



COVID-19 Quarterly Report

Supporting the Government response to the pandemic



Acronyms

a2i	Aspire to Innovate
ACT-Accelerator	Access to COVID-19 Tools-Accelerator
AMR	Antimicrobial resistance
BBS	Bangladesh Bureau of Statistics
BGMEA	Bangladesh Garment Manufacturers and Exporters Association
BPRP	Bangladesh Preparedness and Response Plan
CAMPE	Campaign for Popular Education
CEPI	Coalition for Epidemic Preparedness Innovations
CFR	Case fatality rate
COVAX	COVID-19 Vaccines Global Access
CST	Community Support Team
DGHS	Directorate General of Health Services
DHIS2 platform	District Health Information Software 2
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization of the United Nations
FCDO	Foreign Commonwealth and Development Office
FMLP	Facility Management and Leadership Programme
GAVI	The Global Alliance for Vaccines and Immunizations
GBV	Gender-Based Violence
GED	General Economic Division
GoB	Government of Bangladesh
ICT	Information and Communication Technology
IEDCR	Institute of Epidemiology, Disease Control and Research
IFB	Islamic Foundation Bangladesh
IHR	International Health Regulations
ILO	International Labour Organization
IOM	International Organization for Migration
IPC	Infection Prevention and Control
ISERP	United Nations Immediate Socioeconomic Response to COVID-19 for Bangladesh
LMO	Liquid Medical Oxygen
MOEWOE	Ministry of Expatriates' Welfare and Overseas Employment
MOHFW	Ministry of Health and Family Welfare
MSME	Micro, Small and Medium Enterprise
MTaPS	Medicines, Technologies and Pharmaceutical Services
NHRC	National Human Rights Commission
PEF	Pandemic Emergency Financing
POE	Points of Entry
PPP	Purchasing power parity
QA	Quality Assurance
SDGs	Sustainable Development Goals
Sida	Swedish International Development Cooperation Agency
UHC	Upazila Health Complex
UNCDF	United Nations Capital Development Fund
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSDCF	UN Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

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Preface

This COVID-19 Quarterly Report highlights achievements of work of the United Nations in Bangladesh in support of the national COVID-19 response. The report is presented in two main sections. The first section reports on activities tied to the government's COVID-19 specific emergency response under the Bangladesh Preparedness and Response Plan (BPRP). The second section reports on work towards the broader and longer-term preparedness plan for socio-economic recovery in Bangladesh. A timely 'feature story' introduces the report. This quarterly feature addresses *evolving* national priorities in response to the *evolving* pandemic. The topic for this quarter is school reopening, addressing the impact of the pandemic on children's education and how policymakers can move forward.

Global overview

On 28 January, the United Nations Secretary-General, in his [remarks](#) to Member States, identified ten priorities for 2021. They are to (a) respond to COVID-19; (b) inclusive and sustainable economic recovery; (c) address climate and biodiversity challenges; (d) tackle the pandemic of poverty and inequality; (e) reverse the assault on human rights; (f) ensure gender equality; (g) heal geopolitical rifts and find common ground; (h) reverse the erosion of the nuclear disarmament and non-proliferation regime; (i) seize the opportunities of digital technologies while protecting against their growing dangers; and (j) a reset for the 21st century by reinforcing and re-imagining governance.

All ten are highly relevant to Bangladesh and the new [Eighth Five-Year Plan](#) of the Government of Bangladesh (GoB), first published in December identifies many of the same issues as priorities for Bangladesh. The United Nations in Bangladesh is now formulating its new Sustainable Development Cooperation Framework (UNSDCF), which will support the government's strategic priorities to enable a strong, equitable and green recovery from the pandemic and achievement of the Sustainable Development Goals (SDGs) by 2030.

The Expert Group Meeting (EGM) of the UN Committee for Development Policy (CDP) met from 8-15 January 2021 in preparation for the upcoming triennial review.¹ The objective was to review preliminary estimates of the Least Developed Country (LDC) indicators of the reviewee countries to ascertain graduation eligibility and also took account of additional information and analysis, including the implications of the impact of the COVID-19 crisis on least developed countries and countries graduating from the LDC category. Bangladesh government presented their case before the expert group on 12 January led by the Principal SDG Coordinator.

Although Bangladesh met all the graduation thresholds, the government requested for an extended five-year transition period in order to tackle the adverse challenges posed by COVID-19 and climate change, to align the transition period with the Eighth Five-Year Plan, and to reinforce SDGs. The triennial review was held from 22-26 February 2021 and Bangladesh has been recommended for graduation, a significant milestone for the country in its development.

Thus far 221.7 million doses of COVID-19 vaccines have been administered globally driven largely by a few countries like the USA, China, UK, EU, and UAE, though several other countries are rolling out vaccination quickly. COVAX, the vaccine pillar of the [ACT-Accelerator](#), convened by [CEPI](#), [GAVI](#) and [WHO](#), continued to expedite the manufacturing and deployment of effective vaccines for all countries. Its goal is to have 2 billion doses distributed by the end of 2021.

¹ [EGM on the Preparation of the Triennial Review of the List of LDCs | Department of Economic and Social Affairs \(un.org\)](#)

As vaccines are now being distributed in many countries globally, the issue of fair and just distribution regains importance. The UN Secretary-General called for countries to share excess doses of vaccines to COVAX to ensure rapid and equitable access to COVID-19 vaccines for all countries.²

1. Feature story – School Reopening: Investing in education to address impacts of COVID-19



Figure 1. A child in her classroom in Bangladesh

There are three important points to note regarding children, schools and COVID-19 based on the evidence throughout the world – (1) neither children nor schools are the main driver of the COVID-19 pandemic; (2) there are multiple and extremely serious impacts of prolonged school closure on children; and (3) there are ways to keep schools open safely even during the COVID-19 pandemic period.

Neither children nor schools are the main drivers of the COVID-19 pandemic

Children are at a substantially lower risk of acquiring and transmitting the infection than adults and at a markedly lower risk of developing severe disease and/or dying. They make up a very small percentage of COVID-19 cases. For instance, in the

US for the period of March to October 2020, mortality rate of children between 5 and 14 years of age due to COVID-19 represented a very small fraction of the entire mortality of children, equivalent to 6.8% of those who died due to transport accidents and 10.6% of those who died due to suicide (Woolf, 2020, Honein, 2021, Tönshoff, 2021). A number of other studies also show the minimal incidence of COVID-19 infection and very low rates of secondary transmission in schools with no significant linkages to wider community infection rates (Zimmerman, 2021). As such, neither children nor schools are not the main drivers of this pandemic.

Negative impact of prolonged school closure on children

While the evidence to support national closure of schools to combat COVID-19 is very weak as stated above, there has been ample and very clear evidence to show that prolonged school closure has multiple and profoundly negative effects on development, safety and the future of children. These in turn can result in inter-generational transmission of poverty and disparity for a longer period of time well beyond the pandemic. While the use of education technology is important in the spirit of using all the channels available at this critical juncture, it should not give a “false sense of security” to society. In reality, online education still remains a privilege of the few. Even access to relatively “low tech” initiatives like TV schooling is very limited in many countries including Bangladesh (BBS, 2019)³. As a result, the actual participation and utilization rates of distance learning programmes in Bangladesh have been very limited based on the data from various sample surveys conducted over the course of 2020 as summarized in the table below.

² As COVID-19 deaths pass two million worldwide, Guterres warns against self-defeating 'vaccinationalism' || UN News

³ According to a large-scale household sample survey conducted in 2019 in Bangladesh, the percentage of the households owning TV was 50.6% for the country as a whole. Further, there were large disparities in ownership based on the socioeconomic backgrounds. For instance, while 90.2% of the richest 20% households owned a TV, compared to mere 4.8% among the poorest 20% households.

Survey Organization	Period of Survey	Indicator	Value
BRAC (BRAC, 2020)	4 -7 May 2020	Primary and secondary school students who were participating in online classes or <i>Sangsad</i> TV distance learning programme	44%
World Bank (World Bank, 2020)	18 May - 17 June 2020	Grade 9 students who actually watched <i>Sangsad</i> TV distance learning	43%
CAMPE (The Daily Star, 2021)	7 - 22 November 2020	Primary and secondary school students who participated in distance learning in the last 2 weeks prior to the survey	31.50%

Even before the pandemic in 2017, 57% of Bangladesh children could not read and understand simple texts by the end of primary school (Grade 5). According to the latest simulation by the World Bank, without policy changes, this percentage is expected to increase to 76% due to pandemic-related school closures and increase in learning disparities according to the socioeconomic backgrounds of the students (Rahman, 2021)⁴.

Aside from missing out on education, prolonged school closure leads to a host of other issues such as increased risk of drop-out even after schools are reopened (Economist, 2020, O'Donnel, 2020, UNFPA, 2021, Girlsnotbrides.org, 2021)⁵; substantial increase of social protection issues such as neglect, abuse, exploitation, violence, child labour, child marriage and trafficking; and the deterioration of mental health among others⁶. Further, loss of the learning period as a part of an academic year has substantial impact on the concerned individuals' future income and the country's future GDP if nothing is done. According to the latest simulation by the World Bank, economic implications of the learning losses in Bangladesh are huge.

The COVID-19 pandemic is poised to translate into a substantial economic cost on the long run. If we quantify this loss of learning in terms of labour market returns, the average Bangladeshi student will face a reduction between an optimistic and pessimistic range of US\$198 and US\$335 in yearly earnings (2017 PPP) once s/he enters the labour market, which represents between 4% and 6.8% of annual income. Aggregated for all students in Bangladesh and projected ten years into the future (when all graduates have entered the labour market), this would cost the Bangladesh economy between US\$67 billion and US\$114 billion in GDP at Net Present Value (2017 PPP). In the intermediate scenario, aggregating for all students, this would cost the Bangladesh economy to lose US\$ 89 billion in GDP annually (Rahman, 2021, Hanushek, 2020).

Based on these evidence and data, when considering national or regional school closure for COVID-19, policymakers need to be aware of the unequivocal evidence of its extremely negative consequences and very high opportunity costs.

Opening schools safely during the pandemic

We must prioritize reopening schools when COVID-19 related restrictions are lifted in a society. In education, nothing can replace face-to-face interaction for learning between teachers and students and among students. The

⁴ See Tashmina Rahman and Uttam Sharma, *op.cit.* According to the calculation of the Organization for Economic Co-operation and Development (OECD), if a country loses 66% of one academic year, it results in an average loss of individual student's income by 5.3% throughout her/his career, and an average reduction of the concerned country's GDP by 2.9% in the remainder of the century.

⁵ During the Ebola crisis in Sierra Leone in 2014, schools were closed for a protracted period of time. In the same period, teenage pregnancies rose by between 11% and 65% according to various studies, and many girls were unable to continue their education when schools were reopened. This is also a very serious concern in Bangladesh which has the highest adolescent pregnancy rate outside Sub-Saharan Africa and one of the highest incidents of child marriage in the world.

⁶ While it is not easy to obtain statistical data on protection-related issues, information from various sources does indicate very strong possibility of substantial increases in their incidence during the pandemic period. One example is the number of calls to the *Child Helpline 1098* run by the Department of Social Services of the Government of Bangladesh. Until 2020, the Child Helpline was receiving approximately 75,000 calls per year. In 2020, the Child Helpline received 180,315 calls – 2.4 times more than the average number of calls in the previous years. More than 70% of calls were regarding sexual abuse, physical abuse, exploitation or mental health concerns requiring psychosocial support.

question to be asked is “*why must only schools continue to be closed when everything else is open and when neither children nor schools are the main driver of the epidemic?*” We need to put the matter in perspective and recognize that it is possible to keep schools open safely even during the COVID-19 pandemic period.

The basic outlook to be taken is not to expect zero risk but to manage risk by developing and implementing various measures for safe school reopening for which there are a large number of good examples in the world by now (O’Leary, 2021). These measures include various ways of (1) social distancing (keeping students and teachers in small groups that do not mix – known as “cohorting” or “podding”; staggering the start of school, breaks, bathroom, meal and end times; alternate physical presence at schools such as alternate days/shifts; and distancing of desks); (2) establishment and maintenance of clean environment; (3) adequate ventilation in classrooms; (4) hand hygiene; (5) respiratory etiquette; (6) age-appropriate use of masks; (7) reorganization of school transportation and arrival/departure time; (8) system for symptom screening; and (9) regular sharing of information with and feedback to parents, students and teachers (WHO, 2020, UNICEF, 2020, UNESCO, 2020b, UNESCO, 2020a). One of the important emerging lessons learned internationally regarding school reopening is to prioritize early grades and exam-preparatory classes first for physical return to schools – “early grades” because young children are the least susceptible to infection even among children in general, and “exam-preparatory classes” as it can help mitigate the impacts on the concerned students’ educational trajectories (UNESCO, 2020b). Another point that is extremely important is to incorporate large-scale remedial education programs as an integral part of the school reopening plan to mitigate learning losses and prevent further exacerbation of learning inequality, with a focus on literacy and numeracy for primary-age children and disadvantaged children (UNESCO, 2020).

It is important to set clear target dates when schools are reopened in order to kick-start the process of operational planning which requires a substantial amount of time, efforts and resources given the enormity of the task. It includes (1) identification of the actions to be taken at different levels; (2) development of the operational guidelines/standard operating procedures to implement the actions according to the set standards throughout the country; (3) estimation and allocation of the required budget for safe school reopening; (4) training and orientation of the concerned personnel; (5) implementation and monitoring; (6) clear and constant communication with and feedback from the concerned stakeholders, i.e. children, parents, teachers, community leaders and others for adjustments as necessary.

Reopening of schools, first and foremost, is critical for the right of children to education as individual human beings. In addition, it is the key to minimizing the negative impact of the COVID-19 pandemic on the society as a whole and reduce the risk of a vicious cycle of suboptimal human development, poverty, disparity and unsustainable development. We owe it to children both as individual human beings and the future citizens of Bangladesh.

2. BPRP emergency response

The Bangladesh Preparedness and Response Plan (BPRP) outlines the overall national strategy and priorities for COVID-19 surveillance, prevention and management. The main goal of the BPRP is to prevent and control the spread of COVID-19 in Bangladesh in order to reduce its impact on the health, wellbeing and economy of the country.

2.1 Planning, coordination, and response strategy

The magnitude of the COVID-19 pandemic prompted a response of appropriate scale and scope to mitigate the public health impacts of the disease as well as the broader impacts on the economy and social well-being. The national response coordination mechanism is aligned with global WHO operational planning guidance and also aligned with the current United Nations coordination system. A high-level multi-sectoral coordination committee led by the Honourable Minister for Health and Family Welfare was set up to advise the Prime Minister’s Office.

Multiple sub-national multi-sectoral committees at various district and sub-districts levels were set up to lead and coordinate field response. National Technical Advisory Committee, National Public Health Coordination Group provided technical advice on the different aspects of pandemic response and different pillar coordination groups were set up for respective BPRP pillars to coordinate all the stakeholders for coherent, synergistic and efficient response interventions for COVID-19. The response strategy highlighted key interventions such as enforcement of compulsory mask-wearing and safe hygiene practices in all public places; using epidemiological health surveillance data to enforce particular interventions in geographically-focused areas; community-based prevention practices including risk communication, disease identification and quarantining; ensuring social distancing and finally, empowerment of frontline health workers and prioritizing their safety to curb further spread of infection.

At the technical level, the BPBP pillars have also served as practical mechanism to improve not only coordination among government, development, and implementing partners, but also foster novel collaborative interagency initiatives such as the multisectoral RCCE response, the Community Support Team intervention, the interagency IPC strengthening group, and the One Health laboratory biosafety strengthening initiatives described below.

2.2 Surveillance and Laboratory Support

Reliable and efficient surveillance is critical to understand progression of the pandemic and plan appropriate interventions for timely management of patients and disrupting chains of transmission.

Surveillance and laboratory support were led by Institute of Epidemiology Disease Control and Research (IEDCR) with technical support from UN agencies WHO, FAO, UNICEF and UNFPA and bilateral development partners including USAID.

Between 8 March 2020 and 31 December 2020, there have been 513,510 COVID-19 cases confirmed by rRT-PCR, GeneXpert or antigen-based rapid diagnostic test, including 7,559 reported deaths (CFR 1.47%), ranking Bangladesh 27th globally and accounting for 0.62% of the global COVID-19 disease burden.

Dhaka city has experienced the highest incidence of COVID-19 (57.7% of total national case load) followed by Chattogram city. As of 31 January 2021, 68.9% of reported cases were from Dhaka division, 12.4% from Chattogram, 4.7% from Khulna, 4.7% from Rajshahi, 3.0% from Rangpur, 2.9% from Sylhet, 2.0% from Barishal, and 1.5% from Mymensingh division.

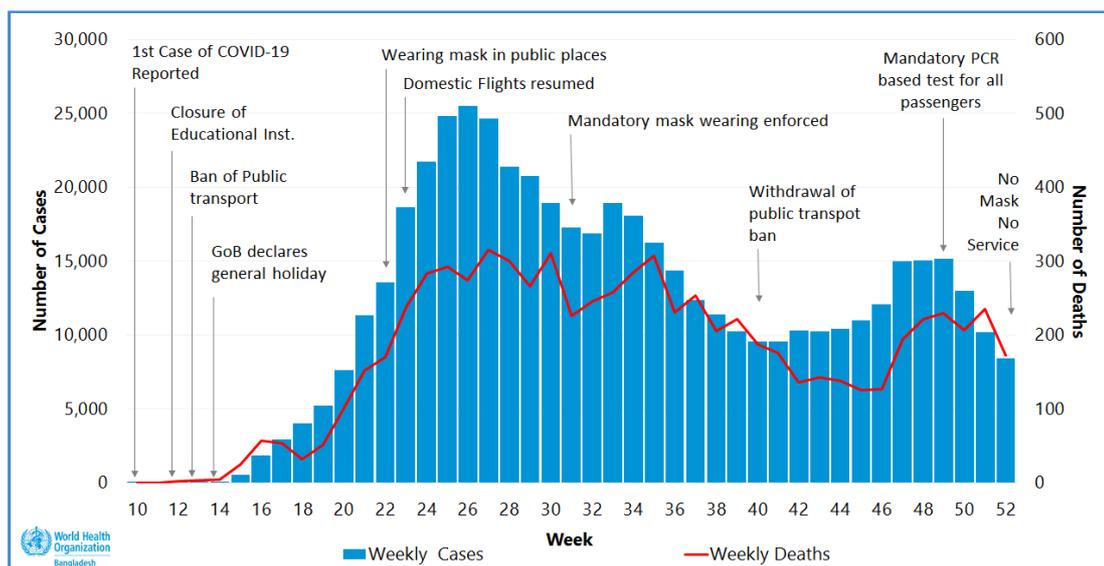


Figure 2. COVID-19 infection rate and morbidity - weekly trend analysis

As of 31 January 2021, COVID-19 testing facilities are available at 204 centres nationwide including 116 RT-PCR Lab, 26 GeneXpert Lab and 60 Rapid Antigen test centres. According to the DGHS press release of the same date, 3,651,722 COVID-19 tests have been conducted in Bangladesh with an overall positivity rate of 14.65%.

Among the reported cases, 6.3% were in the age group below 20 years, 18.0% in 20 to 29 year olds, 26.4% in 30 and 39 year olds, 19.6% in 40 to 49 year olds, 16.7% in 50 and 59 year olds, and 13.0% in individuals 60 years old and over. Out of the total 513,510 COVID-19 cases registered as of 31 December 2020, 89.1% (457,459) recovered, 1.5% (7,559) died and 9.4% (48,492) were active cases. The highest proportion of deaths was in the over 70-year-old age group (32.4%), followed by the 60-69 years old age group (31.8%), and the 50-59 years old age group (20.8%). Individuals below 50 years of age made up about 15.0% of the total number of COVID-19 deaths.

Bangladesh first initiated testing for COVID-19 at IEDCR. Over the course of the year an extensive lab network was established throughout the country involving not only the private sector and government labs under Ministry of Health and Family Welfare (MOHFW) but also various other ministries, as well as academic labs of public universities. Going forward, the plan is to focus on areas with high prevalence of COVID-19 cases, within geographic areas that are difficult to reach or have limited laboratory access. UNFPA provided human resources support (lab technicians, medical technologists, virologists, data operators, etc.,) through World Bank's Pandemic Emergency Financing Facility (PEF) for various laboratories across the country and also provided transportation for sample collection, primarily in Dhaka city. WHO provided HR support and transport support for sample collection from by the mobile teams coordinated by IEDCR. In ensuring quality of samples, WHO through its Surveillance and Immunization Medical Officer (SIMO) network, provided on-site training of sample collectors and handlers, at district level on sample collection, handling, packaging and transportation in collaboration with local health authority throughout the country. WHO continued its support of transportation of samples from district to designated testing laboratories which was closely monitored and coordinated by the SIMO network across the country.

To ensure quality and uniformity of testing; training modules and molecular diagnostic SOPs for lab personnel were developed in order to build capacity, particularly for newly established rRT-PCR labs. Four-day long, on-site, hands-on training sessions were provided to 32 government labs (five in Dhaka City and the remaining across the country)⁷.

For continuous monitoring, support and troubleshooting leveraging the One Health approach, a mentoring and training by a pool of laboratory biosafety experts was initiated by FAO and resulted in quick expert assessment of 29 COVID-19 private labs in Dhaka, Gazipur and Narayanganj. The expert pool continued its training, backstopping, mentoring, troubleshooting using structured tool. By end of December 2020, the members of expert pool visited 32 laboratories. As part of Quality Assurance (QA), IEDCR is periodically 'triangulating' and overseeing the national effort through testing samples of both public and private COVID-19 laboratories. In phase I, 47 laboratories participated in the QA Proficiency Testing programme with support from WHO.

2.3 Contact tracing and mitigating community transmission

Contact tracing is an epidemiological tool to reduce contact and prevent COVID-19 transmission between infected individuals and surrounding populations; it is specifically useful in certain points of the epidemic curve when most if not all contacts of infected individuals can be traced to limit infection spread. considering the high population

⁷ Apart from fundamental training, five-day long, hands on personnel training (Virologist/Micro-biologist/Molecular Biologist and laboratory Technician) from each of 20 labs on different methods of Nucleic Acid Extraction, particularly fundamental method (column extraction) and machine-automated extraction.

density of Bangladesh, effective contact tracing requires a very large trained human resource pool. As the number of cases increases, other tools with similar outcomes need to be explored for efficient prevention of infection spread.

Contact tracing was initiated at the very beginning of the pandemic by IEDCR and the WHO. During the last quarter of 2020, training sessions on contact tracing in nine city corporations and four divisions of the country, including all districts and sub-districts, were conducted by IEDCR with technical support from WHO. Training sessions were conducted in person at district level and participants comprised of staff with both medical and non-medical backgrounds. Trainees were oriented on contact tracing including its importance in containment, isolation and quarantine in structured ways.

Adequate financial resources for communicating with cases and contacts are key for effective contact tracing. To solve this resource gap, WHO provided financial support to cover telephone bill for the contact tracers. Going forward, IEDCR is negotiating with mobile operators to obtain 1,500 SIM cards to support continued communications for the next six months. This initiative is likely to significantly improve contact tracing approaches across the country.

Community Support Team (CST) initiative

To complement the contact tracing tool, a community-based syndromic surveillance and home quarantining intervention called the Community Support Team (CST) was initiated in Dhaka North City Corporation at the end of June. CST was designed under the leadership of DGHS in partnership with UN Organizations (FAO, UNFPA, UNICEF, WFP), NGOs (BRAC), volunteer organizations (Platform, Himu, Young Bangla) and technical partners including Aspire to Innovate (a2i), icddr,b and IEDCR. The goal of the initiative is to preserve hospital capacity by slowing down disease spread at community level through targeted home isolation and family quarantine for symptomatic individuals combined with promotion of public mask-wearing.

Teams of community-based volunteers and local community health workers known as CSTs are trained to clinically assess individuals reporting COVID-19 symptoms, provide syndromic diagnosis for COVID-19, and counsel individuals for home-quarantining along with their entire households. Individuals are connected to telemedicine services and referred to hospitals as needed. Other features of the intervention include identification of vulnerable groups such as elderly, diabetics, and hypertensives, through health screening and prioritizing them for vaccination. Additional support through UNFPA is provided in identifying pregnant women from the community and connecting them with a midwifery hotline operated through the Bangladesh Midwifery Society. Since November, to further strengthen case management and surveillance, probable cases identified through CSTs are also offered COVID-19 testing by IEDCR.

To rapidly establish and expand the programme, FAO technically supported the design of CST SOPs and related CST training modules followed by the development of 16 CST trainers across the network of supporting NGOs with financial support from USAID. As of year-end, FAO conducted 12 in-service trainings with technical and financial support from UNFPA and the World Bank PEF facility, producing 659 CST-trained health workers and volunteers (288 female and 371 male). These CSTs then individually screened 181,887 people within their communities and 47,978 individuals were subsequently identified as having symptoms consistent with COVID-19 infection (approximately 25%). All of these individuals were then counselled by CST on home quarantining and referred to telemedicine services. From September to December 2020, a total of 35,687 of these probable COVID-19 individuals received food support through WFP-USAID food support programme in DNCC. Additionally, around 10,500 pregnant women and around 2,400 pregnant women with COVID-19 like symptoms have been identified through this CST intervention between August and December 2020 and all of these women were referred to telemedicine services as well.

Rural iterations of the CST model is currently also being implemented by USAID-supported Integrated Safe Motherhood, Newborn Care, and Family Planning (MaMoni) Project in six districts (Faridpur, Gopalganj, Kushtia, Laxmipur, and Madaripur) and by BRAC in six districts (Bogura, Bhola, Bagerhat, Kishoreganj, Narayanganj, Sherpur). As part of the community engagement support, UNICEF has developed a number of communication materials for both urban and rural audiences. The materials include posters, stickers, leaflets for mosque miking and local miking. UNICEF is also supporting the involvement of mosque management committees and religious leaders through Islamic Foundation Bangladesh (IFB). After successful implementation by BRAC in DNCC, the CST initiative has now been expanded to Dhaka South City Corporation.

2.4 Points of entry and quarantine

Points of International Entry (POE) surveillance is an approach to identify and quarantine individuals who are at risk for bringing COVID-19 across international borders into Bangladesh. POE surveillance works to prevent further outbreaks from international passengers once the epidemic has slowed down in Bangladesh. DGHS in collaboration with International Organization for Migration (IOM) and WHO coordinates POE surveillance for preventing cross border transmission of COVID-19.

Assessments of 18 major POEs identified the need for standardized SOPs, training on screening for the screeners, data management as well as the need for proper infrastructure, personal protective equipment (PPE), equipment and communication materials on screening. The identified gaps were addressed through the following interventions:

- Crisis Management Teams (CMTs) consisting of POE stakeholders was established at Hazrat Shahjalal International Airport (Dhaka), Benapole land port (Jashore), Osmani International Airport (Sylhet), Shahamanat International Airport (Chattogram). These CMTs meet regularly to ensure timely and effective screening and management of challenges at the POEs.
- A surveillance system has been established for digitizing Health Declaration Forms (HRF) of international travellers.
- Human resources (doctors, data managers, and data operators) and IT equipment (computers, QR scanners, display boards) were supplied.
- PPEs (masks, gloves and hand sanitizers) have been provided
- The All-Hazard Contingency Plan for International Airports was revised and an SOP on Health Screening of International Travellers at POEs developed as per the International Health Regulation (IHR 2005) requirements.



Figure 3. POE Seminar discussion



Figure 4. POE airport health screening point

In addition, institutional quarantine has been increased to 629 centres across the country with a capacity of accommodating 31,991 persons. Two quarantine centres for designated airports (capacity 2,500 persons) and one for the designated land port (capacity 600 persons) have also been assigned for managing incoming international travellers

2.5 Infection prevention and control

Infection prevention and control (IPC) measures safeguard both patients and healthcare workers and aims to manage communicable disease threats to the community. Early identification, prompt isolation and specialized patient care are essential to contain and mitigate the impact of COVID-19. The IPC pillar is led by DGHS with technical support from UN agencies WHO, UNICEF, FAO and UNFPA and development partners including BRAC, icddr,b, and USAID.

In the fourth quarter of 2020 the IPC coordination group implemented important steps to accelerate the activities of IPC and case management with the aim of a) improved regular monitoring of all major hospitals, b) establishment of 'triage system' in every hospital and ensure an effective referral system, c) creating a national resource pool of expert trainers for hands-on clinical and ICU management, d) establishing and strengthening critical care medicine at district levels with appropriate human resources and equipment as per national ICU guidelines, and e) developing a standalone telemedicine guideline for COVID-19 management and providing e-training to doctors.

UN stakeholders have pursued these collaborative actions with urgency. WHO has facilitated the provision of 200 oxygen concentrators, 400 pulse oximeters, 100 venturi masks, and 100 nasal cannulas across 17 district hospitals and provided 65 patient monitors to 10 tertiary level health facilities. USAID has provided 100 ventilators and UNICEF supported the establishment of 30 oxygen plants. The Communicable Disease Control division under the DGHS, trained 5,000 doctors and 2,500 nursing staff on IPC. USAID supported e-mentoring is being provided regularly to health care providers. UNICEF, icddr,b and UNFPA provided IPC training to 11,800 doctors and nurses.

WHO supported advocacy workshops on monitoring and supervision on infection prevention and control is in progress in 25 health facilities (15 district hospitals and 10 tertiary hospitals); thus far 200 doctors and 200 nursing staff have been trained in monitoring and IPC supervision through this programme. Additional support in strengthening IPC has been provided through the Facility Management and Leadership Programme (FMLP) technically supported by FAO which utilizes a One Health approach to build competencies in both IPC and prudent usage of antimicrobials for improving COVID-19 case management in 12 COVID-19 hospitals in Dhaka and Chattogram. During the last quarter of 2020 FAO developed a cohort of 28 FMLP participatory trainers in COVID-19 case management from within the COVID-19 clinical care and Bangladesh AMR Response Alliance communities with technical and financial support from UNFPA and World Bank PEF. These trainers then conducted two FMLP trainings for 72 medical doctors and 12 nurses in COVID-19 hospitals supported by FMLP with additional trainings scheduled for the first quarter 2021.

With UNDP's capacity-building support, 158 volunteers, of which were 27 women, engaged in managing COVID-19 deceased bodies in two cities as part of the government initiatives during the fourth quarter of 2020. UNDP also increased awareness on the safe burial process of the COVID-19 deceased persons for about 330,000 people.

COVID-19 vaccine preparedness and deployment

Bangladesh have taken strong measures to contain the spread of COVID-19 disease through better diagnostics and treatment, however vaccine would provide a lasting solution by enhancing immunity and containing the disease

spread. Globally, over 274 candidate vaccines are in different stages of development⁸. Anticipating the COVID-19 vaccine may soon be available, the Government of Bangladesh initiated preparations for COVID-19 vaccine introduction.

Rollout plan

National Vaccine Development plan (NVDP) for COVID-19 vaccine rollout was developed on 6 Dec 2020. The same is revised and endorsed by the Secretary Health on 3 Feb 2021 before the nationwide vaccine rollout. The vaccination strategy is well drafted to vaccinate hard to reach and high-risk population like Rohingya refugees. The framework complements the principles on equitable access and fair allocation of COVID-19 vaccine. Three high level committees constituted at National level to provide direct oversight to plan and implement a high-quality vaccination campaign with vaccine safety for the adult age group. Considering the limited availability of vaccines initially and to protect the most vulnerable group, vaccination is designed in different phases and has prioritized certain population groups for vaccination. The priority group includes Health Care workers, Front line workers, population above 40 years of age which was initially 55 years. Surekha app designed and developed for online registration of beneficiaries. Multiple trainings at National level followed by cascaded trainings of Health workers and Medical Officers were conducted nationwide. Adverse event following immunization trainings were emphasized and capacity built to respond an advert event following immunization following COVID-19 vaccination. Human resources identified. The number of vaccination teams identified is 2,590, each composed of six members and were trained for vaccination. A total of 671 vaccination sites have been equipped with AEFI management system for COVID-19 vaccination. The plans of geographical expansion of vaccination sites is planned for further priority group vaccination in NVDP.

Government of Bangladesh has made a bilateral agreement with the Serum Institute of India (SII) for 30 million doses which will be provided in phased manner with slot of 5 million vaccine doses every month. Bangladesh is entitled to vaccine doses equal to 20% of population from COVAX facility. Government of India provided 2 million doses of SII – COVISHIELD to Bangladesh as a gift.



Figure 5. Citizens receiving COVID-19 vaccine in Bangladesh

COVID-19 vaccination was launched by Her Excellency Prime Minister Sheikh Hasina on 27 January with nationwide rollout from 7 February 2021. Officials including Health Minister, top court judges and frontline workers were inoculated to boost public confidence in the vaccine. The government has nearly halved its target of 7 million people for the first month with first dose of COVID-19 vaccine. The country is seeking to inoculate 80% of its population of around 170 million, with each person getting two doses administered eight weeks apart.

WHO and UNICEF are directly supporting DGHS on the development of the material and guidelines, training curriculum and training plan as well facilitating nationwide training of vaccinators and volunteers. In every stage of the planning process, MOHFW is consulting UNICEF and WHO as key partners. UNICEF supported DGHS on cold chain assessment and. Key messages on COVID-19 vaccinations are developed and regularly updated according to the change situation. Newspaper advertisement, social media post, design of posters, public service announcement and television scroll messages are prepared and

⁸ <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines>

disseminated. Also developed short videos about the experience of vaccine recipients and vaccinators which has been shared with all relevant partners, RCCE and television channels.

Immunization team (IVD) WHO, provided support to develop “National Deployment and Vaccination Plan” including technical assistance for preparation of application, guidelines and other documents to COVAX. Provided technical assistance and facilitated functioning of various committees – National Immunization Technical Advisory Group (NITAG), AEFI committees and others. IVD Team conducted multiple capacity building workshops and orientations at different levels to excel the skills and knowledge of the health care workers vaccination including adverse event following immunization. Supported expansion and strengthening of COVID-19 testing laboratories in the districts followed by tracking samples sent to these labs. IVD staff continuously supporting field operations towards COVID-19 response at various level with multiple activities ongoing.

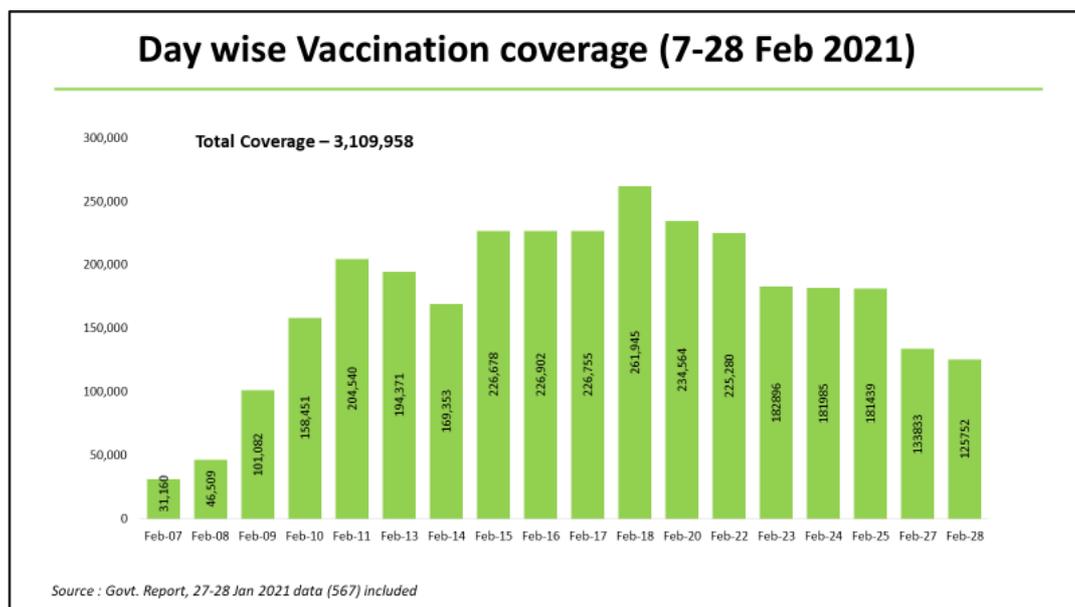


Figure 6. Day wise vaccination coverage in Bangladesh from 7-28 February 2021

2.6 COVID-19 case management including telemedicine

Like IPC, COVID-19 case management was led by DGHS with technical support from WHO, UNICEF, UNFPA, USAID, UNDP, BRAC, a2i and other development partners. The DGHS and MOHFW developed an e-Mentoring program for hospital managers and clinicians involved in COVID-19 case management in both public and private hospitals in Bangladesh. The objective of the program is to improve the capacity of clinicians on COVID-19 case management and to create a supportive environment for clinicians.

The USAID-supported MaMoni Project implemented by Save the Children has been coordinating these e-Mentoring sessions, with technical support of Project ECHO of the University of New Mexico, USA. To date, twenty sessions of e-Mentoring have been completed.

Given risk of infection at crowded health facilities, telemedicine and clinical referrals with case management follow-ups has become popular in Bangladesh. In the fourth quarter of 2020, UNDP provided telemedicine services and essential healthcare support to citizens 730,945 times to prevent and recover from the COVID-19 infection through the UNDP-led national information helpline (333), the COVID-19 Telehealth centre, and the Bangabandhu Sheikh Mujib Medical University-a2i Specialized Tele-Health Centre. Twenty-nine telemedicine companies have been

engaged in the UNDP-led network to offer an initial medical diagnosis to citizens. UNFPA also supported telemedicine services being provided through the UNDP-a2i network with support from the World Bank PEF facility.

In collaboration with the DGHS, UNDP also launched Maa Telehealth Centre to provide necessary healthcare services to pregnant women and new mothers 90,000 times, who were deprived of essential healthcare services due to the COVID-19 pandemic.

Regular immunization services had dropped as low as 47% in April due to the pandemic but started to increase again from July 2020. A total 3,771,669 children under one years old were vaccinated with the BCG vaccine and 3,606,623 children vaccinated with the third dose of Penta vaccine through the routine Expanded Programme on Immunization (EPI) in 2020 against a target of 3,838,319 with a coverage of 98% and 94%, respectively (source-DHIS2, DGHS). The nationwide Measles-Rubella (MR) campaign 2020 was launched successfully throughout the country in December. A total of 36,585,691 children between the ages of nine months to 10 years old were vaccinated with one additional dose of MR vaccine with an estimated coverage of >100% to prevent transmission of both measles and rubella viruses for achieving the goal of measles elimination.

2.7 Ensuring essential health, population, and nutrition services delivery while responding to COVID-19

The national health care system has been struggling to ensure adequate COVID-19 response while still maintaining delivery of essential and lifesaving health services since the start of the pandemic. As the health system shifted focus to the COVID-19 response, there is continued risk of increasing mortality from other illnesses due to disruption in the delivery of routine services. Protecting health systems, particularly at the primary care level, is central to addressing the broader health impacts of COVID-19.

The pandemic resulted in a drastic reduction in utilization of the major essential health services across all levels of health systems between April and May 2020. These reductions in service utilization were due to multiple factors such as the shortening of outpatient visiting hours, redistribution, and re-assignment of frontline health workers towards the COVID-19 pandemic response. Among the most affected areas were essential maternal and new-born health services as well as supply chain of essential medicines for non-communicable diseases like hypertension, diabetes, mental health, and other chronic diseases and cancers.

While the restoration of essential health services began under the directives of DGHS, facilities were initially overwhelmed with increased pressure to deal with both COVID-19 and non-COVID-19 services. On the demand side, the change in health-seeking behaviour of communities triggered by travel restrictions, fear of infection from health facilities, loss of income among vulnerable sections of society also affected the utilization rate and access to routine health services. Additionally, infections among frontline health workers contributed to the reduction in demand and in health systems capacity to deliver essential health services.

Divisional level health administrators prioritized the timely restoration of essential services by adopting innovative local strategies. Among these included regular monitoring of essential services delivery through physical visits and virtual meetings with field health care providers. MOHFW and DGHS also provided continuous monitoring and coordination support.

In coordination with DGHS, several development partners including FCDO, icddr,b, MTaPS, Save the Children, UNFPA , UNICEF, USAID and WHO conducted a facility-wide assessment of 120 facilities across 64 districts. The assessment covered facility standards, including maternal, newborn and paediatric care, infection prevention and control practices in hospitals and, importantly, oxygen infrastructure within the facilities. The assessment reports provided vital information for revitalizing the maternal, newborn, and child health services including oxygen therapy to manage hypoxemia during the pandemic period.

The assessment also covered the initiation of the IPC system within the district hospitals and upazila health complexes (UHC) by introducing a triage system, establishing hand washing stations, formation of IPC committees and training of healthcare providers.

Under the leadership of DGHS, UNFPA, UNICEF WHO, USAID, Save the Children, icddr,b and other partners developed guidelines and training packages on addressing reproductive, maternal, newborn and child health during the COVID-19 pandemic. UNFPA also led the development of a Labour Room Protocol to ensure safe IPC practices and evidence-based obstetric care for both COVID-19 positive and negative women.

In parallel to the above-mentioned assessment, another assessment focused on maternity areas in UHC was conducted by Save the Children and UNFPA in coordination with DGHS. This assessment identified gaps and facilitated implementation of the above mentioned COVID-19 maternity guidelines. This assessment included 91 UHC in 16 districts and assessed the current implementation levels of IPC, triage and case management for both COVID-19 positive and COVID-19 negative maternity patients. Following the assessment, training and mentoring was provided and over a period of a few months' implementation for separate maternity areas for COVID-19 and non-COVID-19 pregnant women, continuation of services, and use of PPE improved significantly. In response to reports of health facilities closing or reducing essential services, UNFPA expanded the number of midwives in selected medical college, district and UHCs (40 facilities in five districts including Dhaka City). These midwives were termed as surge midwives and were placed at facilities carrying the largest burden of COVID-19 cases and affected staff. Facilities with these additional midwives were able to attain pre-COVID-19 facility delivery numbers contrary to the rest of the hospitals nationwide.

MOHFW and UNFPA also formed a Family Planning Task Force consisting of experts, researchers, academia, development partners, NGO representatives to identify strategic priorities and support implementation of proposed interventions during COVID-19 pandemic. The Task Force recommended interventions to strengthen the continuity of family planning as essential services during COVID-19 pandemic. As a result, uptake of family planning services increased in the latter half of 2020.

WHO developed the Bangla guidelines on Infection prevention and control and triage protocol for the frontline health workers including the community-based health care providers. WHO supported DGHS MIS to analyse the utilisation of essential health services using DHIS2 data and disseminated the findings through workshops at central as well at divisional level.

By integrating the quality improvement initiative into this project, UNICEF introduced 'Plan-Do-Check-Action' cycles in both MNCH care and IPC systems within facilities. This quality improvement approach has been implemented in other seven districts of Bangladesh, yielding significant results. More than 500 health care providers received the quality improvement training from UNICEF technical bodies and mentors from the National Institute of Prevention and Social Medicine.

In collaboration with the World Bank organization, UNICEF is preparing for installations of liquid medical oxygen (LMO) tanks in 30 district hospitals across Bangladesh. The project emphasizes upgrading of oxygen supply throughout facilities including LMO source and oxygen distribution system (pipelines) as well as oxygen delivery surfaces (outlets). In relation to case management for oxygen therapy in children and newborns, UNICEF created oxygen therapy modules based on WHO guidelines. Both webinar and face to face training were provided to HCPs -especially those working in special care units and paediatric units. Likewise, WHO supported the Hospital Service Management (HSM), DGHS to conduct an oxygen requirement survey in across 27 UHCs, 13 district hospitals and six tertiary level hospitals. WHO also provided 200 oxygen concentrators in 17 district hospitals. Additionally, daily monitoring routines and revised case reporting forms were introduced for new-born and children receiving oxygen therapy, based on the WHO quality of care standards.

2.8 Procurement, logistics, and supply management

In order to urgently scale up the procurement of medical equipment, a robust supply chain strategy ensured efficient procurement of essential supplies for the COVID-19 response. The Logistics and Procurement Pillar has



Figure 7. Procurement of medical equipment

been coordinated by the DGHS and Directorate General of Drug Administration with support from UN agencies WFP and WHO together with other development partners. Weekly regular interagency meetings provided a sound platform for coordination and more timely logistics support.

Substantial achievements have been made, including development of protocols and guidelines for local production of PPEs as per global standards, finalization of the supply plan, and compilation of procurement activities of different UN agencies. The pillar coordinated very closely with DGHS and particularly with the National Board of Revenue for the Statutory

Regulatory Order on the exemption of customs duty for the importation of medical items.

In the last quarter of 2020, a total of thirteen different items (valued at US\$ 6 million), ordered by WHO and WFP, were supplied to Bangladesh through WHO's Global Supply Portal. Moreover, a total of 151,286 kg of medical items (biomedical, PPE, and diagnostics), were delivered in the last quarter of 2020, through WFP Emergency Service Marketplace (free-to-user transport service) on behalf of Oxfam, UNICEF, WHO, and WFP. As of December 2020, over US\$ 104 million worth of medical items were procured internationally and \$56,140,921 provided through local procurement. The MTaPS project distributed 100 ventilators to 45 health facilities in coordination with MOHFW.

MTaPS also developed an online COVID-19 inventory management information system (COVID-19 eLMIS) with customized WHO Quantification Tools in for DGHS. These tools are intended to track supply of commodities at the national, district and facility levels. Capacity building training for officials from DGHS MIS and 92 health facilities is underway. A three staff model (Residential Medical Officer, Statistician, Storekeeper) from each health facility are currently in training. To date, 36 facility trainings have been completed.

2.9 Risk communication and community engagement (RCCE)

The national RCCE campaign focuses on encouraging the spirit of solidarity, across communities to stop the spread of COVID-19 through behaviour change, informed decisions and collective action. In lieu of immunity against the disease and as vaccines and treatments are in early stages of development, engaging and communicating risks among the general populations has been essential in the last quarter of 2020. The following indicators present a brief quantitative overview of community engagement under the RCCE pillar:

People reached on COVID-19 through messaging on prevention and access to services	76,000,000 ⁹
Persons engaged on COVID-19 through RCCE actions	46,742,133 ¹⁰
Persons having shared concerns and questions through RCCE support services	2,229,040 ¹¹

The RCCE pillar is led by DGHS with technical support from UNICEF with other UN partners and an extensive NGO network.

RCCE partner collaboration at national and sub-national levels

The 4Ws (who, what, where, when) monitoring matrix has enabled RCCE partners to update their 4Ws data and check real time visual dashboards of [national](#) and [sub-national](#) level RCCE activities on Google Drive at any time. A visual overview of this matrix is found in the graph below:

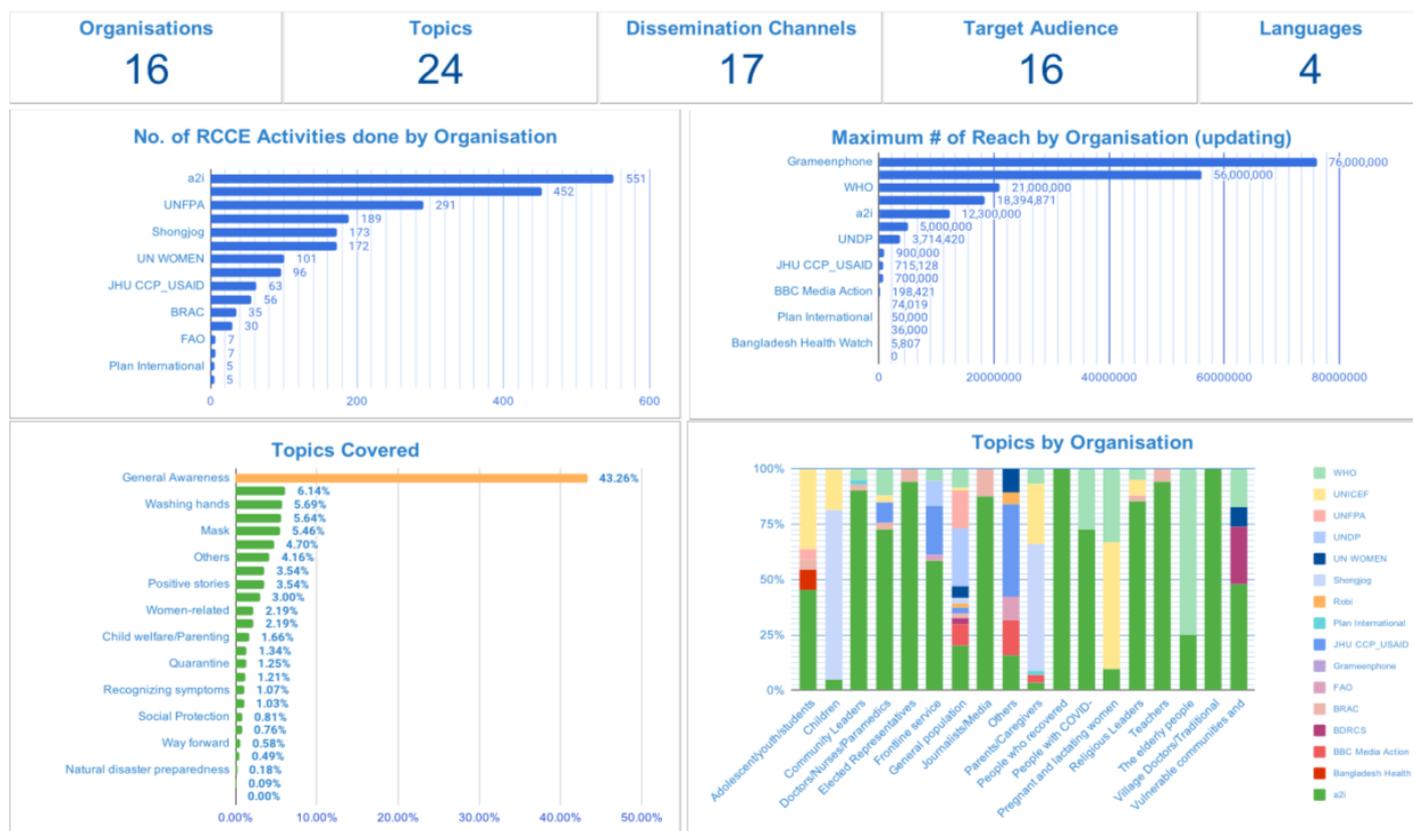


Figure 8. Figure: RCCE 4Ws monitoring dashboard

⁹ The number reflects the coverage for the single channel that gives the highest reach, i.e., mobile pre-call notifications of Grameen Phone (GP), which is the total subscriber base of GP

¹⁰ For the reporting period: a2i total reach includes multiple channels such as HDM, i-talk, Newspapers, YouTube, WebTV, TV, Corona helpline 333, Corona info website, Corona BD apps and others, therefore, there is a possibility of overlapping between the channels

¹¹ Number of times questions have been asked/clarified through a2i Corona helpline 333, Corona info website, Corona BD apps (1,039,658), and UNICEF feedback mechanism (766,166 people asking questions/clarifications via U-Report/helpline and 423,216 via social media totaling 1,189,382

At the sub-national level, with the support of four NGO network partners and their local-level NGOs, 4Ws data from 378 activities have been collected from START network, Bangladesh Community Radio Association, International Federation of Red Cross and Red Crescent Societies, Bangladesh Red Crescent Society, and the Network for Information, Response and Preparedness Activities on Disasters.

Q4 2020 study on mask wearing behaviour

A second round of the observation study was conducted in October 2020 to get an updated picture of mask-wearing practices in Bangladesh, especially in urban slums and rural areas and to compare findings from the first study. With the support of RCCE NGO network partners, mask wearing practices of 252,897 people were observed in 7,308 hotspots for the study. Following are the key findings:

- There was a significant drop in mask-wearing practice from 71% in July to 31% in October 2020. Surgical masks (54%) followed by cloth masks (29%) are most popular across gender and different geographical areas. There is a decrease in the proper use of mask from 38% in July to 19% in October.

Q4 2020 study on risk perception

The RCCE pillar conducted a rapid assessment survey in October 2020, focusing on risk perception. This survey was administered through Facebook Messenger, WhatsApp and SMS, and was facilitated by the U-Report mobile-based messaging platform. A total of 6,865 respondents participated in the survey from all eight divisions of the country. Following are the key findings:

- Among the participants, 32% think they have no risk of getting infected by COVID-19 and 26% think they are at medium risk. Respondents who always wear mask outside were 38%, 19% said they wear mask rarely and 8% said they never wear masks; 38% respondents said they do not wear mask because it is uncomfortable.

RCCE resource mobilization efforts

A meeting was held with the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) on the mass mask movement where BGMEA agreed in principle to provide free masks for the vulnerable populations and support RCCE community engagement activities.

Social media

Between October to December 2020, over 38 million unique social media users were reached with vital risk communication messaging on COVID-19 prevention; symptoms; hand washing; mask wearing; mental health care; adolescent health; nutrition for immunity; advice for vulnerable populations such as the elderly, sick and pregnant women and essential workers; routine immunization; school reopening; vitamin A campaign; the national measles and rubella vaccination campaign; helplines and gender-based violence. In addition, over 11 million unique users were engaged in discussions around COVID-19 and in amplifying critical communication.

In total, over 11 million female followers and over four million followers between the ages of 13 and 17 were reached with risk communication messaging, making social media an effective platform for reaching women and children. While spread of COVID-19 related misinformation and rumours decreased, there was a spike in spread of inaccurate information regarding vaccination.

Community feedback

The seventeenth edition of *Corona Kotha* [[Bangla](#) | [English](#)] – a bulletin summarizing community feedback and perceptions about COVID-19 collected by a range of agencies around the country was published.

It is produced by BBC Media Action and Bangladesh Red Crescent Society on behalf of [Shongjog](#), the national multi-stakeholder platform for community engagement and accountability. The publication highlighted community

perceptions such as inequitable vaccination distribution and rising cases of gender-based violence and physical abuse arising from increasing financial insecurity.

2.10 Research

Both local and international researchers from different fields of study have been collaborating to study patterns of disease spread, risk factors, clinical management, socio-economic impacts of COVID-19, since the beginning of the pandemic with the common goal to reduce its impact on the health, well-being and economy of the population.

MOHFW has nominated IEDCR to coordinate all research activities related to COVID-19 in partnership with WHO in Bangladesh. The country is contributing to global research by participating in WHO Solidarity Trial and WHO Unity studies.

Several other research studies are being carried out within the country, for example, data collection for investigating seroprevalence of COVID-19 among Rohingya Refugees in Cox's Bazar has been completed while the protocol for a study investigating national seroprevalence is being developed.

IEDCR and icddr,b are conducting a case-control research study to understand risk factors of COVID-19 spread among health care workers. Building on the One Health approach to emerging disease surveillance, IEDCR, with technical support from FAO, the University of Glasgow and Columbia University is conducting a study to investigate the effectiveness of rapid antigen tests in diagnosing COVID-19 cases compared to standard rRT-PCR testing.

Another study being led by FAO with support from icrd,b and University of Glasgow is evaluating the effectiveness of the Community Support Team (CST) intervention in reducing COVID-19 spread and preserving hospital-bed capacity in Dhaka City. Several other research studies are also underway to understand COVID-19 spread in slums, mental health impacts of the pandemic, risk factors driving transmission, and vaccine effectiveness, which all contribute to a better understanding of disease transmission and prevention practices for not only for COVID-19, but also future emerging disease outbreaks.

3. ISERP socio-economic response

3. ISERP socio-economic response The United Nations' Immediate Socio-economic Response Plan (ISERP) for Bangladesh aims to mitigate and to support recovery from the multifaceted socioeconomic impacts of the COVID-19 pandemic. Recognizing that the COVID-19 pandemic was going to slow and reverse progress towards the SDGs, the United Nations made an early decision to move into development-in-emergency mode globally. In April 2020 guidance was provided to all United Nations Country Teams to prepare a plan for [immediate socioeconomic response to COVID-19](#).

3.1 Protecting people and basic services

The pandemic has caused a massive disruption of livelihoods of people in Bangladesh. The situation is further exacerbated by several rounds of regional flooding and cyclones in the coast. The scale of current and emergent socio-economic needs has called for a revision of the UN's social protection and basic services approach to address the twin crisis together with Ministry of Disaster Management and Relief (MoDMR). The Mid-Term Review of National Social Security Strategy (NSSS) was further revised by General Economic Division (GED), with support from UNDP, in the context of COVID-19 as an input to the Eighth Five-Year Plan.

Social protection and continuity of social services

In partnership with Cox's Bazar district administration, UNDP provided cash support to 8,558 people (of which 37% were female). UNDP and MoDMR intensified their effort to bring together health and disaster committees at local level to ensure that search and rescue efforts follow COVID-19 guidelines. UNDP supported district administration to assist a total number of 8,009 persons (of which 32% were female) in Barguna, Patuakhali, Khulna, and Satkhira districts with activities for quick income and restoration of public infrastructure. These activities contributed to speedy recovery.

Education

UNDP launched an e-learning platform ('Virtual Class') to enable 8,765 students to take online classes from universities and training institutes during schools' closure. In total, 2,865 classes were provided as of Q4, 2020.

Food security and Nutrition

A total of 119,899 people (46% female) across the country, including hard-to-reach areas in the Chittagong Hill Tracts, received food packages from UNDP. Specifically targeted were ethnic minorities, vulnerable groups, poor women, women-headed households, persons with disabilities, and marginalized Dalit communities.

Water sanitation and hygiene

A total of 428,799 people (50% female) received UNDP's sanitation and hygiene support, including hand washing facilities and hygiene packages including masks, hand sanitizers, and PPE.

3.2 Protecting jobs, MSMEs, and most vulnerable productive sectors

COVID-19 has intensified the needs of vulnerable groups, including informal and returning overseas migrant workers. The pandemic related economic effects threaten to undermine years of steady progress in poverty reduction in Bangladesh.

Employment and sustainable business

UNDP launched a COVID-19 Private Sector Platform, which served as a mechanism for business communities to be engaged in response and recovery, particularly in the areas of data analytics, healthcare, skills and employment, and supply chain.

UNDP also facilitated the development of knowledge products on innovative business models for COVID-19 response and recovery. For example, a knowledge product on pre-paid business models inspired Unilever to invest in Praava to increase PCR testing capacity while ensuring Unilever's employees' healthcare. These innovations were published in the New Normal website that UNDP/a2i program worked with the government to boost innovation for COVID-19 recovery.

UNDP also worked with Unilever and HSBC to support safe waste management practices in Dhaka South City Corporation, reaching 5,300 waste pickers in coordination with the World Bank Water Resources Group.

Support to Cottage, micro-, small-, and medium-enterprises (CSMEs)

In partnership with the Innovation, Creativity, and Entrepreneurship (ICE) Center of the University of Dhaka, UNDP continued supporting SMEs throughout Bangladesh. The initiative was set out to support SMEs with regaining confidence to start business, facilitating accessing GOB's financial stimulus package, disseminating business information and helping the government to deliver the package following Leave No One Behind Principle. The initiative mobilised 110 facilitators and graduate students of business faculty of various universities. As a result, the

business entities in eight divisions received information regarding stimulus package and roughly 3,500 MSMEs received direct confidence building support. A series of national level dialogue was launched with key policymakers from Bangladesh Bank, the Prime Minister's Office, and key Ministries, including Finance, Commerce and Industry for co-designing policy solutions to reach the most vulnerable MSMEs.

UNDP-led a 'Digital Transport Platform' that reached over one million SMEs and enabled 5,300 SMEs to access supply chains and transparent transport systems, including Bangladesh Post, top six logistic service providers, and fast consumer goods companies. The platform was used to test innovative pricing and transparent use of supply and demand data to lower transport prices for SMEs and improve supply chain access.

UN Women produced a policy brief on the recovery of MSMEs for women. Policy recommendations included rights-based targeting of women MSMEs implementation of credit guarantee schemes, promotion of e-commerce; and highlighting the need to recognize and provide financial support towards unpaid care work facing women entrepreneurs.

Migration

To address the immediate needs of the migrants who returned to Bangladesh due to COVID-19 outbreak, IOM provided an Emergency Cash Grant to cover food, medical needs, transportation upon return. The initiative was funded by EU funded IOM project titled 'Bangladesh: Improved Migration Governance and Sustainable Reintegration (PROTASHA)' - led by the Ministry of Expatriates' Welfare and Overseas Employment (MoEWOE) and implemented in partnership with BRAC.

Returnees received BDT 5,000 as the Emergency Cash Grant upon return while returnees who had previously received reintegration assistance from the project, received additional stimulus grants of BDT 10,000 each to meet their basic and immediate needs.

Restrictions on movement during the pandemic made it challenging to contact and physically assess the needs and vulnerabilities of returning migrants. Identification of the returnees was done in close coordination with district administration. Assessments through telephone communication and grants were transferred to the returnees electronically through mobile banking. To address psychological well-being of the returning migrants during COVID-19 pandemic, tele-counselling support was provided through trained counsellors.

IOM supported the MoEWOE to develop a database of the returning migrants who came back to Bangladesh during the COVID-19 pandemic. The MoEWOE supplied information on 897 returnees top private sector partners who are looking for qualified workers for major construction projects. This service/facility/initiative, coordinated by the ICT Ministry, is part of the support the Government is providing to returning migrant workers.

UN Women supported women returnee migrant workers affected by COVID-19 with a focus on socio-economic reintegration. A total of 10,000 dignity packages with health-hygiene products and masks were distributed in 10 geographical areas in 2020.

Women migrant workers were fully engaged into the process of packaging and distribution of dignity packages and basic food items under a cash for work scheme. They were also involved in the mobilization of other women to create awareness on the COVID-19 prevention and protection. A group of returnee women are also engaged in mask production. They received skills development training from professional trainers and are making good quality masks as a part of economic reintegration activity. This was first of its kind intervention during COVID-19 to engage women into the community level work. MoEWOE, local Government and parliament members attended the distribution events of dignity packages in the respective areas. The above interventions were carried out by the

respective UN Agencies, as well as, members of the Bangladesh United Nations Network on Migration and the Migration subgroup established under the ISERP Pillar 3.

Support to Vulnerable Producers

FAO, through funding from the Embassy of Japan is supporting an emergency response to agricultural producers and supply chain actors affected by the breakdowns in key supply chains from rural production areas in a rice production area known as the 'Haor wetlands'.

The Haor area is remote and suffers from poor transportation linkages to major urban markets. It also has a unique agro-ecological profile which is ideal for seasonal rice cultivation but challenging for other traditional crops.

FAO has partnered with the Bangladesh Agriculture University Haor and Char Development Institute and the Bangladesh Agricultural Research Institute to provide technical, material and financial support to actors along critical food supply chains in the area. Working closely with local NGOs and government partners, FAO is assisting to make supply chains more resilient through incorporation of food safety measures and diversification for farmers and farmer groups.

FAO is also introducing new crop species which are suitable to the area and in demand along with technical support for production and marketing. The programme will reach over 3,00 producer households.

FAO, WFP and BRAC with support from Sida works to strengthen supply chains from rural producers to vulnerable poor beneficiaries in urban informal settlements. Early assessments undertaken by FAO and WFP showed a significant impact on the urban poor as supply chains broke down in the wake of the COVID-19 pandemic lockdowns. The lockdowns highlighted vulnerability along supply chains and ultimately in urban markets. The collaborative initiative support targets urban poor populations with cash transfer support linked to participating shops which offer fresh produce to programme participants.

Rural producers benefit from improved market access facilitated through the programme and technical support from FAO. The programme also builds linkages to social safety nets by identifying eligible households and individuals for uptake by the growing network of government social protection programmes. The programme will reach over 2,500 producer households.

3.3 Macroeconomic response and multilateral collaborations

The pandemic has unsettled Bangladesh's long-standing macroeconomic stability. The UN works to support the GoB in macro-economic crisis management and to envision a sustainable post COVID-19 economy.

Throughout Q4, UNDP continued to conduct macro-meso economic needs assessments, gender sensitive impact assessments, and labour market impact analyses for evidence-based programme design and policy formulation. UNDP also conducted assessments on socio-economic impact of urban poor (most vulnerable) caused by COVID-19. UNDP, with a2i also developed several websites, apps, skills development portal, and online platforms for effective and efficient implementation of the government's social safety net program.

Four UN agencies (UNDP, ILO, UNCDF and UN Women) are implementing the Integrated National Financing Framework project under the overall coordination of the UN Resident Coordinator and technical leadership of UNDP with support from a joint SDG fund. The Joint Programme (JP) will support the government to put in place an integrated financing framework to more effectively mobilize required resources from public and private sources for attaining SDGs by 2030.

Through the JP support, the government will be able to estimate the gaps in SDG financing and envision a forward-looking approach for public and private sector and partners in anticipation for the country's LDC graduation in 2024.

Through the JP, the government will engage in a fiscal space analysis to explore and identify new fiscal spaces and business models for the private sector with the aim of pursuing SDGs. This JP will include strong governance and coordination and oversight mechanisms to ensure expenditure efficiency and impact.

3.4 Social cohesion and community resilience

Promoting social cohesion and community resilience are critical to ensuring an equal rights-based and effective response. Here the UN partners have focused on nexus governance, rule of law, human rights and gender-based violence as means to reduce social tensions and to promote environments of sustainable well-being.

Under the Combatting Gender Based Violence (GBV) in Bangladesh, UN Women has supported civil society organization to advocate for Rape Law Reform and conducted webinars and live discussions on critical issues, especially around character evidence and compensation for GBV survivors. More specifically, UN Women supported Bangladesh Legal Aid Trust (BLAST), to continue its work on advocating for rape law reform, also informed by the Rape Law Reform Research series. Additionally, BLAST coordinated the Rape Law Reform Coalition in promulgating and disseminating a 10-point demands for Rape Law Reform.



Figure 9. Distribution of 'Dignity kits'

Civil and political rights, governance, and rule of law

In Q4 2020, based on human rights monitoring, UNDP produced seven weekly factsheets to highlight emerging human rights trends and concerns during the COVID-19 pandemic to support the National Human Rights Commission's (NHRC) response to the pandemic from a human rights perspective.

On occasion of the 16 days of activism 2020, the UN family and the Ministry of Women and Children Affairs (MoWCA) organized a two-part National Dialogue on Actions against Sexual Violence as a follow-up from the 2019's National Dialogue. The dialogue was a hybrid event that consisted of an in-person series of Experts Meetings, focused on drivers of GBV, access to justice and comprehensive sexuality education,

the outcome of which was presented and discussed during a Virtual Dialogue that took place on 25th November.

Gender-based violence

UNDP helped the National Legal Aid Services Organization to re-start their hotline services to address an increasing trend of GBV during the COVID-19 pandemic. UNDP also organized many advocacy and awareness-raising programmes and supported the NHRC to address GBV during the COVID-19 pandemic.

The key contribution from UNFPA to essential GBV services provision was adoption of safe and ethical standard operating procedures for remote case management and referral in COVID-19 pandemic context, implemented in UNFPA supported facilities (such as women friendly spaces, family welfare centre centres) in Cox's Bazar, Jamalpur, Bogura and Patuakhali. More than 3,000 women and girls received multi-sectoral services.

UNFPA also supported more than 20,000 women and girls, including individuals from third gender communities, who are vulnerable in the pandemic context and affected by Cyclone Amphan and monsoon flood, with essential personal and hygiene items in dignity kits that eased their access to other services and enhanced protection measures. One breakthrough in dignity kit support was that, for the first time, an emergency package was custom made for the third gender/transgender community based on their needs.

The COVID-19 pandemic has severely affected the service sector, particularly health, police, justice and social services, that are essential to support any survivor of GBV. In response, UNFPA, UNWOMEN and UNICEF initiated an assessment of these existing services both government and non-government, to identify gaps and challenges that hinders quality as well as availability of GBV services during COVID-19 pandemic context.

Stability and peace

Evidence based data has been disseminated through UNDP's COVID-19 data initiatives to Government, UN agencies, development partners, and local media – focusing on the social and political impacts of the COVID-19 outbreak. This work has contributed to shaping the COVID-19 'policy conversation' in the country to mitigate social tension, stigmatization and discrimination emerged around the pandemic. This data driven analysis has proven useful to guide the national COVID-19 response. UNDP's inclusive awareness campaign also reached 18 million people, helping address stigmatization and discrimination on COVID-19.

UNFPA produced a policy brief for advocacy with parliamentarians and policymakers on the effects of COVID-19 pandemic on maternal and child health and reproductive health services in Bangladesh. This document was discussed in a policy dialogue at the Planning Commission and was used to make specific recommendations to the GED for inclusion in the Eighth Five-Year Plan (2021-2025).

UNFPA, in collaboration with the Department of Population Sciences of the University of Dhaka, conducted a study to measure the effects of the COVID-19 on family planning and maternal health services in Bangladesh. The study findings can be used as evidence of informed programme planning to address issues related to maternal health and family planning services during the COVID-19 pandemic. Under the UN SDGs Joint programme, UNFPA facilitated a study on COVID-19 pandemic in 25 selected tea garden health facilities (Sylhet division) to explore the perception, practices, and challenges of tea garden workers and the community people of the tea gardens.

Through UN Women's support to enhance effective participation of women and youth in promoting peace and social cohesion, 156 young women and men strengthened their skills on social entrepreneurship and engaged in the Women Peace Ambassador initiative under the Women Peace Café (WPC), a university-based platform for female socialsss entrepreneurs, to support women affected by the COVID-19 pandemic. Furthermore, the WPC members successfully organized various virtual events to promote tolerance and inclusion, especially given the context of increased misinformation, hate speech and misogyny in the virtual space during the COVID-19 pandemic. WPCs also used social media as an effective means of spreading their message of peace as well as addressing issues of gender inequality and GBV by reaching over 807,800 individuals through WPC social media pages.



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