837 were repaired with support of the flood response project. The remaining 163 HHs had already managed to repair their damaged latrines on their own or with technical support from the ongoing DRM project. The beneficiaries were selected through HH survey by the project staffs, the required technical and material support was ensured by the existing SanMark Centres and the project contributed with the cost.

Shelter (Houses) Repairing Support: To increase safety and security of the poor people in Gaibandha, the village disaster management committees (VDMC) in cooperation with the project staff identified 200 vulnerable families whose houses had been damaged by the monsoon floods. They received restricted cash grants of BDT 4’500 for shelter repair.

The VDMCs of the four unions first prepared a list of extremely poor and vulnerable families, whose houses were damaged during the floods. The project team crosschecked the list with the houses and selected 200 most eligible beneficiaries, which was then shared with the VDMC. After consensus, the list was shared with the UDMCs for approval and finalization. After the approval, the respective beneficiaries were asked to prepare a shelter repair plan following the standard format supplied by the project. As per their plan, the beneficiaries started repairing their houses with Corrugated Iron (CI) sheets, timber, and other materials. The project awarded them a fixed amount of BDT 4’500. If the cost was higher it had to be borne by the beneficiaries. The project team, along with the community volunteers, regularly monitored the progress of the shelter repair component of this project. Since it was the harvesting season and people were confined for a long time due to Covid-19, it was tough for them to accommodate time and labour. Moreover, most of the beneficiaries were elderly persons and, in most cases, no one was available to assist them in repairing their home. In this situation, the respective VDMC either organized a helping hand or put their own efforts to support the house repair. These are important learnings for future response initiatives of a similar kind.

Picture taken by Sheikh Kamal: On the left one HH of Majida Begum, before repairing, on right after repairing Katlamari village.

Finally, all identified beneficiaries were able to complete the repair work within the scheduled time. They are satisfied and grateful to BDRCS-SRC as their houses are now more secure than before the floods, especially in the upcoming winter. In this regard, the VDMCs played a key role both in beneficiary selection and monitoring the shelter repair progress. The project supported the VDMCs in their monitoring functions and the payments were made following the completion of the repair work.

Other organizations providing relief aid

BDRCS received CHF 234,803 from IFRC as they have activated the Early Action Protocol (EAP) in June 2020. With that, BDRCS supported 3,300 households with multipurpose cash support of BDT 4,500 (approximately CHF 49) in the districts of Jamalpur, Gaibandha and Kurigram. On 17 July 2020, IFRC released CHF 577,496 from its Disaster Relief Emergency Fund (DREF) fund to enable BDRCS to reach another 25,000 families with livelihood and basic needs; shelter; water, sanitation, and hygiene (WASH); health and protection, gender and inclusion (PGI).

The GoB distributed the following among the affected people - 7,193.375 metric ton GR Rice (total allocation made 11,710 M. Ton); 70,172 dry food packs (total allocation made 112,000); BDT 24.2 million (CHF 259,319) cash (total allocation made BDT 32,950,000/CHF 352,569); BDT 3.09 million (CHF 33,106) worth child food distributed (total allocation made BDT 7,000,000/CHF 74,900.80) 180 bundles iron sheet (allocation made of 300 bundles); BDT 4.26 million (CHF 45,678) worth fodder/animal food distributed (total allocation made of BDT 14600000/CHF 156,222); 878 medical teams formed, out of them 412 teams are actively working at this moment. Apart from the above, the GoB also allocated BDT 900,000 (CHF 9,630) for house repair of the flood-affected people.

So far, 51,868 people have been reached by different organizations (Care, FAO, PIB, UNFPA, WFP, Solidarity, RDRS, ESDO, MJSKS, SKC) through FbF at Kurigram (19,374), Gaibandha (17,916), Jamalpur (12,930) Sirajganj (1,633) and Boghra. OCHA’s anticipatory action framework funded by the UN’s CERF released ex-ante funds of USD 5.4 million to implement early actions for the flood.

Apart from BDRCS-SRC, a number of NGOs have provided relief aid in Gaibandha during/after the 2020 monsoon floods. These included the SKS Foundation, Gono Unnayan Sangstha (GUK), SDS, Friendship, RDRS Bangladesh, CARE Bangladesh, ICCO Netherlands, different LGIs (UDMCs, Upazila Parishad), ASOD etc. In Shariatpur START fund supported 1000 families with food support. Besides the NGO resilience platform that supported coordination of response efforts in Gaibandha, the District Commissioner's office through the District Relief and Rehabilitation Officer (DRRO) coordinates the response efforts of all actors. This is true for all districts where the BDRCS implemented response measures.

Emergency cash support in Jamalpur District:

Upazila	Union	# of families receiving cash	Amount per family (BDT)
Islampur	Islampur	292	4'500
Islampur	Palabandha	381	4'500
Islampur	Partharshi	327	4'500
	Total	**1000**	**4,500,000**

Emergency cash support in Shariatpur District:

Upazila	Union	# of families receiving cash	Amount per family (BDT)
Jazira	Kunderchar	401	4'500
Noria	Charatra	267	4'500
Vedorganj	Kachikata	332	4'500
	Total	**1000**	**4,500,000**

Shelter repair support in Gaibandha:

Upazila	Union	# of shelter supported families	Total cost for shelter repair (BDT)	SRC-BDRCS Contribution (BDT)	Beneficiary Contribution (BDT)	Beneficiary Contribution Percentage %
Fulchari	Erendabari	50	353,409	225,000	128,409	36.33
Fulchari	Fazlupur	50	342,344	225,000	117,344	34.27
Fulchari	Fulchari	50	337,224	225,000	112,224	33.27
Fulchari	Gazaria	50	984,290	225,000	759,290	77.14
	Total	**200**	**2,017,267**	**900,000**	**1,117,267**	**55.38%**

Latrine repair support in Gaibandha:

Upazila	Union	# of latrines repaired	Total amount (BDT)
Fulchari	Erendabari	232	349,144
Fulchari	Fazlupur	171	242,070
Fulchari	Fulchari	291	324,858
Fulchari	Gazaria	143	180,548
	Total	**837**	**1,096,620**

The 3-monthly monsoon flood response project has come to an end on 30th November 2020 and it took three months to complete the full process, except PDM which generally takes place after 4 weeks of completing a cash distribution. PDM took place at the end of December 2020, as a standard process in line with the cash SoP of BDRCS. The latrines which are constructed from this response project is dovetailed into the Universal Sanitation Coverage objective of the longer-term development project (440514). The development project will monitor the interventions, so that all the constructed latrines and shelters are maintained properly. BDRCS branches of Jamalpur and Shariatpur were closely involved with the response operation where no further action is foreseen.

4 Transversal topics

4.1 DRM Mainstreaming

In the Barind area, where the IWRM project is operational, agriculture is a high priority and within that reducing the traditional cultivation of like Boro rice which is not rain-fed and completely dependent on ground water. Due to extreme weather events including recurrence of drought like conditions in Barind along with extremely high reliance of users on ground water, farmers are increasingly suffering from water shortages for both their agricultural and domestic uses, and there is a growing demand for improved access to water for rural livelihoods. Climate conditions and geography determine how much water is available (supply) while well-being imperatives, particularly livelihood compulsions, determine how much water we need (demand) in the short and long term. In light of this, the IWRM project (440511) has initiated an array of measures to combat the disaster and climate risks of the Barind area. To mainstream climate and disaster risk into IWRM, a transformation of the current practices towards improved performance and outcomes based on 4R principles – reducing over-abstraction and water pollution; reusing rainwater; recycling water resources; and restoring water supply – is being applied to encourage the community to adopt and enhance water-sensitive practices to optimize benefits. Furthermore, the IWRM project promotes alternative water practices such as switching to a combination of ground water and surface water sources.

Mainstreaming DRR into health is generally seen to be making health systems more resilient to the impacts of disasters. In the context of disasters, the resilience of a health system is seen to be the ability of health institutions and actors to prepare for and effectively respond to disasters/crises so that health services continue to protect human life and produce good health outcomes during and after the event. To this effect, PHIIR III trained health service providers on DRR and supported the development and implementation of contextualized DRR plans for 44 and 29 CCs in Rajshahi and Naogaon, respectively. The plans led to structural measures to ensure their safety in the event of floods and water logging. The FWC renovation work, on the other hand, implemented low cost hazard protection measures. However, during 2020, the objective of making health facilities disaster resistant could be only partially achieved and will be taken forward to 2021.

The delegation preparedness (DP) exercise undertaken in 2020 reflected on the institutional capacities of SRC and BDRCS in response readiness. Some of the findings and follow up actions emerging from the DP workshop are as follows:

→ BDRCS' current capacity for response is already strong. They have good technical skills and reasonable human resources and manage initial assessments and immediate response efforts to annual flooding events well. However, there are still gaps in branch capacity to respond. Many of BDRCS' human, technical and financial resources are currently located at the national level. Decentralisation of capacities to regional levels should be supported by SRC. In line with this SRC supported BDRCS and IFRC in drafting an HR optimisation plan which advocated establishment of regional hubs in the flood and cyclone prone regions

→ BDRCS' capacity to deliver cash rapidly is adequately demonstrated in various emergencies. While the capacity to distribute cash was well demonstrated, the scale was still limited considering the extent of need.

→ During the workshop it was evident that many participants understood parts of the current cooperation processes between SRC and BDRCS, but there were also different understandings, and a complete picture was missing. SRC should ensure that a holistic understanding of BDRCS around the current cooperation process. (This has been significantly achieved once the Director, Response department became SRC's focal person who at the time of DP workshop was new to SRC's cooperation model)

→ In the scenario built during the workshop, participants considered a response to a large flooding event coinciding with the occurrence of a cyclone in the country, it was very likely that BDRCS would face gaps in capacity at the national level in terms of human and financial resourcing and technical expertise. It was agreed that the following supplementary support would be required: deployment of ERUs or FACT to provide further technical support for assessments; support with

procurement and logistics; Financial management support, particularly at unit level and; the building of capacity of branches (units) to respond to disasters. Further, in this scenario SRC would prefer to offer bi-lateral support on flooding but would consider making a multi-lateral contribution through a Federation led Emergency Appeal. The use of these modalities will also reduce the pressure on the delegation to potentially co-manage two response operations while SRC would still be free to offer technical assistance to a cyclone response, as necessary, through the Federation's system of ERU deployment.

→ The Capacity Mapping exercise was particularly useful for gaining better insight into BDRCS' capacity at both the national and unit level as well as that of the Government. The basis of the capacity identified by BDRCS was taken from the Preparedness for Effective Response (PER) assessment, which was built on through the exercise. This also greatly assisted in identifying areas where SRC could support BDRCS not only in response but also in long-term capacity development, particularly at the unit level. These are: a) developing SOP covering emergency response procedures, b) logistics management and supply chain, c) resource mobilisation, and d) emergency health preparedness and response

4.2 CSPM Mainstreaming

SRC strives for building institutional capacity at all levels, with the aim that BDRCS / DASCOH's actions in the country and in the field are informed by the context, minimize negative impacts (Do no Harm), contribute to positive change (do good), and react in a flexible and context-appropriate way to changing conditions on the ground.

DASCOH rigorously applies conflict sensitive project management (CSPM) across the entire project cycle in all its projects, with special attention to beneficiary selection, resource transfer via the different sectoral interventions, selection of staff, partners and suppliers, communication and behaviour and support to factors that potentially divide society. All staff development trainings at DASCOH essentially have sessions devoted to CSPM where existing and potential conflicts / tensions are analysed along with measures to mitigate them.

With BDRCS, the CSPM initiatives of SRC have not been so successful, as such initiatives will have to be driven by the IFRC. Though the national society is familiar with IFRC's "Better Programming Initiatives (BPI)" and "do no harm" concept, none is institutionally or programmatically embedded. SRC's HQ level initiative to support IFRC in transforming BPI into a more comprehensive CSPM framework will permit in-country dialogue with BDRCS on mainstreaming CSPM both at the institutional and programme level. Hitherto, CSPM initiatives are entirely delegation-driven and project-centred. In 2021, all BDRCS staff involved with SRC programming will receive another round of orientation in CSPM tools and processes that will enhance conflict sensitive management of ongoing projects.

The CSPM workshop planned for BDRCS in the context of urban slum programming where CXB SRC – BDRCS staff were to be oriented in the concepts and tools to be applied for conflict sensitive programme management did not take place due to Covid restrictions and the associated engagement focusing more on Covid – 19 response. It will be carried out in the first semester of 2021.

In the meantime, SRC HQ initiatives to mainstream CSPM into the federation's BPI tool proved successful: BPI has incorporated almost all the tools and concepts related to CSPM that was developed by SRC in collaboration with SwissPeace. However, the planned ToT in the revised BPI at IFRC Geneva level that was planned for 2020 could not be carried out due to Covid – 19 restrictions. SRC is looking at options as to how the ToT can be undertaken while BPI can be rolled out regionally in 2021. This is a great accomplishment which paves the way for institutionalization of CSPM with National Societies.

4.3 Gender & Diversity Mainstreaming

The Bangladesh Country Programme emphasises women's equal access and control over resources, their equal participation in decision making processes, and their proportionate representation and participation in all institutions whether mandated by the government or promoted by numerous projects. At the same time, diversity and inclusion considerations are taken into account at all stages of the project cycle

management so that traditionally excluded and marginalised groups have a voice in various forms and the decision making processes. All committees (whether these are VDMC in the DRM project, WDCC and BMCs in the urban slum project or the WRMCs in the IWRM project) have equal representation of women. In the management committees for the various health facilities, women participation is ensured as per government rules and guidelines. In IWRM intervention area, adequate representation of ethnic and religious minorities are ensured in the water resources management committees (WRMC).

During the outcome survey of the urban slum project, the majority of the women interviewed expressed satisfaction with their quantitative and qualitative (especially decision-making) participation in WDCC and the block management committees. At Gaibandha, women outnumber men in their representation in the VDMC that decide on risk reduction priorities informing the DRM actions of the local government.

The central role of women as providers and users of water and custodians of the living environment is rarely reflected in institutional arrangements for the development and management of water resources. The IWRM project does, however, through its positive policies, emphasise the principle of gender equality and seeks to address women's specific needs while equipping and empowering them to participate at all levels in water resources programs. This includes decision-making and implementation, in ways defined by them. The project has created a cadre of local caretakers and water managers, favouring positive discrimination in the selection process, whereby a certain number of such positions is secured for those belonging to the extreme poor, the marginalised (especially ethnic minorities) and women.

The health interventions, be it under the PHIIR project in Rajshahi (440519), or in the camps of Cox's Bazar (440518), endeavour to foster optimal control of women over the reproductive health and the consequent well-being it inheres. Nothing can be a stronger determinant of maternal health in all its forms than the well-being of her expected/delivered/infant and growing child. Thus, ensuring improved access of women to reproductive and child health services is as much a project objective as an ethical imperative of the project.

IEC interventions have heightened the awareness of women on not only health and its social determinants but also the imperatives of their participation, on the one hand, in civic duties related to environmental sanitation, and, on the other, in securing their social entitlements. The cadre of IEC volunteers with female preponderance is well suited to target women in larger groups (including mixed groups) and in interpersonal and smaller group interaction, with health, hygiene and wellbeing messages and messages that delegitimise values and practices rooted in patriarchy. Across projects, folk theatre and songs are being organised to drive the importance of women's participation in project actions while underscoring the explicit and latent forms of gender discrimination and the overwhelming need to end them. Given the roaring vulnerability of women from Rakhine, the camp interventions will require rigour and continuous reflection and adaptation using a contextualised gender lens to achieve successful gender outcomes.

5 Budget vs. Expenses (in CHF)

	Budget 2020	Expenses 2020	*Comment if deviation >10%, see below*
440514	*698'850*	*657'590*	*94.1%*
440517	*357'728*	*342'471*	*95.7%*
440519	*704'724*	*514'397*	*73%*
440511	*1'222'491*	*1'020'463*	*83.5%*
Subtotal development cooperation	***2'983'793***	***2'534'921***	***85%***
440495	*385'000*	*377'729*	*98.1%*
440518	*922'878*	*778'854*	*84.4%*
440521	*486'606*	*465'410*	*95.6%*
Subtotal Emergency relief	***1'794'484***	***1'621'993***	***90.4%***
Overall total	***4'778'277***	***4'156'914***	***87%***

Explanations on Efficiency and Deviations

The DRM programme (**440514**) and the urban slum programme (**440517**) were highly efficient in meeting their annual budget targets to the tune of 94.1% and 95.7% respectively. In case of the former, there was overspending against the outcomes 1 + 2. As large number of latrines were built during the reporting period (under OC 1), the expense exceeded the budgeted amount. Further, the inclusion of two new branches, which required more workshops to be organised than planned, led to over-expenditure against outcome 2. On the other hand, due restrictions on travel and social gathering, staff movements were on the lower side leading to lower operating expenses. Moreover, the budgeted cost of the OD advisor was not utilized which also led to some underspending. In case of 440517, the 2% shortfall has been entirely due to the absence (non-recruitment) of a field coordinator.

For **440511,** the overall financial spending of 83.5% of the annual budget has been quite satisfactory. The expenditure against outcome 1 was 86.5% of the budgeted amount while that of Outcome 2 and 3 were quite low (33 and 35% respectively). This is because, these outcomes depend largely on WARPO's involvement in the field that could not be possible during 2020.

For **440518**, less funds were used than planned, as under all outcomes there is a training budget. Due to the COVID-19 pandemic many trainings were postponed, as larger gatherings were neither recommended nor permitted during a large part of 2020. The construction of the 5th PHC is postponed to 2021. This delay was caused by the COVID-19 pandemic and resulted in savings on construction, maintenance and HR costs. Although it was planned to complete the MRF construction in host communities and recruit all SWM staff in 2020, this could not be achieved. The negotiation process and discussions with UNDP partners and the Union Parishad, the MRF design and procurement process as well as the BDRCS recruitment processes took longer than anticipated. Hence, the result is an underspending. Less Community Health Volunteers were recruited, and hence lower allowances were paid, as the construction of the 5th PHC was postponed to 2021 and the 2E facility was not operated as PHC until October 2020. BDRCS HEC position was vacant for 3 months in 2020. Some December 2020 salaries are to be paid in January 2021. Staff did not receive travel allowances in most of 2020, as vehicles were hired for safe movement under the separate COVID-19 project (**440521**). Overall, this resulted in lower travel costs due to less field movement during the pandemic. Support and coordination expenses are lower relative to implementation expenses.

In spite of HR challenges**, the PHIIR III project (**440519**)** was reasonably efficient though it could not meet the projected target for year-end expenses**.** Some of the planned costs could not be incurred due to delays in HR placement in the government facilities, hiring a consultant to develop communication strategies for webpage development, and delays in finalisation of the MoU with private facilities. Coordination meetings (national & divisional) did not materialize due to restrictions on social / public gatherings. To minimize travels, the ANC, PNC and waste management trainings were organised at union facilities instead of residential facilities. Equipment for facilities have been purchased based on needs instead of a similar package for all facilities. For Covid – 19 response, the lower expenditure has been due to lower number of installations of handwashing stations as some of these were installed by LGIs while the emergency fund for project staffs remained underutilised. The personnel expenses were lower due to recruitment delays, postponing staff development training and less field movement due to Covid – 19 restrictions. Maintenance, electricity and fuel cost were need based.

In case of 440521 and 440495, 96% and 98.1% of the project budget was spent. For 440521, the underspending has been largely due to the earlier than planned closure of the ITC at camp 2E, savings were allocated to a COVID-19 component at the PHC in camp 2E. Transitioning from ITC to PHC took longer, and hence, one-month salary could be saved from PHC staff. Further, infrastructure support to the Union Sub-Center was not undertaken. IFRC supported this facility with a new centre, rendering the initially envisaged infrastructure support unnecessary. For operating costs, projections during modification could not be reached due to a lower need of office costs. In case of 440495, the health camps that aimed at rendering emergency health services to vulnerable communities was not required as these were covered by BDRCS through IFRC support, thus no expenditure was incurred against this budget line. Also, the project covered the repair of lower number of latrines (837 latrines as) the rest of them were already fixed by individual families or with the ongoing DRM project

6 Risk Management

Unlike any other year, Covid – 19 added a layer of risk that was unprecedented in recent history. It intensified the needs of an adequate and speedy response to the pandemic, which in turn had a bearing on the entire gamut of risks and even beyond in terms of potential health risks to the entire population of a kind that made business continuity extremely difficult. Containment strategies required support of all citizens, which essentially meant being completely confined under lockdown conditions to strictly observing 3Ws – watch your distance, wear a mask, and wash your hands – when the lockdown was withdrawn. Business continuity required a level of ingenuity rarely exercised by the entire population engaged with any form of meaningful employment. The rapidity of response necessitated by multiple crises that 2020 witnessed meant not only recalibration of programmatic activities but brought in its fold heightened risks to programming, partnerships and financial management.

On the positive side, the Covid – 19 restrictions led to greater localisation of aid hitherto never witnessed by many countries. The localisation study conducted by IFRC APRO acknowledges that "*the pandemic has forced the IFRC Secretariat to take a step back. It has challenged our ways of working and demonstrated that there are new ways to work and provide support. In the shift towards more locally led humanitarian action, there have always been tensions between risk and compliance – and COVID-19 has amplified these – but the pandemic has also compelled us to simplify our processes and consider more flexible, efficient, and locally driven support to meet the needs of national societies and the communities they serve*." The study cites BDRCS' food procurements as an example where procurement processes were simplified to expedite food distribution. Cyclone Amphan is cited as another good example of accelerating more locally led humanitarian action.

The SRC delegation, in close consultation with HQ, carried out a comprehensive risk assessment exercise to develop proper risk management strategies with a special view to analyse and mitigate Covid – 19 associated risks. The analysis also included an appraisal of risks that had been identified through earlier risk cockpits. A detailed outcome of the risk analysis and risk management strategies reveals the following high risks, some of which are not directly related to Covid–19, that were reasonably well addressed during the course of the year:

Risk Category	Risk Description	Matrix Score
Programme	With the onset of the monsoon season, floods can be expected to cover half of the districts of Bangladesh.	6.3
Programme	The economic disruption caused by COVID-19 threatens the livelihoods of millions of people in Bangladesh. Existing vulnerabilities will be further exacerbated.	4.9
Governance	The occurrence of multiple disasters simultaneously has exposed BDRCS' preparedness and capacity to effectively and efficiently manage multiple large-scale response operations. In such a situation, BDRCS' capacity is restricted. Robust contingency plans that clearly depict the preparedness for effective response, are missing.	4.9
Partner	Changes in Leadership of BDRCS / IFRC: The entire leadership of IFRC is expected to change in the months (Nov-Dec 2020) ahead, incl. the Head of the IFRC sub-office in Cox's Bazar. The chairman of BDRCS will also change in the coming months (by March 2021).	4.9
Partner	DASCOH operates from a rented premise and was recently asked by the property owner, which is the Lutheran mission, to vacate the premises. Due to Covid - 19 this is on hold but an abrupt eviction in future will undermine organisational functioning and performance especially as Rajshahi does not afford many options to house an organisation like DASCOH, meeting all its requirements.	4.9
Partner	The absence of a credible second line leadership at DASCOH makes the organisation completely dependent on the CEO. This puts the long term organisational	4.9

Risk Category	Risk Description	Matrix Score
	sustainability at serious risk. Moreover, the high dependence on one person undermines various aspects of programming and its subsequent implementation.	
Programme	Attendance at Health Facilities may be lower due to COVID-19-induced fears. Some Health Service Providers are not operating during the COVID-19 pandemic.	4.9
Programme	Due to protracted suspension of project activities and therefore shortened timeframe for implementation, severe setbacks in attaining programme goals and objectives are expected (BDRCS and DASCOH). Moreover, project priorities may no longer be a priority for the target communities. Even reviving some of the services (esp. low priority ones for beneficiaries and other stakeholders) will pose a challenge.	4.9
Fundraising	The funding for the long-term development cooperation projects might be impacted due to economic impact of COVID-19 on donor countries. The cut down in funding of long term DC programmes can be from moderate to severe depending on the impact of the pandemic	4.5
Programme	Highly qualified and skilled staff is hard to find in Bangladesh (especially women). Those who are qualified either work abroad, are not ready to work in remote areas or not willing to work for the salary we are able to offer with our budget.	4.5

At a more operational level with the expanding engagement of BDRCS and RC/RC in multi-purpose cash assistance, the movement in general and BDRCS in particular has to be vigilant against reputational risks inherent in this mode of response. Any leakage or fraud and corruption in cash transfers not only violates the RC/RC fundamental principles but can pose long term damage to RC/RC's reputation in the country. As reported above under 440514, integrity incidents like that at Gaibandha can be avoided by reinforcing the robustness of community engagement and accountability processes in cash transfers. The investigation into the Gaibandha incident recommended following set of measures which can be considered, but not limited to, in revamping the CEA processes:

- Before beneficiary selection for cash grants, all RCYs and staff should undergo an orientation in Community Engagement and Accountability (CEA) and its special bearing on cash assistance. This should include orientation in feedback and complain resolution mechanisms focusing upon proper recording of all complaints and ways and means to respond quickly to resolve them.
- The hotline number card needs to be shared with every beneficiary when providing relief or cash grant.
- Post distribution monitoring should be integral to all cash transfers to follow up on the effectiveness of the cash transfer. The learnings should inform consistent improvements / strengthening of cash assistance processes and outcomes
- The whistleblowing system should be strengthened and promoted by NHQ by enforcing the existing policy

The engagement of BDRCS with the Population Movement Operation at Cox's Bazar and the multiple crises in 2020 has resulted in a huge diversion of attention/interest from urgent policy and strategic issues and also the long-term development cooperation projects. The human resources are over-stretched and the senior management of BDRCS is equally occupied in sorting out HR, funding, and coordination issues that continue to hamper the response to various emergencies. This is affecting the overall performance of BDRCS including the long-term development cooperation programmes. IFRC, on the other hand, finds it difficult to balance between its emergency response and National Society development and coordination mandate. This results in absence of synergies in PNS's efforts directed at NS capacity development. Risks of sub-optimal capacities persist which will make it difficult for NS to attain its strategic priorities.

At CXB, the social cohesion agenda is at further risk due to repeated occurrence of security incidents. With the massive influx of Foreign Displaced Myanmar Nationals (FDMN) in 2017, Bangladesh is not only hosting one of the largest refugee populations in the world but is also confronted with a set of security challenges and risks that are typically associated with mass displacement where the host country is strongly opposed to integration of refugees in host society. Even historically, Cox's Bazar has been a centre for drug and human trafficking due to its proximity to international maritime routes. Since the refugee population is deprived of educational and livelihood opportunities, their extremely high potential to engage in all forms of trafficking is not only likely but its beginnings are already writ large on the recent security incidents in the camps. Violence between gangs led by disenchanted youth is becoming commonplace. At the same time, growing disenchantment with living conditions and lack of opportunity for any meaningful engagement makes the camp condition ripe for proselytization of camp population in extremist ideology and actions. Media reports indicate that extremist activities are on the rise in the camps. To this can be added the growing tension between the guest and the host communities over sharing of scare physical and environmental resources, declining wages for host population, and disproportionate attention of aid community. If these growing tensions and subterranean conflicts between guest and host communities are not well managed, it is very likely to result in civil disorder with potentially disastrous consequences. The vast presence of international aid workers also makes them vulnerable to probable extremist attacks, which have already happened in the recent past in Bangladesh. This risk has to be examined from the lens of recent IS announcement to target humanitarian actors. Thus, security risks need continuous monitoring especially in the camps for drugs and human trafficking. Further, attempts to regulate mobility through fencing might trigger latent tensions.

In the continued absence of a credible second line of leadership, the successful growth story scripted by DASCOH in recent years remains at risk and so is the **business continuity of the organisation**. This risk remains despite DASCOH having addressed many of the HR recommendations proposed by the OD exercise. DASCOH, in line with the OD recommendation, has developed numerous policies and guidelines (child and staff protection, gender policy, security plans). Even the organisational organogram as been reviewed and revised. A director level position for health environment is being supported by SRC and a suitable person was recruited for this position in 2020. Though the position is based at Dhaka, regular visits were undertaken to the project area once Covid – 19 restrictions were lifted.

7 Conclusions and outlook

To address the huge constraints imposed by Covid–19 containment measures, all programmes were reviewed or modified. This included the review of operational and budgetary plans. Following the review (in some case modifications), additional strategic priorities were set for the long-term programmes, which all had an in-built Covid – 19 response component.

In the table below, a self-assessment has been done of the levels of attainment of various strategic priorities that ranges from entirely done (ED), to reasonably done (RD), to partly done (PD) to not done (ND). The assessment results indicate that a broad range of strategic priorities could be either entirely or reasonably achieved. The failures in attaining some of the strategic priorities can be attributed not only to Covid – 19 and its impact but also to the huge engagement of project teams in addressing people's suffering due to the pandemic and severe monsoon floods.

Strategic Priorities for 2020				
440511	**440514**	**440517**	**440518**	**440519**
• Sign all pending MoUs (tripartite with SDC, WARPO, CYMMIT, NILG, Cotton Board) (PD) • Strengthen engagement with WARPO while flagging risks with SDC (PD) • Activate IWRM committees at Upazila and Zila	• Accelerate universal sanitation coverage (ED) • Strengthen DMCs (BDRCS representation, draw attention/support of civil administration, resilience platform involvement) (ED) • Implement response measures (ED)	• Expand SWM (D2D collection) to all HH (100% coverage) (ED) • Establish 3 decentralised temporary MRF to process 50-60% of waste generated; Initiate construction of MRF (permanent) (PD) • SSNP – facilitate inclusion of eligible	• Continuity of PHC services – improved MIS, joint monitoring of service quality and implement strategies to address quality gaps (ED) • Review and strengthen internal coordination systems at PHCs (ED)	• Ensure facility readiness at all levels and all health facilities (upgradation, logistic, equipment, supplies) (RD) • Plug HR gaps for all FWCs through recruitments supported by govt. / UP / FMC (PD)

level as per BWR (ND) • Implement IWRM and DW (drinking water) schemes as planned by UP/WRMC (RD) • Modernise GW (ground water) monitoring system / analysis of findings and factors with all sub-national stakeholders (ED) • CB exercises (contd.) (RD)	• Review early warning and preparedness instruments (ED) • Support implementation of outcome 2 (branch development as per plan) (RD) • Implement WASH & shelter repair (flood response) (ED) • Initiate endline assessment and new phase programming (Patrick Bolte) (ED)	beneficiaries in social protection schemes (ED) • Implement response programming (ED) • Revitalise GCC DMC (RD) • Water safety and sanitation piloting (ED) • CB exercises contd. (including community sensitisation) (RD)	• Strengthen outreach: review current practices (ED) • CBHFA refresher, involve opinion / spiritual leaders (RD) • Conclude implementation of all CBHFA modules in entire catchment; strengthen SWM sensitisation (RD) • Expand SWM services to 50% camp population; formalise collaboration with HEKS; market / onward linkages for recyclables and compost (RD) • Initiate SWM for host community (as planned) (PD) • Finalise agreement with UNDP and construction of MRF (PD) • Backstopping visit of Sanjay (RD) • Decision on 5th PHC and plan transition of ITC into PHC (ED)	• Capacity development of HSPs as per plan (RD) • Review and develop a strategy paper to address referral gaps followed by its implementation (ND) • MoU with private health facilities to ensure CEmONC services (PD) • MoU with BDRCS on BFA and Training of HSPs in basic first aid (ED) • Activate management committees at all levels (at least one UHC MC meeting for all the 5UHC) (ED) • National and sub-national coordination meetings with government (PD) • Workshop with LGI / health authorities to scale up "whole upazila approach" (PD) • Continue streamlined supervision & mentoring visits (RD) • Strengthen focus of outreach programme on MNCH, fathers' club, adolescent health (PD)

440511

Working with citizens and LGIs, especially the UPs, on IWRM processes has been extremely successful and result oriented. However, the project recognises the massive challenges associated with the reform of the institutional arrangements that sustain the current water sector landscape. Another challenge will be to overcome both perceived and real negative financial implications on the asset owners from a functional regulatory regime. Along with the national component, suitable measures will have to evolve to address challenges associated with the sheer number of water sector actors and, especially, in monitoring their compliance with the regulatory regime. Covid-19 pandemic also interrupted the normal flow of the project.

Out of the three outcomes, good progress can be reported against Outcome 1 where 86.5% of the allocated budget was spent. The progress against outcome 2 and 3 were unsatisfactory owing to reasons explained above, mainly the absence of WARPO's engagement in project activities.
The outlook of 2021 will focus on the following strategic initiatives:

a. Initiation of the national component resulting in duly staffed WARPO office at Rajshahi (n)
b. Contracting and initiation of participatory rural appraisal of water resources and water management practices in Barind (n)
c. Contracting of an expert firm followed by initiation of hydrological investigation in the intervention area (n)

d. Strengthening of IWRM committees at the Union level: formation and activation of district and Upazila IWRM committees by WARPO (sn/n)
e. Enabling UPs to manage and utilise the web-based water resources mapping for fulfilling their regulatory functions assigned by the rules and their good governance obligations to ensure right to water to their citizens; a server is also planned to host the web-based water resources database to a permanent website for sustainability of the database (sn)
f. Continuing the co-financing procedure and its compliance to support implementation of suitable IWRM measures (sn)
g. Monitoring support to participatory rural appraisal and hydrological investigation exercise (sn)
h. Exit planning of IWRM project with LGIs for sustainability of project interventions (sn)
i. Support to registration as a cooperative society of surface water irrigation scheme O&M committees (sn); and
j. Formal partnership with BCDB followed by intensification of farmer campaigns and handholding support to accelerate crop diversification.

440514

At Gaibandha, despite Covid–19 restrictions, the project proved extremely efficient as can be seen from the high rate of budget utilization. In part, this was due to re-purposing the programme to redirect resources for Covid-19 cash response that also included the review of the annual plan of action to make it realistic and achievable. Moreover, the project was driven to a no cost extension as it was not possible to achieve branch development goals, as the existing branches were not able to implement the branch development initiatives. Moreover, replication of branch selection process was required to select two additional branches. Quality assurance was ensured through regular monitoring of infrastructure works supported by capacity building initiatives targeted at the levels of users, entrepreneurs, village institutions (VDMCs) and LGIs and UDMCs. The UDMCs and the UzDMC gained in strength. The NRP was expanded to bring in new members and numerous consultations helped better coordination in humanitarian and development initiatives.

In 2021 apart from continuing the drive for universal sanitation coverage mitigation options liked plinth raising will be completed. Reopening of schools will also permit revival of school WASH sessions. Training on flood shelter management is planned along with orientation of DMCs in forecast-based financing. UPs will be supported in making the ward shavas and open budget sessions regular. At the beginning of 2021, the DRM review and end-line assessment are scheduled, and their findings will inform the design and content of new program phase. Under the review process the output and outcome wise indicators will be analysed with the support of the external consultancy firm and their local assistant. More information on the proposed DRM review and needs assessment can be found in the Terms of Reference of Banyaneer, the international consulting firm hired to carry out his exercise. Under outcome 2: project will basically focus on implementing the planned activities at the branch level along with a lesson learned exercise.

440517

Looking at the results of 440517, one can conclude that the project was able to cover substantial grounds despite the severe challenges posed by Covid – 19. This in large measure can be attributed to smart revision of the annual plan in mid – July and subsequent revision of the project budget. Of course, there remains significant room for improvement in SWM, improving people's access to services, and unit development. On the other hand, significant gains can be reported in the areas of health, WASH and DRR.

Following the LRRD approach, along with regular project activities, Covid-19 emergency cash grants were also distributed in the reporting year and a Covid-19 livelihoods recovery component was planned and approved by SDC under the IWRM project (440511), which shall be implemented in Gazipur in 2021. The project outlook for 2021 is as follows:

Covid-19 Recovery	▪ Kick-off recovery project in the field and recruit the staffs. ▪ Build partnership with training providers including those supported by SDC ▪ Beneficiary selection for skill development and small business recovery based on sound business plan ▪ Cash-distribution and follow up ▪ Conduct GBV assessment and implement the protection component

Health and WASH	▪ Continue court-yard sessions. ▪ Install more hand washing stations and model latrines. ▪ Increase hand-washing coverage from 90% now to 100% at the end of 2021.
SWM	▪ Increase subscriber households from 73% in 2020 to 100% by June 2021. ▪ Increase and regularise service fee collection from 1589 to 2600 at the end of 2021. ▪ Increase waste composting capacity and streamline their marketing ▪ Define business modality for the recyclables ▪ Increase the capacity of managing waste by exploring both centralized and decentralized system and implement the most suitable option for the slum setting ▪ Establish systems for proper disposal of reject with the support of GCC.
DRR	▪ Facilitate GCC to form Disaster Management Committee (DMC) at ward level. ▪ Ensure BDRCS representation in all ward DMC. Identify one potential member in each of the wards and orient them on their roles and responsibilities.. ▪ Support DMC to form a volunteer team and provide them necessary training. ▪ Support DMC to prepare DRM plan, Contingency plan etc.
Community Engagement	▪ Complete the reformation of WDCC, BMC following their constitution ▪ Support BMC to make them more active and implement community-led interventions. ▪ Sharing the PASSA findings with WDMC for reducing the community level risks
Access to urban/municipal services	▪ Increase mass public awareness on social safety net program. ▪ Establish effective CRM system. ▪ Facilitate continuation of dialogue between community and service providers to address PASSA findings. .
Unit Development	▪ Facilitate unit to prepare annual action plan and support them to implement it which includes capacity building of the RCY and EC committees, develop mechanism of fund raising in a cost sharing modality ▪ Include all commitments made by units in their "declaration for positive transformation 2020" and support them in its realisation. ▪ Build capacity of the unit to play their roles effectively in the Disaster Management Committee.
Internal review	The main purpose of the internal review will be to comprehensively understand the reasons and factors that have led to lower than expected achievements against those outcome and output indicators as indicated by the findings of the annual outcome survey carried out at the end of 2020. The findings of the internal review will inform future strategies and mid-course corrections with the aim to attain project objectives. The PMER department in close consultation with the SRC's focal person and BDRCS project team will bear the overall responsibility of the internal review. SRC delegation will render technical and management support to the review.

440518

At CXB, the PEH project (440518) is well underway in terms of reaching outcome and output indicators. While the COVID-19 has led to delays, especially in constructing and operating the 4th and 5th PHCs, in conducting numerous trainings planned for the year, and in operationalizing the SWM system in host communities, the BDRCS-SRC project team was able to mitigate the worst by their tireless engagement.

The operational context in Cox's Bazar remains volatile and dynamic. There continues to be a high level of uncertainty of what will happen once camp access controls for refugees and host communities start being implemented after completion of the fencing around the Kutupalong-Balukhali expansion sites. The increasing scrutiny by the GoB on cash-for-work programming may have unintended consequences as well. In December 2020, some CiCs were pressurizing humanitarian organisations to hire 50% host community inhabitants under camp cash-for-work programming.

Under outcome 1, the main priorities will be to operationalize the 4th and 5th PHCs in camps 2E and 6, respectively. The PHCs shall be equipped with a 24/7 IPD in addition to the services already present at the running PHCs. The following operational priorities are set under outcome 1 (please also see the attached updated implementation plan):

- While the land has been selected and necessary approvals obtained, complete the procurement process and initiate works of PHC at camp 6. Ensure the PHC can be operationalized in line with the revised MPEHS starting from April 2021, while ensuring that UNFPA partners, FHF and ACF are on board.

- Seek new partnerships to operate the OPD and IPD at the to be constructed PHC at camp 6.
- Complete the operationalization of the PHC at camp 2E in line with the revised MPEHS and including a 24/7 IPD. Ensure that IRC, ACF and FHF are on board during the first quarter of 2021.
- Conduct workshop with the aim of establishing a systematic referral system at PHCs.

Under outcome 2, a strong emphasis will be put on the SWM host community component. The endeavour was kick-started in late 2020, while many activities, such as operationalization of the new MRF are still underway. The following operational priorities are set under outcome 2 (please also see the attached updated implementation plan):

- Complete construction works for the MRF in Palongkhali Union.
- Orient and establish the SWM Steering Committee as the main body to govern the SWM system at Palongkhali.
- Start levying a collection fee for waste collection services.
- Initiate the second phase of SWM by working at 20 schools/madrasahs and additional households in Wards 6, 7 and 8.
- Restore access to the camp 15 MRF. If not successful, re-locate and re-construct the MRF in camp 15.
- Assess feasibility for further scaling of SWM in camp 15, and if possible, scale to further blocks in camp 15.

Under outcome 3, the outreach work will be further improved, and pending trainings shall be undertaken. The following operational priorities are set under outcome 3 (please also see the attached updated implementation plan):

- Complete the new staffing of the outreach team (2 CHF and 12 Volunteers per camp/PHC) and orient them.
- Conduct at least 2 trainings for all outreach workers (CHF and Volunteers).
- Conduct at least 2 trainings for waste workers.
- Roll out 3 SWM cleaning campaigns in camp 15.

8 Good practice example (project 440517)

A young mother becomes a Red Cross volunteer to educate others

Sabina Akter Sharmin, Red Crescent Youth Volunteer/peer educator,

Sabina Akter Sharmin, 23 years' young woman lives with her parents at block 6 in Ershadnagor, where the Urban Empowerment and Resilience (UER) project is implemented.

Sharmin completed her higher secondary education in 2020. Previous year, she got married and became pregnant within three months of her marriage. And then, from the early part of her pregnancy, she started attending the courtyard health sessions which were organized by the Red Crescent Youths (RCYs) or community volunteers of UER project. She followed up on almost all advices regarding the do's and don'ts during the pregnancy. She attended the prescribed 4 ANC visits, took enough rest, sufficient food and followed the midwives' suggestions and discussed everything including the suggestions received from the midwives with her husband. She also tried her best to inform others of the services, as much as she could. Then before the delivery date, she got herself admitted to the nearby health center and give birth to a baby girl in October 2020 without any complications. Now her daughter is two and half months old and in good health.

While sharing her journey to become a volunteer, she mentioned "I had to fight with both my parents and in-laws to follow all the do's and don'ts during the pregnancy, and even afterwards, specially to stop them from feeding honey to my newborn girl and also to prevent them from applying anything to the raw umbilical stump of my daughter, including mustered oil."

During her pregnancy, she realized the importance of Maternal and Neonatal Child Health (MNCH) related knowledge which she gained from the health sessions. She was quite concerned with the gap she found amongst her peers and the elderly women in her community, regarding MNCH and decided to do something about it. She realized that she has all the qualities or potential to become a volunteer, with the education she already has. Despite having to take care of the newborn, she decided to become a volunteer to educate other women on her knowledge and experiences. She informed her husband about it, who gladly supported her decision, as this will enhance their family's prestige among the community and will also be a source of potential income. She immediately sought out one of the project's community volunteers and informed about her willingness to become a volunteer, and after completing all necessary procedures, finally joined as a volunteer about two months back. She said, "*I did not have any idea before about the care during pregnancy and newborn care. But in the health session I understood about the ANC, dangers during pregnancy, PNC, care of pregnant women, breast feeding the child, how important it is, and immunization program. The more I realize the importance of all these, the more passionate I feel to take the health session in the community courtyards. Now I know even some of our social and cultural norms can be harmful, as we do not know the truth, and follow bad practices blindly. I wondered that like me most of the women in my community do not have enough knowledge on all of these. So, in the health session I ensure that they all understand everything we discuss and also follow them up at their homes, as they are all neighbors. The best thing is I share my experience and cite my example, which they appreciate very much*."