

NOBO JATRA-NEW BEGINNING
USAID's Development Food Security Activity

COVID-19
Impact Assessment Report



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EXECUTIVE SUMMARY

The COVID-19 crisis is having macro level impacts on health systems, economies and social dynamics that will take much longer to recover from. In Bangladesh, lockdowns to prevent transmission have taken a heavy toll on economies and millions of people are struggling with poverty and food security. This assessment highlights the impact of COVID-19 on livelihoods, food security, nutrition and health of poor and extreme poor households covered by USAID's Development Food Security Activity 'Nobo Jatra-New Beginning,' implemented by World Vision Bangladesh in Dacope, Koyra, Shyamnagar and Kaliganj sub districts in southwest Bangladesh. This region is characterized by frequent cyclones – the most recent being cyclone Amphan¹ which made landfall on 20th May 2020 causing damages to 1,327 hectares of crops, 9,404 hectares of aqua culture² (fisheries and hatcheries), homes and water sources at a time when communities are already weakened from the impacts of COVID-19.

On 26 March 2020, the Government of Bangladesh first initiated lockdown measures³ to contain the pandemic. This impact assessment took place from 21 June – 25 June and highlights the extent to which Nobo Jatra's direct participant households are affected. As found through the assessment, the top priorities for households during the pandemic are:

- Food consumption (81.6%)
- Livelihoods (71.8%)
- Medicines and healthcare (62.2%)
- Water Sanitation and Hygiene (54.4%)

The impact of COVID-19 is evident in the following areas:

Health and Nutrition

- Since the COVID-19 lockdown in March 2020, there has been a sharp decrease in the number of people accessing basic primary health services through community health structures** such as community clinics, expanded programme for immunization sites and Union Health and Family Welfare centers. These findings are in line with the Bangladesh COVID-19 Multi-Sectoral Impact and Needs Analysis⁴ by the Needs Assessment Working Group, which found that 45% of

¹ A cyclone Amphan impact assessment in Nobo Jatra working areas is underway and the final report will be shared end July 2020.

² Form for Assessment of Damage and Loss, Form - D, Ministry of Food and Disaster Management, May 2020

³ Starting from 26 March 2020, the Government of Bangladesh announced general holidays for a period of two weeks. The general holiday was extended seven times till 30 May. During this time all Government offices, education institutions and private companies remained closed. Since 1 June Government offices and other offices have partially opened and movement restrictions have been relaxed.

⁴ COVID-19 Multi-Sectoral Anticipatory Impact and Needs Analysis, Needs Assessment Working Group, April 2020



- women and children are unable to access health and nutrition services at health facilities.
- ii) The survey found a **31.4 percent decrease in households accessing services at community clinics** - 91.7% accessed services pre COVID-19 (before lockdown started on 26 March) in comparison to 60.3% at present. A 14.5 percent decline was seen for access to services through expanded programme for immunization sites – 85.4% pre COVID-19 and 70.9% now. A drop of 27.1 percent was also seen in accessing services from Union Health and Family Welfare Centers (46.8% pre COVID-19 and 19.7% now). These are all community level health service delivery points and are typically used by poor and extreme poor households in rural Bangladesh - the sharp drop in households accessing services is a cause for concern. Whilst services were scaled back in March, the main deterrent for communities has been fear of exposure to COVID-19 at clinics and centers. Heavy rainfall, flooding due to cyclone Amphan and the rainy season and limited public transport options have also been constraints in accessing services. **Reducing access to basic health care is one of the most critical secondary impacts of COVID-19 – and one that increases health and malnutrition risks for pregnant and lactating women and children under 2.**
 - iii) An overwhelming **92% of respondents**, both from female and male headed households, said they were facing **mental stress as a result of the COVID-19** pandemic. Also, **13% of households** said that a family member was going through high stress levels due to COVID-19.
 - iv) Of the households with children under 2, more than **50% said they were unable to provide a diverse, nutritious diet to the child due to lack of incomes and access to markets** as a result of COVID-19.

Food Security

- i) The impact assessment found that **56.4% of households had to borrow food or relied on help from relatives or neighbors in the previous week**. Similarly, 51.7% of households ate less preferred, cheaper food impacting daily nutritional intake leading to poor nutritional status for children and mothers.
- ii) **Household food security also has intersections with gender as the ability of women headed households to access safe, nutritious and diverse diets is at greater risk as seen through the extent of coping mechanisms used**. For example, 33% of female headed households reduced portion sizes of meals in comparison to 24.7% of male headed households.
- iii) Access to a diverse, balanced range of foods is affected due to COVID-19. 67.6% of households did not have access to milk products and 46.9% did not have access to protein rich foods.

Water, Sanitation and Hygiene

- i) **Access to water for cooking and drinking has decreased from 80.1% to 67.1% since the start of the COVID-19 lockdown in March 2020.** Also, 74.3% of households reported that since COVID-19 it takes longer to collect water due to lengthy queues, limited transportation options and specific timings (as per local Government instructions) when people can leave their homes. There is also greater pressure on the limited number of water resources available due to reverse migration back to rural areas and also the damages to water points caused by cyclone Amphan
- ii) In terms of hygiene practices, **82.5% said they were wearing masks when going outside their home** and 49.7% said they keep their homes and latrines clean. This can be attributed to mass awareness efforts by the Government of Bangladesh and Social Behavior Change campaigning on COVID-19 by Nobo Jatra.

Gender

- i) Since COVID-19, closure of schools, disrupted or no livelihoods and reverse migration back to rural areas has resulted in entire families staying at home which has further exacerbated the burden of unpaid care work on women, who now must absorb the additional work of constant family care duties. **The impact assessment found 57.7% of households reported increased time spent on childcare and 51% of households are spending more time cooking (unpaid work).** Remarkably, **84.7% of households reported that husbands or other male caregivers were helping with childcare and housework.**
- ii) **28% of households reported that risks of child marriage and other forms of Gender Based Violence have increased during COVID-19.** The current lockdown and loss of livelihood may inevitably work as a trigger of domestic violence against women and girls. The impact assessment also found that 60% of respondents felt that the safety and security of women and girls was a concern in the context of COVID-19.

Livelihoods

- i) As a result of COVID-19, household incomes are adversely affected. A decrease in incomes since the previous month was reported by **55.3%** of households. Critically, **6.9%** of households also reported that they had **no incomes** in the previous month. There are **important gender differentials** in reduced incomes. For example, the number of female headed households reporting no incomes was 14.7% in comparison to 5.6% male headed households reporting no incomes. This indicates a marked gendered difference of the impact of COVID-19 on female headed households bearing in mind that in rural areas 93.3 % of women typically work in the informal sector⁵ which is hard hit by the COVID-19 pandemic due to lockdown measures.

⁵ [Bangladesh Bureau of Statistics Labor Force Survey 2016-2017](#)

- ii) Reduced incomes are also affecting the health, safety and social wellbeing of families. Falling sick and being unable to afford treatment was cited by 36.2% of households as one of the main knock on effects of reduced incomes.
- iii) Reduced incomes are also having an adverse effect on **children's health, safety and wellbeing**; **13.7%** of respondents said they were sending **children out to work**, **11.7%** of respondents said they had to send their **children to live with a relative**, **5%** had to send **children to religious residential institutions** ('madrassa's') and **3.9%** had to **marry their children off early (before the age of 18)**.

Savings

- i) The COVID-19 impact assessment found that **80.5%** of households had no savings.
- ii) To cope with reduced incomes, **12.5% households took loans in the previous month – and the average monthly interest rate for these loans is an alarming 10.9%**. The majority of loans were taken from Micro Finance Institutions, followed by NGOs, family and local loan sharks. This highlights the urgency to restart and ramp up Village Savings Lending Associations so that the most vulnerable families have access to equitable finances, without exorbitant and unrealistic interest rates that perpetuate a chronic cycle of poverty.

Conclusion

The resilience capacities of Nobo Jatra's direct participant households are weakened from the impacts of COVID-19. Government lockdowns to prevent disease transmission have taken a heavy toll on local economies in southwest Bangladesh - directly affecting livelihoods and incomes which poses a severe risk to the purchasing power of households and their ability to buy food to survive. In addition to livelihoods, COVID-19 has affected households' access to healthcare and health seeking behaviors, heightened food insecurity and reduced access to safe drinking water. Critically, Nobo Jatra's direct participant households are struggling with the effects of COVID-19 **and** the damages caused by cyclone Amphan which is slowing down their abilities to recover. Negative coping mechanisms are being used by households such as **sending children out to work, marrying children off before the age of 18, taking loans at high interest rates and selling productive and household assets**. Both in the short and long term, these coping mechanisms will exacerbate poverty, increase the risks of chronic malnutrition especially for pregnant and lactating women and children and Gender Based Violence – including child marriage.

OBJECTIVES

The objectives of the Nobo Jatra COVID-19 Impact Assessment are:

1. To assess the impact of COVID-19 on food security, livelihoods, nutrition, and health of poor and extreme poor households through an equitable, gender sensitive lens.
2. To assess the capacity of affected populations in order to meet early recovery needs.
3. To identify specific challenges and gaps that will inform adaptation strategies, influence the design of new activities and service delivery models.

METHODOLOGY

The COVID-19 impact assessment is a cross sectional study that covers a representative sample of Nobo Jatra participants. The sample includes participants across all of the projects technical components including Water Sanitation and Hygiene, Maternal Child Health and Nutrition, Agriculture and Alternative Livelihoods, Disaster Risk Reduction, Gender and Good Governance and Social Accountability.

USAID's guideline on 'Participant-Based Surveys for Non Agricultural Annual Monitoring Indicators'⁶ has been applied to determine the sample size. Data from the Nobo Jatra Management Information System (MIS) was used for the sample frame. New, existing and graduated participants were included in the sample frame as per the participant registration system which is continuously updated.

SAMPLE DESIGN AND SAMPLING METHODS

A two-stage cluster sampling design was considered for the sample frame. In the first stage of sampling, villages were randomly selected. In the second stage, a list was generated of households supported by the project and households were randomly selected from the sampled clusters. The sample size was adjusted with the design effect for a two-stage Probability Proportional to Size (PPS7) of the clusters (villages). The procedure to calculate sample size to obtain point estimation for two-stage cluster sampling is shown below:

$$n_0 = \frac{z_{\alpha}^2 \times p(1-p)}{\xi^2}$$

⁶ Participant-Based Survey Sampling Guide for Feed the Future Annual Monitoring Indicators, September 2018, page 32

⁷ When samples from different sized clusters are used and sampling is taken with the same probability, the chances of selecting a member from a large cluster are less than selecting a member from a smaller cluster. This is known as probability proportional to size (PPS). This is offset that larger clusters have greater chance to be in the sample but the probability of selecting a beneficiary from that cluster is less than the beneficiary in smaller cluster. For example, if one sample had 20,000 members, the probability of a member being selected would be 1/20000 or .005 percent. If another sample had 10,000 members, the chance of a member being selected would be 1/10000 or .01 percent.

Initial sample size:

Final adjusted sample size:
$$n = d \times f_{pc} \times n_r \times \frac{z_{\alpha}^2 \times p(1-p)}{\epsilon^2}$$

For Ultra Poor Graduation

N	= Total number of (Covid-19 assessment beneficiaries)	118,505
d	= Design effect ⁸	2
Z _α	= Z-score corresponding to the degree of confidence	
P	= Estimated prevalence of an indicator at the time of first survey**	0.50
ε	= Relative precision required (margin of error 5.5%)	0.055
n _r	= Non-response rate (5%)	1.05
n₀	= Initial sample size	318
Z _{95%}	= Z value corresponding to 95% confidence level for two-tailed test	1.96
f _{pc}	= Finite population correction factor: 1 / (1+n ₀ /N)	1.0
n	= Adjusted sample size (design effect, non-response, finite population correction)	669
n _c	= Sample size per village (cluster)	16
k	= Number of cluster to be selected	45

** P attains it's maximum value when it is 0.50 (50%)

SAMPLING FRAME

The sampling frame included:

- i. Unique ID number for the cluster/village
- ii. Name of the cluster (e.g., village)
- iii. Location of the cluster (e.g., census geographic code)
- iv. Information on geographic location (e.g. district)
- v. Number of project participants in the cluster

The second stage participant frame included:

- i. Unique participant and/or household ID number
- ii. Participant's complete name
- iii. Participant's age and sex
- iv. Participant's household location (e.g. address or relative location, GPS coordinates)
- v. Village name and location
- vi. Information on geographic location (e.g. district)

⁸ The loss of effectiveness by the use of cluster sampling, instead of simple random sampling, is the **design effect**. The design effect is the ratio of the actual variance, under the sampling method actually used, to the variance computed under the assumption of simple random sampling. Usually, the design effect 2.0 is used for a two-stage cluster sampling procedure.

45 clusters were selected from Nobo Jatra sub districts and unions using a Probability Proportional to Size⁹ sampling procedure. The first cluster was selected randomly, and the remaining 44 clusters were selected systematically with probability proportional to the size of cluster. The minimum required sample from each cluster was 16 participants.

Survey respondents were selected prior to fieldwork using fractional interval systematic sampling from a comprehensive list of participants using an equal probability method. 16 participants from the selected 45 clusters were drawn from the sampling frame. Thus (45 X16) 720 households were selected for the assessment.

DATA COLLECTION

A customized digital application under the Open Data Kit platform was used for data collection. Data was collected at household level using tablets, Kobo Toolbox and a structured questionnaire. The impact assessment is guided by the 'Do No Harm' principle and seeks to ensure the safety and confidentiality of individuals and considers that partners and staff in many cases are under pressure.

LESSONS LEARNED

- i. Even in a dynamic, evolving pandemic, it was possible to move fast. The impact assessment took 14 days (21st June - 4th July) starting from the development of the questionnaire to the final report.
- ii. Using digital tools (Kobo Toolbox, tablets) expedited the process as frontline staff have access to and are familiar with using tablets and all data collected is synced with the Nobo Jatra server. Even in a short time frame, taking a systematic approach is critical. For example, in the current situation there are movement restrictions and limitations on gatherings. Therefore, training of staff and data collectors was virtual (using Zoom) and staff from different field locations participated in the training from their respective locations. The virtual training covered data collection processes, tools and revised Standard Operating Procedures on health and safety during COVID-19 – all participants had also participated in online orientation sessions (organized for all Nobo Jatra field staff at the start of the COVID-19 pandemic in March when work from home was first initiated) to increase familiarity with Zoom.

⁹ When samples from different sized clusters are used and sampling is taken with the same probability, the chances of selecting a member from a large cluster are less than selecting a member from a smaller cluster. This is known as probability proportional to size (PPS). This is offset that larger clusters have greater chance to be in the sample but the probability of selecting a beneficiary from that cluster is less than the beneficiary in smaller cluster. For example, if one sample had 20,000 members, the probability of a member being selected would be 1/20000 or .005 percent. If another sample had 10,000 members, the chance of a member being selected would be 1/10000 or .01 percent.

- iii. Another lesson learned was that deploying a large, well trained team is critical. Recognizing that the impact assessment was critical to determine project strategies, adaptations and design new activities, 65 field staff (including staff from partners and local partner NGOs) were trained and deployed on ground to collect data.
- iv. Integrating gender throughout the process is crucial. Promising practices include having the gender focal point involved in the development of the questionnaire, methodology and analysis and an equal balance of male and female staff undertake data collection. This helped in highlighting gender issues and will also inform adaptations and service delivery models that address specific needs and priorities for women and girls. Cyclone Amphan made landfall on 20th May 2020 with gale force winds and heavy rains. The scale of damages in Nobo Jatra working areas was immense and have exacerbated needs – when communities are already weakened from the prolonged impact of COVID-19. Given the flooding and water logging in the aftermath of the cyclone, accessibility was a constraint in some unions in Koyra and Shyamnagar sub districts.

ASSESSMENT FINDINGS

I: HOUSEHOLD INFORMATION

Table I: Household Information			
Household Participation in Data Collection	Male Headed Households (N)	Female Headed Households (N)	Total (N)
Present	594	101	695
Temporarily absent	8	0	8
Migrated	7	0	7
Did not participate	10	0	5
Total	619	101	720

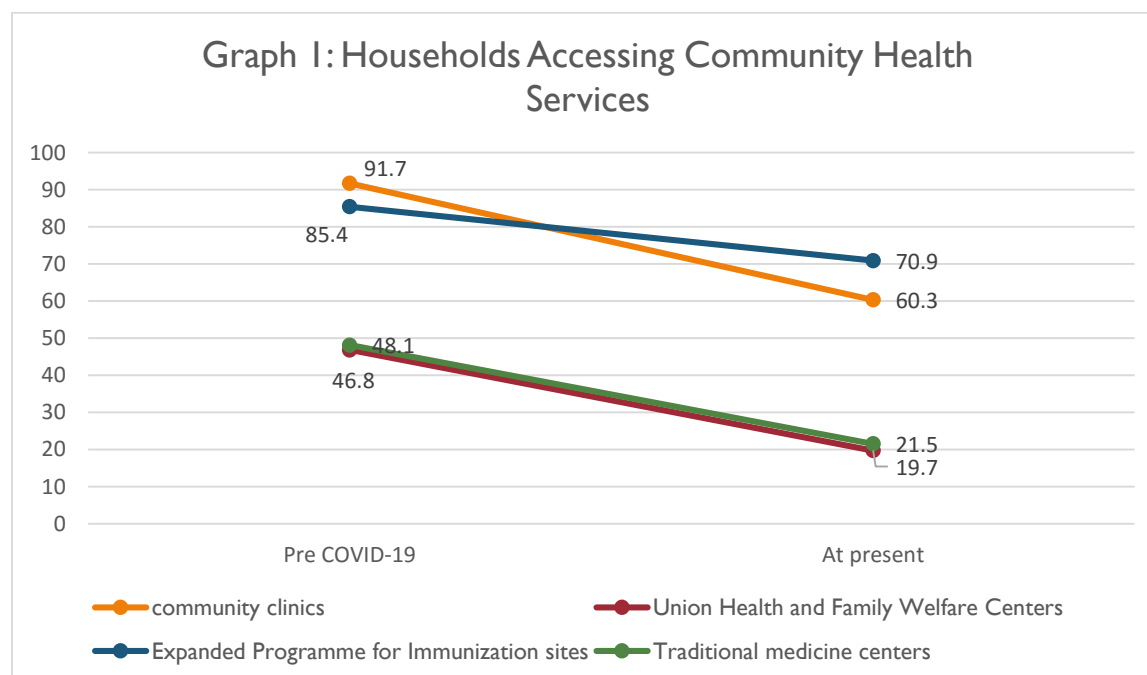
Of a total of 720 households in the sample, 695 (96.5%) households participated as respondents in the impact assessment. Ten households chose not participate due to time constraints or a lack of interest. Among the 695 participating households, 5 (0.7%) were headed by a person aged below 18 and 87 (12.5%) households were headed by a person aged over 60. The vast majority, 599 (83%), households were headed by persons aged 19-60 years. 125 (18%) of households had a family member with a disability, 118 (17%) households had a lactating mother and 26 (3.8%) had a pregnant woman.

Table 2: Ages of family members in households participating in the assessment			
Age group	Male	Female	Total
Age <5	186	189	375
Age <18	384	307	691
Age <60	980	1068	2048
Age 60>	247	359	606
Total	1797	1923	3720

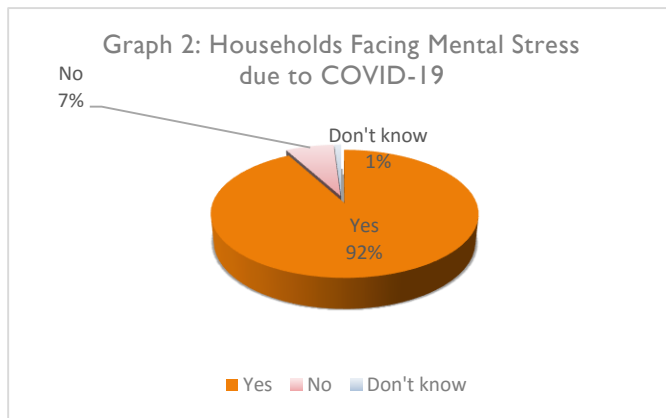
I: HEALTH AND NUTRITION

In rural Bangladesh, community health systems such as community clinics and Union Family Health and Welfare Centers are the first port of call for affordable, basic health and nutrition services including Growth Monitoring and Promotion, nutrition counselling, immunization and Ante and Post Natal care. To illustrate this point further, the impact assessment found that 85% of respondents were aware that Growth Monitoring and Promotion sessions and 57.9% were aware that Ante-Natal Care services were available at their nearest health care facility.

However, since **COVID-19 lockdown restrictions started in March 2020, there has been a sharp decrease in the number of people accessing basic primary health services through these community health structures.** These findings are in line with the Bangladesh COVID-19 Anticipatory Needs Assessment by the Needs Assessment Working Group, which found that 49% of women and children are unable to access health and nutrition services at health facilities.



The survey found a sharp decrease in households accessing services at community clinics – **91.7% pre COVID-19 lockdown in comparison to 60.3% at present**. A similar decline was seen for Expanded Programme for Immunization sites – 85.4% pre COVID-19 and 70.9% now. A drop of 27.1% was also seen in accessing services from Union Health and Family Welfare Centers (46.8 pre COVID-19 and 19.7% now). All of these health service points are the first point of call for poor and extreme poor households in rural Bangladesh and the sharp drop in households accessing services is a cause for concern. Whilst services were scaled back at the start of the pandemic, the main deterrent has been fear of exposure to COVID-19 at clinics and centers. Heavy rainfall, flooding due to cyclone Amphan and the rainy season and limited public transport options have also been constraints in accessing services. **Reducing access to basic health care is one of the most critical secondary impacts of COVID-19 – and one that increases the risks of malnutrition for pregnant and lactating women and children under 2.** Growth Monitoring Promotion sessions, supported by Nobo Jatra, are one of the main conduits to track the health and nutrition of children under 2, and provide counselling on Infant and Young Child Feeding to care givers. Attendance at these sessions are critical and the survey findings highlight an urgent need to ramp up household counselling and community messaging to encourage regular attendance, dispel fears of transmission and reassure families that sessions will follow health and safety protocols for all participants.



The impact assessment also found that **79.4%** of households knew where to access services if they had symptoms of COVID-19. However, an almost proportional number, **70.4%** of households, said they would not access services due to fear of exposure to COVID-19 and a lack of resources to pay for treatment. An overwhelming **92% of respondents, both from female and male headed households, said they were facing**

mental stress as a result of the COVID-19 pandemic. Also, 13% of households said that a family member was going through high stress levels due to COVID-19.

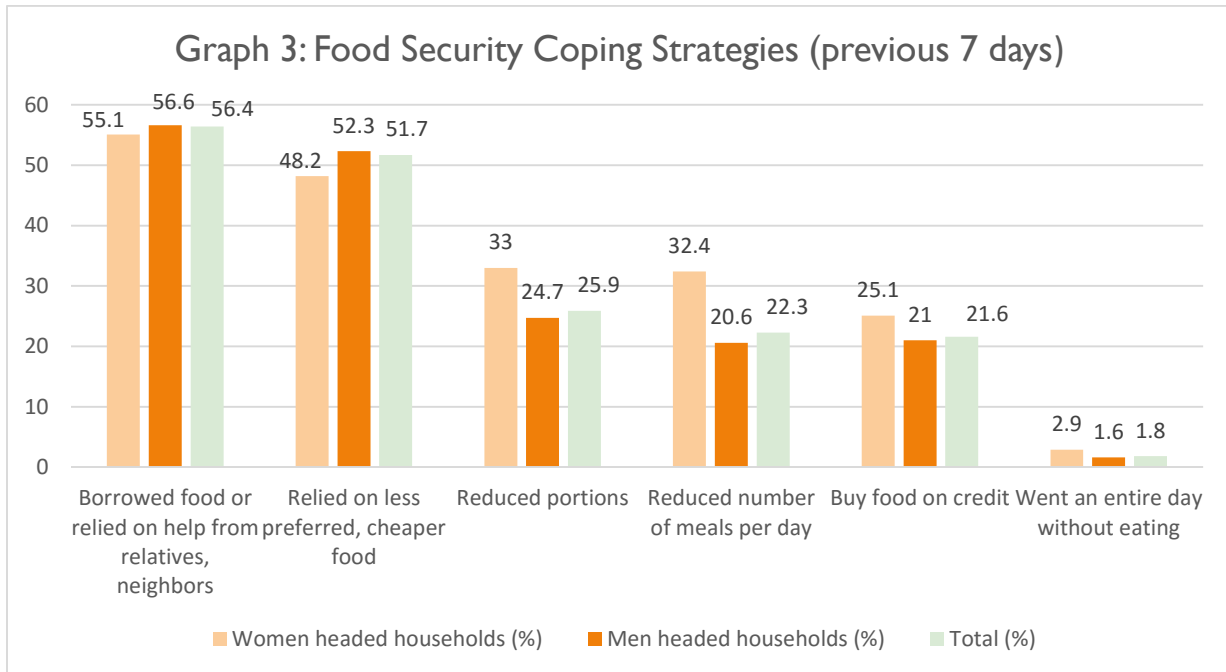
Of the households with children under 2, more than **50% said they were unable to provide a diverse, nutritious diet to the child due to lack of incomes and access to markets** as a result of COVID-19. With regard to immunizations, 17.7% of households mentioned that they have immunized their children (between 0-23 months) whereas 4% of households could not immunize their children (between 0-23 months) due to COVID-19.

2: FOOD SECURITY

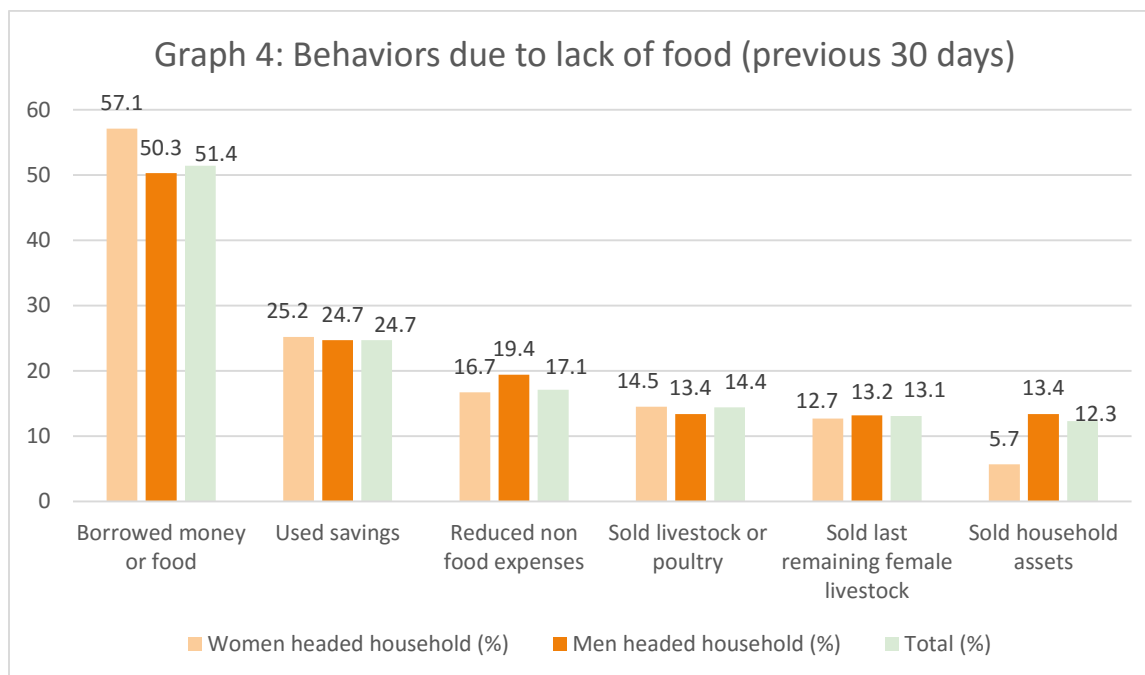
COVID-19 related containment measures in Bangladesh range from basic hygiene recommendations to lockdowns and movement restrictions designed to limit the concentration and movement of populations. Movement restrictions and their knock-on effects have undermined households' access to food by limiting the amount of food they can produce or collect (i.e. crops, milk/meat, and fish); reducing the amount of cash they can generate (from both on-farm and off-farm sources as described in 2: Livelihoods); and changing the available supplies and prices of commodities they need to buy, including staple foods, productive inputs and other essential items.

Seasonality is also an important factor; in Bangladesh containment measures started in end March when farmers in Nobo Jatra working areas were getting ready to harvest watermelon, bottle gourd, eggplant and okra. On the production side, restrictions on vehicle movement and home quarantine, obstructed farmers' access to markets. Farmers had limited access to inputs such as seeds and fertilizers, which shortens their productive capacities and hindered them from selling their produce at the volume and prices anticipated. Supply of inputs such as quality seeds and presence of the private sector (retailers, input and output buyers), were also disrupted due to containment efforts. Making matters worse, cyclone Amphan made landfall on 20th May 2020 with gale force winds and heavy rains. The scale of damages was immense; 1,327 hectares of crops and 9,404 hectares of aqua culture¹⁰ (fisheries and hatcheries) were lost across all 4 sub districts covered by Nobo Jatra.

¹⁰ Form for Assessment of Damage and Loss, Form - D, Ministry of Food and Disaster Management, May 2020



The impact assessment found that **56.4% of households had to borrow food or relied on help from relatives or neighbors in the previous week**. Similarly, 51.7% of households ate less preferred, cheaper food. **Household food security also has intersections with gender as the ability of women headed households to access safe, nutritious and diverse diets is at greater risk as seen through the extent of coping mechanisms used**. For example, 33% of women headed households reduced portion sizes of meals in comparison to 24.7% of men headed households. Households also reported reducing the number of meals as a coping mechanism - with 32.4% of women headed household using this tactic in comparison to 20.6% of men headed households.



To meet immediate household consumption needs, 51.4% of respondents reported taking loans or borrowing food in the previous 30 days. The impact assessment showed that 57.1% of women headed households had borrowed food or money in the previous 30 days in comparison to 50.3% of men headed households.

Selling livestock and household assets such as jewelry, furniture, radios were all reported ways in which households were meeting consumption needs in the previous 30 days to the survey. This is further depleting household resilience capacities – particularly when it comes to paying medical treatments or reviving livelihoods that are affected by the double impacts of COVID-19 and cyclone Amphan.

Remarkably, 43.5% of households surveyed had no food provisions or stock. Again, there are marked gendered differentials; 60.7% of female headed households reported having no food supplies or stock in comparison to 40.5% of male headed households. Having food supplies for 1 week was reported by 33.6% of households – with 24.2% of women headed households reporting this in comparison to 35.2% of men headed households.

Table 4: Availability of food groups									
Available food groups	Male headed (%)			Female headed (%)			Total		
	Yes	No	Sometimes	Yes	No	Sometimes	Yes	No	Sometimes
Starch (Cereals, rice, flour, bread, potato, sweet potato)	45.3	19.4	35.2	32.2	33.2	34.6	43.4	21.4	35.1

Protein rich animal source foods (eggs, fish, meat)	10.0	45.2	44.8	7.5	56.6	35.9	9.6	46.9	43.5
Pulses and legumes	20.4	39.5	40.1	15.5	43.9	40.6	19.6	40.2	40.2
Green leafy vegetables	53.8	19.4	26.9	40.5	24.0	35.5	51.9	19.9	28.1
Other vegetables and fruits	35.0	30.3	34.7	21.4	46.1	32.5	33.0	32.5	32.4
Energy dense foods (oil, nuts, sugar)	24.3	37.7	38.0	22.0	42.9	35.1	23.9	38.5	37.6
Milk products (fresh Milk, margarine, butter)	7.7	61.6	24.7	4.7	74.4	20.9	7.2	67.6	25.1

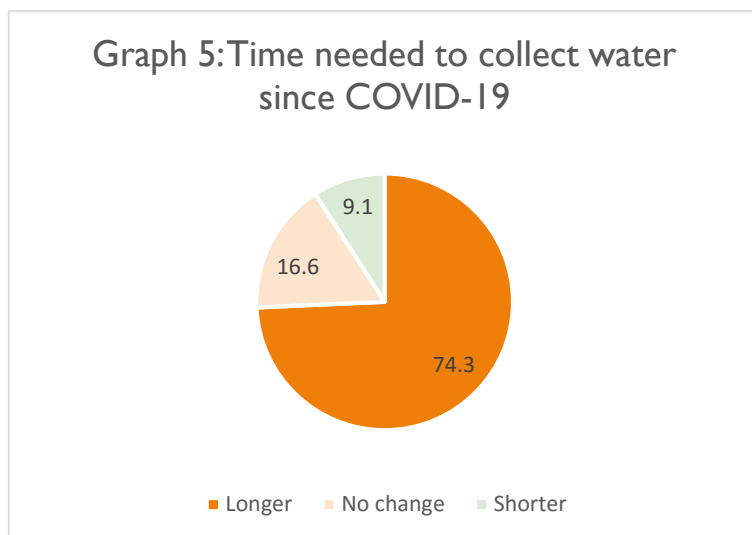
Access to a diverse, balanced range of foods is also affected due to COVID-19. As shown in Table 3, 67.6% of households did not have access to milk products and 46.9% did not have access to protein rich foods. This correlates to food security coping mechanisms used by families – where 51.7% of households reported eating cheaper, less preferred food (Graph 4: Food Security and Coping Strategies in previous 7 days). Once again, female headed households reported these constraints on dietary diversity to a higher extent than male headed households (74.4% of female headed households were unable to consume milk products in comparison to 61.6% of male headed households).

3: WATER, SANITATION AND HYGIENE

Safe water, sanitation and hygienic conditions are essential for protecting health during all infectious disease outbreaks, including COVID-19. Now, more than ever, households need access to safe drinking water and hygienic latrines.

Table 5: Households able to meet needs for clean, safe, drinking water								
Household water needs	Before COVID-19				Since COVID-19			
	Fully	Partially	Not at all	Don't know	Fully	Partially	Not at all	Don't know
Drinking and cooking	80%	19%	1%	-	67%	30%	3%	-
Latrines	66%	31%	3%	-	58%	39%	3%	-
Handwashing	78%	19%	3%	-	47%	51%	2%	-
Bathing and personal hygiene	70%	27%	3%	-	56%	40%	3%	1%

Household cleaning	70%	27%	2%	1%	50%	47%	2%	1%
Livelihoods (irrigation, livestock)	39%	31%	20%	10%	27%	42%	21%	10%



Across all categories we see a drop in access to clean, safe water since COVID-19. **Access to water for cooking and drinking has decreased from 80% to 67% the start of the COVID-19 lockdown on 26 March 2020.** Similarly, there is a drop in access to water for handwashing, bathing, cleaning and for livestock. This can be attributed to restrictions on movement due to COVID-19, limited transportation options also greater pressure on the limited

number of water resources available due to reverse migration back to rural areas and also the damages to water points caused by cyclone Amphan. Poor and extreme poor populations covered by Nobo Jatra typically rely on community water points (deep tube wells, shallow tube wells, pond sand filters, Reverse Osmosis plants, Arsenic Iron Removal plants). People, typically women and adolescent girls, have been unable to leave their homes as frequently as needed to collect water from water points. **Also, 74.3% of households reported that since COVID-19 lockdown measures in March it takes longer to collect water due to long queues, specific timings (as per local Government instructions) and greater pressure on limited number of resources due to reverse migration back to rural areas.**

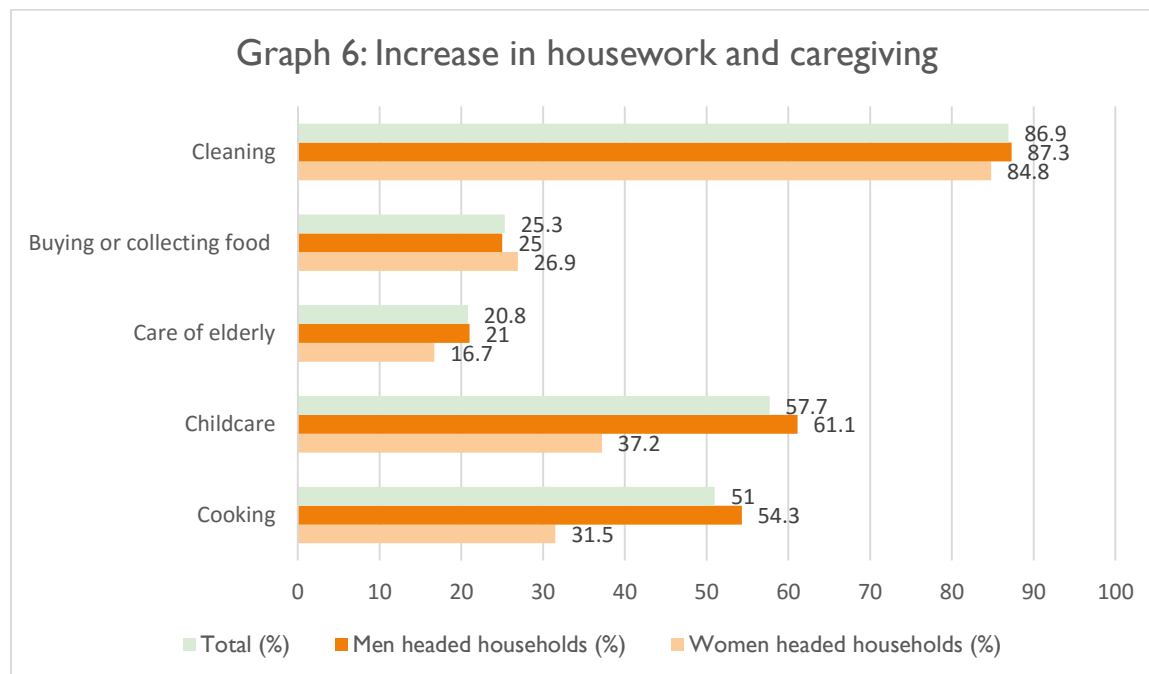
Access to safe sanitation has also dropped 8.2% from 66% pre COVID-19 lock down measures in March to 57.8% now. Households also confirmed a drop in being able to meet bathing and personal hygiene needs – 70% were able to meet these needs pre COVID-19 lockdown restrictions in comparison to 55.9% now. Access to water for livestock and irrigation purposes has also been affected – 38.9% of households were able to fully meet needs prior to COVID-19 in comparison to 27.6% now.

In terms of hygiene practices, 82.5% said they were wearing masks when going outside their home and 49.7% said they keep their homes and latrines clean. This can be attributed to mass Social Behavior Change campaigning by the Government of Bangladesh and NGOs. Bearing in mind that households are directly involved with Nobo Jatra, these hygiene behaviors can also be credited to multiple awareness activities including voice messages on health and hygiene, household

counselling, public awareness messaging at community level and through faith leaders and religious institutions.

4: GENDER

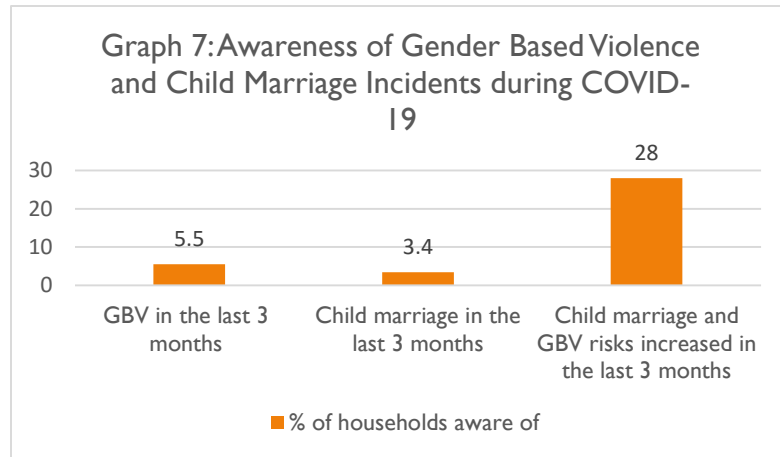
Whilst lifesaving, the COVID-19 lockdown is disproportionately impacting women as existing gender inequalities are exacerbating gender-based disparities between women, men, girls and boys in terms of access to information, resources to cope with the pandemic, and its socio-economic impact.



COVID-19 has increased the burden of unpaid domestic and childcare work for everyone, especially for mothers or female caregivers. In Bangladesh, pre-COVID-19, women on average performed 3.43 times more unpaid domestic care work than men (Bangladesh Bureau of Statistics Gender Statistics 2018)¹¹. Since COVID-19, closure of schools, disrupted or no livelihoods, reverse migration back to rural areas has resulted in entire families staying at home which has further exacerbated the burden of unpaid care work on women, who now must absorb the additional work of constant family care duties. **The impact assessment found that 86.9% of households reported increased time on cleaning (unpaid work).** This can be attributed to having additional family members at home and massive COVID-19 health and hygiene awareness by the Government of Bangladesh and NGOs. 57.7% of households also reported increased time spent on childcare and 51% of households are spending more time cooking.

¹¹ [Bangladesh Bureau of Statistics Gender Statistics 2018](#)

Remarkably, 84.7% of households reported that husbands or other male caregivers were helping with childcare and housework.



Increases in Gender Based Violence is a real risk in the context of a dynamic, evolving pandemic. In southwest Bangladesh, child marriage is a critical challenge and the average age of marriage for women is 15.2¹². Since 2015, Nobo Jatra has taken a holistic approach to address this challenge; working to strengthen Government Child Protection Committees, rolling

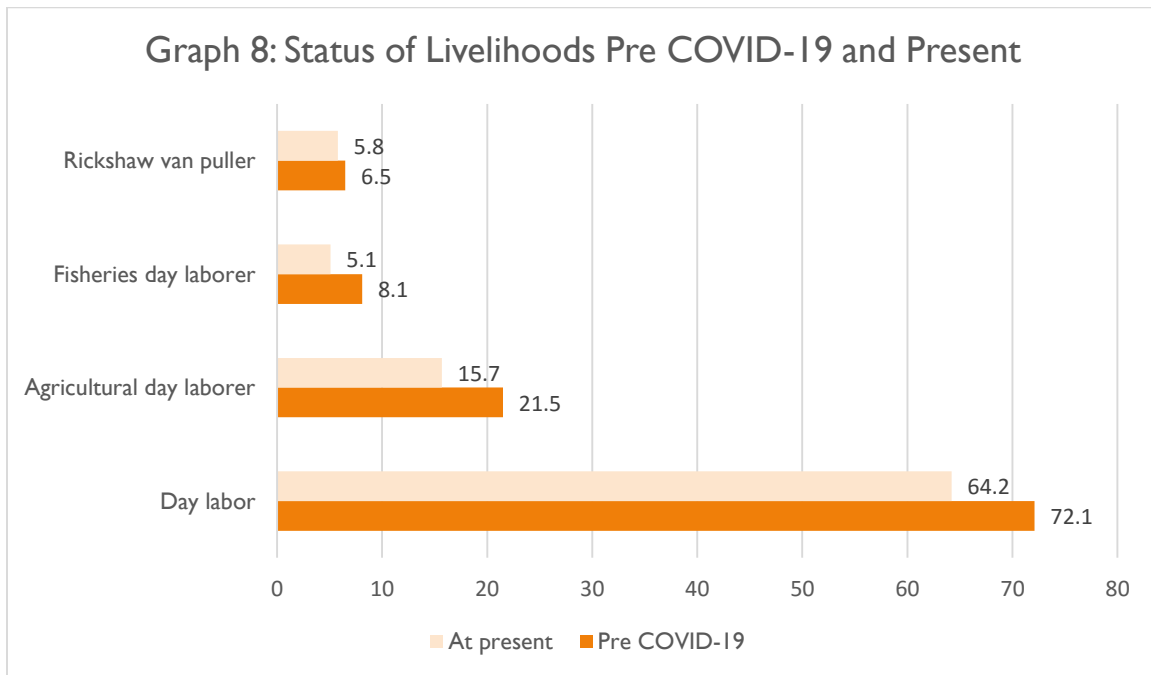
out a deeply contextualized Male Engagement for Gender Equality module, a ‘Marriage Not Before 18’ awareness campaign and running Life Skills Based Education in communities and schools. Messaging on Gender Based Violence is also intentionally integrated across all Social Behavior Change activities cutting across all components. However, given the impacts of COVID-19, **28% of households reported that risks of child marriage and other forms of Gender Based Violence have increased during COVID-19.** However, it is worth noting that the actual number of cases are never known; and the Multiple Indicator Cluster Survey 2019¹³ found that 25.4% of women think partner (husband) violence is justified. The current lockdown and loss of livelihood would inevitably work as a trigger of domestic violence against women and girls. The impact assessment also found that 60% of respondents felt that the safety and security of women and girls was a concern in the context of COVID-19. This aligns with the Bangladesh Needs Assessment Working Groups’ Anticipatory Assessment Report which showed that 49.2% of women and girls feel safety and security is an issue in the current lockdown

In terms of reporting of child marriage and Gender Based Violence, 62.1% of households know where and how to report cases (government toll free hotlines, local police and local Government administrations).

¹² Nobo Jatra Baseline 2015

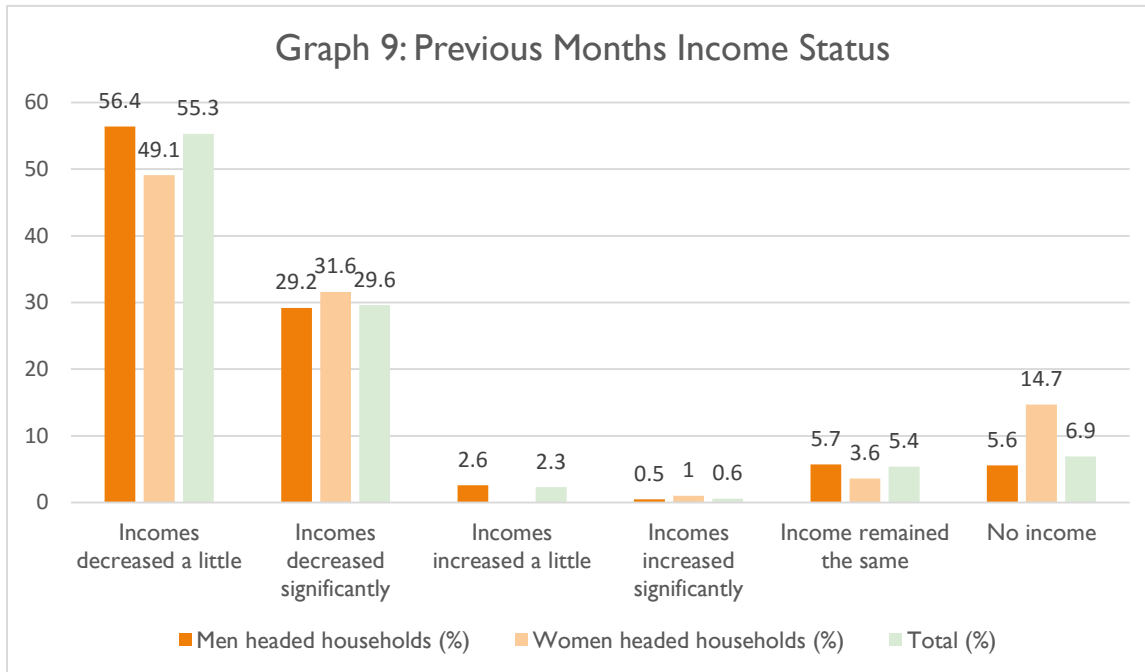
¹³ <https://www.unicef.org/bangladesh/en/reports/progotir-pathay-bangladesh>

5: LIVELIHOODS¹⁴



Of the surveyed households, 72.1% of households said working as a day laborer (casual labor construction, repair of roads, houses, digging ponds, canals) was their main source of income pre COVID-19 lockdowns that started in March. The second most prevalent livelihood pre COVID-19 was working as a agriculture day laborer (working on farms, agricultural lands) and 21.5% households said this was their main source of income. Both of these livelihoods are still the most popular however, both have seen a drop – only 64.7% households continue to rely on day labor and 15.7% households rely on agricultural day labor as their main sources of income. The drop in all livelihoods can be attributed to a number of factors; Government lockdown measures to reduce the risk of COVID-19 transmission, suspended services (for example, construction work which requires day laborers) and also the damages caused by cyclone Amphan to harvests, agricultural lands and aquaculture (reducing the need for agriculture day laborers).

¹⁴ Livelihoods includes Agriculture and Alternative Livelihoods of off-farm and non-farm activities, both wage labor and enterprise income.

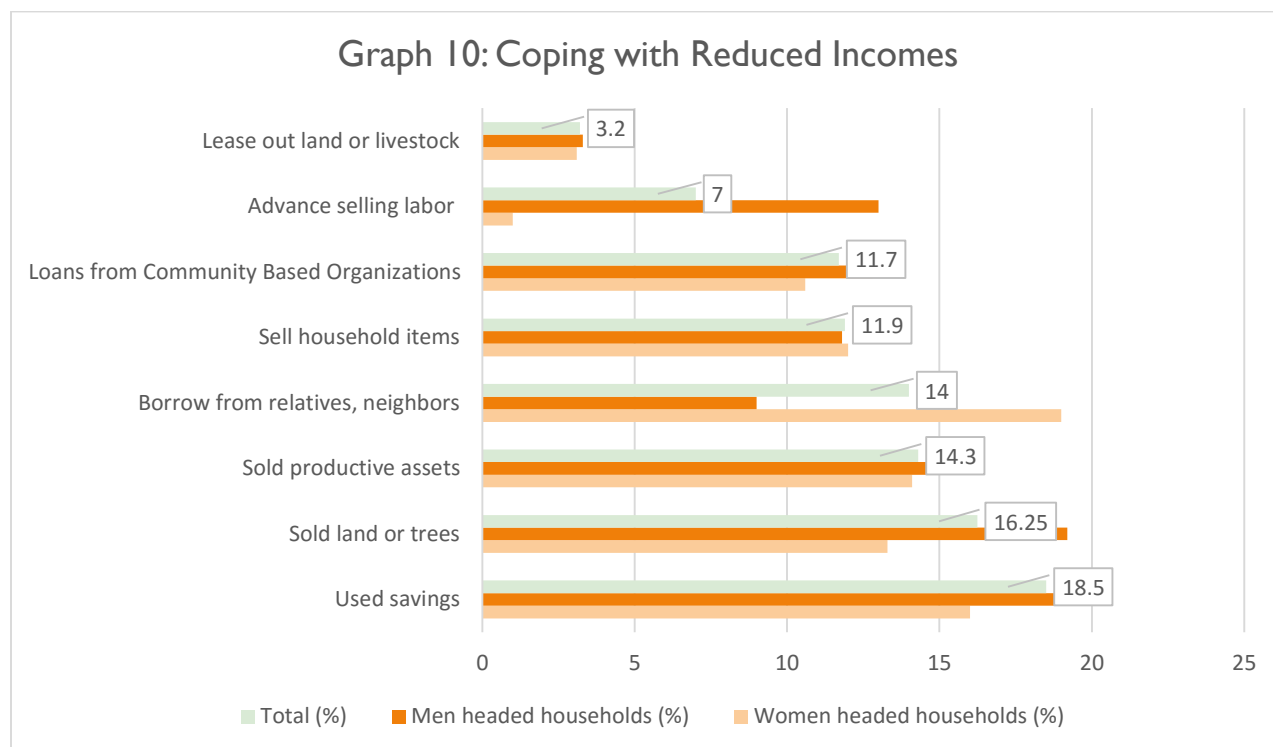


Linked to the status of livelihoods, just over half or 55.3% households reported a decrease in incomes since the previous month. Moreover, 29.6% households said that incomes had decreased significantly since the previous month. It is worth noting that, **6.9% households also reported that they had no incomes in the previous month.** As a result of COVID-19, household incomes are adversely affected, however, there are gender differentials. For example, the number of female headed households reporting no incomes was 14.7% in comparison to 5.6% male headed households reporting no incomes. This indicates a marked gendered difference of the impact of COVID-19 on female headed households bearing in mind that in rural areas 93.3 % of women typically work in the informal sector¹⁵ which is hard hit by the COVID-19 pandemic due to lockdown measures. For example, women entrepreneurs (tailors, embroiderers, paper box and handicraft businesses) have all seen their businesses suffer since the lockdown restrictions were put in place. Orders have reduced or stopped altogether, women have used up business capital to meet immediate household needs and now are unable to restart livelihoods as do not have seed capital to purchase raw materials needed (paper for boxes, cloth and thread for tailoring etc.)

The majority of respondents, 94.1% of households reported that livelihoods were adversely affected as a result of COVID-19. The main reason attributed to disrupting livelihoods were: closure of businesses (48.6%), lockdown, movement restrictions (45%), reduced demands for

¹⁵ [Bangladesh Bureau of Statistics Labor Force Survey 2016-2017](#)

goods and services (37.7%), transport limitations (36.6%), market closures (34.4%), unavailability of inputs (21.7%) and unaffordability of inputs (16.2%).



Reduced incomes are also affecting the health, safety and social wellbeing of families. Falling sick and being unable to afford treatment was cited by 36.2% of households as one of the main knock on effects of reduced incomes. Engaging in high risk jobs (such as fishing in Sundarbans) was also cited by 26.2% of households as a way of mitigating reduced incomes. Reduced incomes are also having an adverse effect on **children’s health, safety and wellbeing; 13.7% of respondents said they were sending children out to work, 11.7% of respondents said they had to send their children to a relative, 5% had to send children to religious residential institutions (‘madrassa’s’) and 3.9% had to marry their children off early (before the age of 18).**

Table 3: Household affordability						
Category	Before COVID-19			Since COVID-19		
	Fully	Partially	Not at all	Fully	Partially	Not at all
Food	66%	32%	2%	11%	81%	2%
Cooking items (gas, wood)	69%	20%	3%	22%	70%	5%
Rent (if applicable)	13%	11%	11%	6%	17%	12%
Healthcare	65%	32%	2%	15%	75%	8%
Loan payment	35%	22%	12%	7%	34%	27%

Personal hygiene and sanitation products	53%	43%	2%	27%	62%	9%
Others items	48%	38%	3%	14%	68%	7%

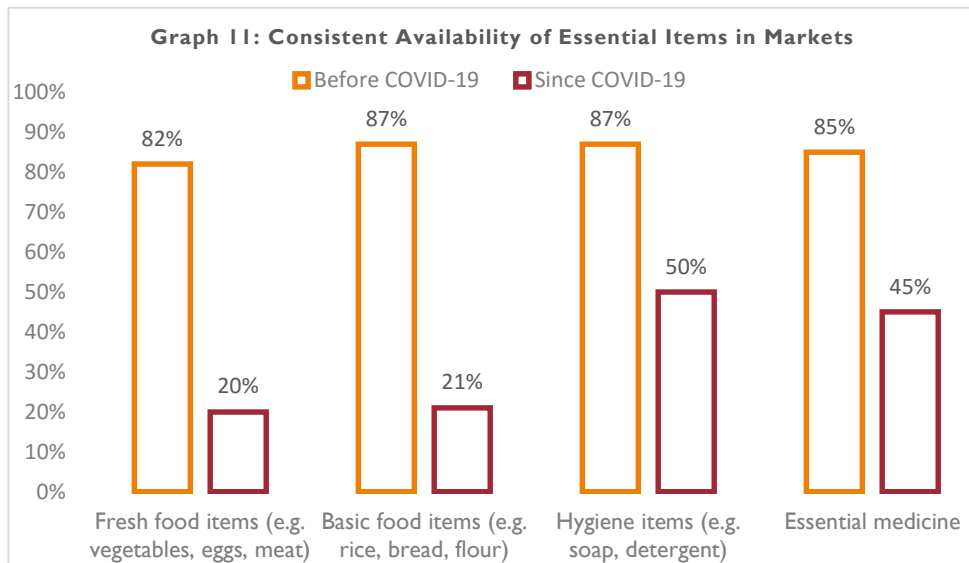
Reduced incomes are drastically affecting the ability of households to afford basic living essentials. There are dramatic drops in affordability pre COVID-19 in comparison to the present. Families are struggling to afford food – 66% of households were able to fully meet their food costs prior to COVID-19 in comparison to 11% now. The drop in healthcare affordability is also notable – 65% were able to cover costs fully prior to COVID-19 in comparison to only 15% of households now.

6: SAVINGS

Now more than ever, savings are critical to counter personal financial crises and unforeseen risks, and increase chances of staying resilient. However, the COVID-19 impact assessment found that **80.5% of households had no savings**. Furthermore, 84.1% of households headed by women had no savings in comparison to 79.9% of households headed by men. Again, this shows the gendered differences of the impact of COVID-19 on households – with female headed households disproportionately affected.

To cope with reduced incomes, **12.5% households took loans in the previous month – and the average interest rate for these loans is 10.9%**. The main reason for taking loans was to meet immediate household consumption needs, followed by medical treatment and repaying other outstanding loans. The majority of loans were taken from Micro Finance Institutions, followed by NGOs, family and local informal money lenders. This highlights the urgency to restart and ramp up Village Savings Lending Associations so that the most vulnerable families have access to equitable finances, without exorbitant and unrealistic interest rates that perpetuate a chronic cycle of poverty. Equally, this also emphasizes the need to revive incomes and livelihoods through creative service delivery models (such as cost share mechanisms, incentivizing private sector, demand creation campaigns).

7: MARKETS

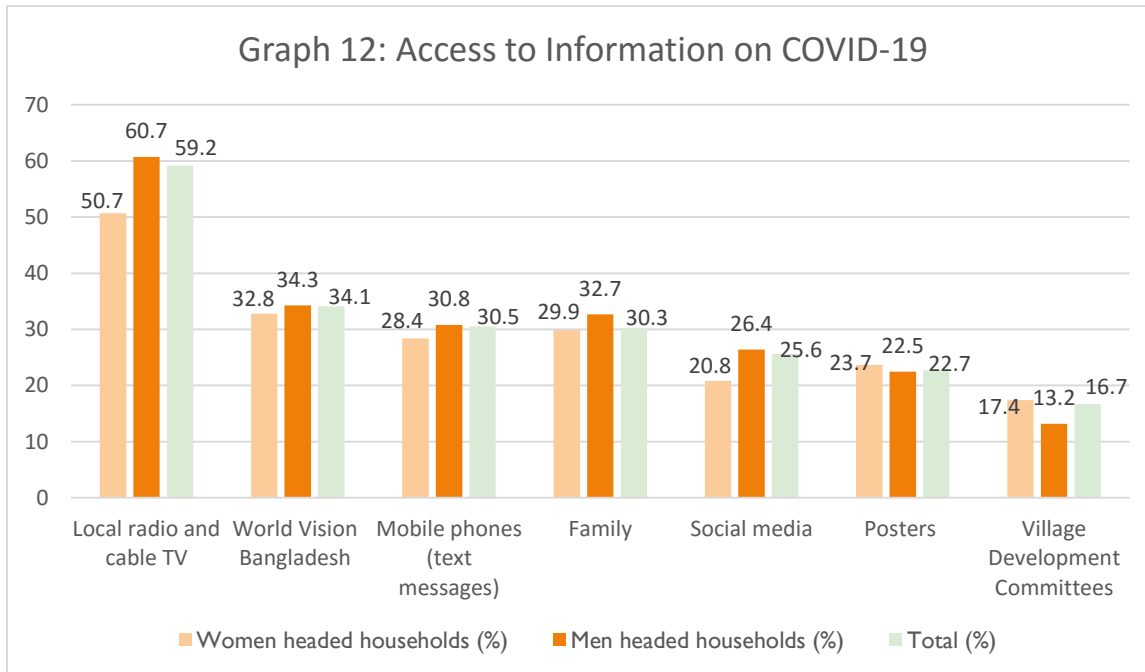


Local markets have largely remained open since the start of the lockdown in end March – albeit for shorter hours, on certain days and in some cases in Nobo Jatra working areas markets have been shifted to open areas where it is easier to follow social distancing rules. However,

availability of fresh foods, dry foods, hygiene items and essential medicines have not been consistent in local markets due to restrictions on vehicle movement and home quarantine, farmers’ access to markets is obstructed and disruptions to transport of goods between different areas of the country.

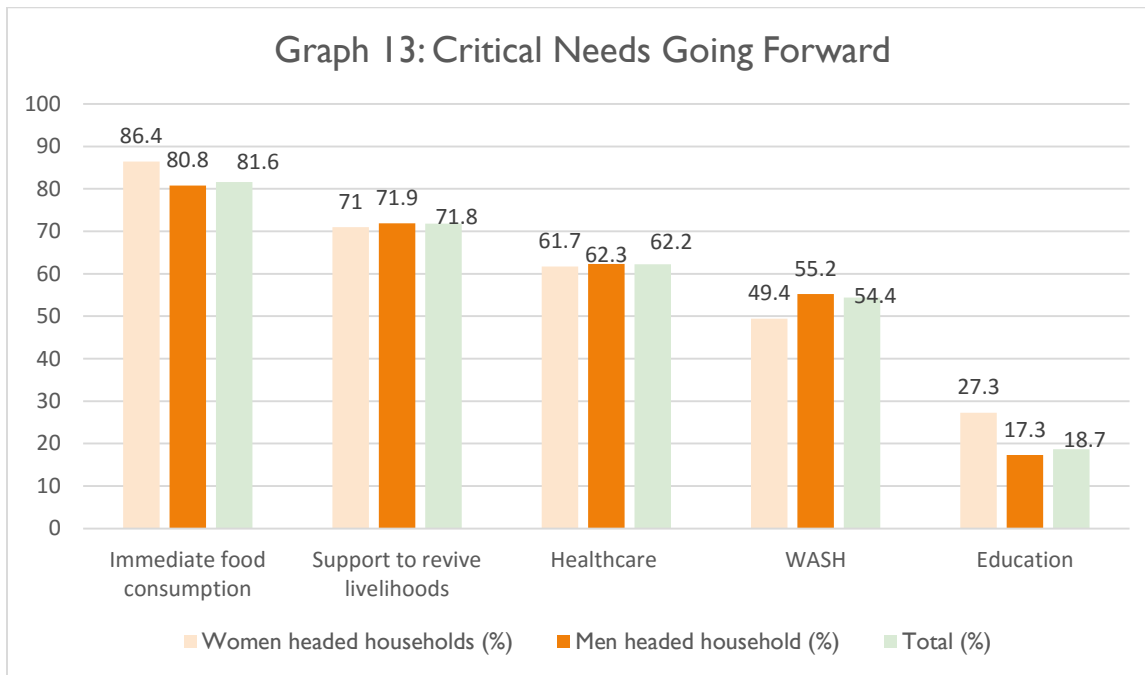
8: ACCESS TO INFORMATION

One of the objectives of the impact assessment was to determine preferred ways for households to access information on COVID-19 so that Nobo Jatra can adapt Social Behavior Change strategies based on this.



The overwhelming preference for information on COVID-19 is through community radio and local cable TV channels. This was followed by information from World Vision Bangladesh – as households were familiar with and trusted the organization to provide accurate and helpful information on COVID-19. Messages through mobile phones – text messages in particular were also popular as a source of information. 13.4% of respondents also said they found voice messages provided by Nobo Jatra useful (bearing in mind that only 44,600 participants receive this service).

9: UNMET NEEDS



The most immediate pressing need is for support with household food consumption – 81.6% of respondents identified this as a top priority. Reviving livelihoods was also a critical concern for 71.8% of households – who are anxious to recover from the prolonged disruption to or loss of incomes caused by COVID-19. It is worth noting that 49.1% of households prefer to receive cash transfers through e wallets linked to mobile phones and 33.9% prefer direct cash assistance.

9: CONCLUSION

Impact of COVID-19 on health, nutrition, food security and livelihoods of poor and extreme poor households

The resilience capacities of Nobo Jatra’s direct participant households are weakened from the impacts of COVID-19. Government lockdowns to prevent disease transmission have taken a heavy toll on local economies in southwest Bangladesh - directly affecting livelihoods and incomes which poses a severe risk to the purchasing power of households and their ability to buy food to survive. In addition to livelihoods, COVID-19 has affected households’ access to healthcare and health seeking behaviors, heightened food insecurity and reduced access to safe drinking water. Critically, Nobo Jatra’s direct participant households are struggling with the effects of COVID-19 **and** the damages caused by cyclone Amphan which is slowing down their abilities to recover. Negative coping mechanisms are being used by households such as **sending children out to work, marrying children off before the age of 18, taking loans at high interest rates and selling productive and household assets**. Both in the short and long term, these coping

mechanisms will exacerbate poverty, increase the risks of chronic malnutrition especially for pregnant and lactating women and children and Gender Based Violence – including child marriage.

Access to basic primary **healthcare** at community health structures such as community clinics, expanded programme for immunization sites and at Union Health and Family Welfare centers has decreased since the start of COVID-19 lockdown measures in March. Whilst Government health services were initially scaled back in March, the main deterrent for communities has been fear of exposure to COVID-19 at clinics and centers. **Reduced access to basic health care is one of the most critical secondary impacts of COVID-19 – and one that increases health and malnutrition risks for pregnant and lactating women and children under 2.** Household **food insecurity** is also compounded mainly due to lower household incomes, reduced availability of fresh and dry foods in markets resulting in households opting for cheaper, less nutritious food. This also has implications for health and nutrition for future generations.

Access to **drinking water** through community based water points has also decreased since the start of the COVID-19 lockdown in March 2020. Households have also reported that since COVID-19 it takes longer to collect water due to lengthy queues, limited transportation options and specific timings (as per local Government instructions) when people can leave their homes. There is also greater pressure on the limited number of water resources available due to reverse migration back to rural areas and also the damages to water points caused by cyclone Amphan.

The impact of COVID-19 on the **livelihoods and incomes** of rural poor households is critical. The majority, 91.8% of households, confirmed that incomes were reduced. Female headed households are most affected by loss of incomes given that in rural areas 93.3 % of women typically work in the informal sector¹⁶ which is hard hit by the COVID-19 pandemic. Reduced incomes are also affecting the health, safety and social wellbeing of families. Falling sick and being unable to afford treatment was cited by 36.2% of households as one of the main knock on effects of reduced incomes.

The findings of the impact assessment have provided rich information that will help Nobo Jatra **influence the design of new activities and service delivery models and to adapt existing activities to better meet the needs of affected households.** The findings of this Impact Assessment have informed the design activities in the submitted 12 months bridge phase cost extension. Recommendations are aligned to the key findings in the assessment:

- 1. Address immediate urgent needs and strengthen resilience capacities of the most vulnerable households**

Multi-Purpose Cash Grants targeted to the most vulnerable households, including those with pregnant and lactating women and children and extreme poor households, are

¹⁶ [Bangladesh Bureau of Statistics Labor Force Survey 2016-2017](#)

essential to meet immediate consumption and other critical household needs. Cash transfers will increase household purchasing power helping them to recover from reduced or total loss of livelihoods and incomes. Digital cash grants through e-wallets linked to mobile phones would work well within the COVID-19 context as this would reduce the need for gatherings at cash distribution sites.

Repair of community water points to enhance access to safe drinking water. This will also include supporting water management committees to repair and maintain water points, advocate for local budgets for water through the Union Parishad open budget process and motivate the Department of Public Health Engineering to provide technical services.

2. **Prioritize economic development, access to equitable financial services and market based approaches**

Accelerate income generating opportunities that reduce the risk transmission of the virus and are market driven even during the crisis. This could include supporting producers to transition into making cloth face masks through cost share mechanisms, incentivizing local entrepreneurs to sell drinking water at household level and scaling up health and nutrition business models through partnerships with private sector (for example, the pilot with Social Marketing Company and ACI Limited to have Gold Star Members sell health and hygiene products at village level).

Adapt and revive Village Savings Lending Associations to provide much needed access to financial services for the poor and extreme poor. As part of the adaptation and to better meet the needs of members, VSLA's can be supported to revise meeting procedures, scale up health and hygiene promotion, adopt digital mechanisms if feasible and revise lending procedures (accelerated lending cycles, waiving service charges). This will help households to access loans to revive or start new livelihoods and also meet other household needs such as food consumption, medical expenses, educational expenses or repair of homes damaged by cyclone Amphan, flooding and heavy rainfall.

Strengthen business management skills and market outreach skills of water management committees to increase water sales by tapping into local entrepreneurs who can deliver water to households and businesses and strengthen business management skills to withstand the crisis.

3. **Strengthen productive capacities of vulnerable households**

Increase production of saline tolerant, nutritious vegetables to support small holder farmers and improve household nutrition. Stimulate demand for small holder and homestead farmers through input vouchers to access saline tolerant, nutrient rich



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vegetable inputs. Promote regular availability of quality seeds through credit supply guarantees to seeds companies and market outreach campaigns with seed companies. Support farmers to organize practical demonstration and learning sessions on improved production and Climate Smart Agriculture technologies focusing on saline, drought and water merged areas. In partnership with the private sector, promote crops like orange flesh sweet potatoes to improve household nutrition.

4. Intensify and expand Social Behavior Change for nutrition, health, hygiene and Gender Based Violence

Expand Social Behavior Change to include awareness and messaging through local radio and cable TV networks as these are the preferred medium for 59.2% of households surveyed. Intensify messaging on health and hygiene including accessing primary health care for pregnant and lactating women and children, dispelling myths around COVID-19 transmission at health service delivery points and highlighting the risks of Gender Based Violence including where to report cases and Government referral systems. Target messaging to men, women, children, grandparents and partner with faith leaders to disseminate messages on disease prevention and to discourage child marriage and other forms of Gender Based Violence.

Capacity building on referral systems for Sexual and Gender Based Violence

The Sexual and Gender Based Violence (SGBV) referral system is weak in Nobo Jatra working areas, there are no specific services for SGBV at community clinics and Union Health and Family Welfare centers and health staff are not trained to respond to SGBV. Accessing the Government One Stop Crisis Cells (at district and sub district level) is a key challenge for women, adolescent girls and victims of SGBV in rural areas. Accessibility is now further compounded due to Government measures to control the spread of COVID-19 (restriction of movement, scaling back services). These measures are increasing risks of Sexual Gender Based Violence, including violence against women, girls and child marriage – which have been used as a negative coping mechanism as confirmed in the impact assessment. To address Sexual Gender Based Violence (SGBV) risks in the context of the pandemic, it is critical to ramp up messaging on SGBV in all Social Behavior Change, including public awareness announcements, posters, leaflets, billboards and via household counselling. It is also critical to train health staff (both male and female) in community clinics, Union Health and Family Welfare Centers and sub district health complexes on how to respond to SGBV including training in psycho-social support and the confidentiality, respect, safety, referral and the non-discrimination of victims.'