Community Nutrition and Health Activity

Equity Gap Analysis

COOPERATIVE AGREEMENT: 72038823CA00003

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Garo woman with child, Tahirpur Upazila, Sunamganj District. All photos taken with consent and permission.

Table of Contents

Acronyms

AOR	Agreement Officer's Representative
BDHS	Bangladesh Demographic and Health Survey
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CG	Community Group
CHCP	Community Health Care Provider
CNHA	Community Nutrition and Health Activity
CSBA	Community Skilled Birth Attendant
CSG	Community Support Group
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DNCC	District Nutrition Coordination Committee
ENA	Essential Nutrition Actions
FP	Family Planning
FLHW	Front Line Health Worker (CHCP, FWA, HA)
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HH	Household
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
KII	Key Informant Interview
LP	Local Partner
MCHN	Maternal and Child Health and Nutrition
MICS	Multiple Indicator Cluster Survey
MEL	Monitoring, Evaluation, and Learning
MTP	Medically Trained Provider
NGO	Non-Governmental Organization
PLW	Pregnant and Lactating Women
PwD	Persons with Disability
SAA	Social Analysis and Action
SBC	Social and Behavior Change
SOP	Standard Operating Procedure
UDCC	Union Development Coordination Committee
UHFWC	Union Health and Family Welfare Center
UNCC	Upazila Nutrition Coordination Committee
UP	Union Parishad
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene

Executive Summary

The CNHA (Community Nutrition and Health Activity) equity gap analysis sought to understand existing inequities in health and nutrition outcomes in its target geographies, discover any additional ones, and to explore the reasons. Results are being used to tailor project activities to increase equitable, effective service coverage and quality as well as engagement of marginalized groups and to work with the Government of Bangladesh (GoB) to improve and implement policies and practices to increase equity in all areas of the country.

Following the six (6) simple steps outlined in USAID's Unofficial Guidance to an Equity Gap Analysis[1], the CNHA team identified the results to achieve (Step 1), identified differential health and nutrition outcomes among population groups using available secondary data (Step 2), and identified reasons for those differential results using available data. To further explore reasons contributing to differential results and to inform intervention adaptation (Step 3), CNHA conducted stakeholder consultations among relevant marginalized groups. Following these stakeholder consultations, CNHA convened staff and partners in a workshop to review the findings of both the secondary data and the stakeholder consultations to tailor interventions to address equity gaps (Step 4). Over two days, workshop participants discussed implications of the findings and generated suggestions on how to apply the findings to existing activities to improve equity across the population in target geographies as well as identify how to monitor progress (Step 5) and adaptively manage project activities (Step 6).

Consortium research partner International Centre for Diarrhoeal Disease Research, Bangladesh (iccdr,b) analyzed available secondary data from surveys including the Bangladesh Multiple Indicator Cluster Survey (MICS). MICS data on wasting among children under 5 years of age and seeking at least one antenatal care (ANC) from a medically trained provider (MTP) show that the two lowest wealth quintiles are most likely to be facing inequity in health outcomes and access to health care. Because of sample sizes, MICS does not disaggregate by ethnicity although the data is collected, however, many of the marginalized groups are in the lowest wealth quintiles. All indicators analyzed identify persons with disabilities (PwD) as excluded.

Building on this secondary data, the Cooperative for Relief and Assistance Everywhere (CARE) conducted stakeholder consultations to understand reasons contributing to inequity in coverage of services offered at community clinics (CC). CARE conducted 33 focus group discussions and 12 key informant interviews, revealing lack of respectful care by community health care providers (CHCP) towards minority groups, and lack of confidence in CHCP skills. The consultations suggest that restrictions on women's mobility, men's dominance in decision-making affecting health and nutrition, and unequal food distribution may affect health and nutrition outcomes. The consultations show little participation of minority or ultra-poor Muslim groups in government safety net programs due to lack of knowledge of eligibility and perception of bribes required. A positive finding is the high level of participation in savings groups, which contributes to resilience.

[1] USAID Bangladesh Office of Population, Health, and Nutrition. Unofficial Guide to an Equity Gap Analysis

In line with findings from the equity gap analysis, CNHA will strengthen the health system by adapting existing government training modules and enhancing mentoring and supervision to build capacity of front-line health workers (CHCP, FWA, HA) to provide respectful, dignified, and person-centered care that is responsive to the needs of various populations. Recognizing the vital role of Community Group (CG) and the Community Support Group (CSG) in Community Clinic administration and health outreach, CNHA will support these groups in community engagement and outreach efforts to increase equity. CNHA will also explore modalities to address social norms through existing systems that affect key drivers of inequity related to health and nutrition outcomes.

Background of CNHA

The USAID Community Nutrition and Health Activity (CNHA) seeks to improve the nutritional status of women and children in 1000-day households i.e. those with pregnant and lactating women (PLW), and/or children under two years of age. CNHA will strengthen delivery of health and nutrition services at the community level and identify and focus on households at risk for malnutrition—households vulnerable due to issues of ethnicity, religion, social status, extreme poverty, disability, frequent dislocation, and climate change.

CNHA has selected 14 target districts from Haor, Coastal, Northwest (Char), and USAID's Zone of Influence (ZoI) regions based on low performance on health and nutrition indicators, vulnerability to climate change, and other key factors (Table 1 below). (USAID's Zone of Influence in Bangladesh comprises districts in the southwest part of the country shown to have high poverty, malnutrition, and stunting among children under five years of age.[2]) In addition, the Activity will implement interventions and actions with potential impact at the national level, including close collaboration with Bangladesh National Nutrition Council (BNNC) and strengthening coordination between the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP).

Table 1. Geographies in Bangladesh covered by CNHA

Cluster	Districts included in CNHA (total of 14)	Key Reasons For Selection
Coastal	Barguna Patuakhali Bhola	• Very low performance on nutrition, health outcome, gender, and poverty indicators; • Opportunities for complementarity and integration with USAID ZoI activities; • Presence of ethnic minority communities • Most vulnerable to nutrition shocks due to climate change including displacement, frequent cyclones/tidal surge, high salinity.
Haor	Netrokona Habiganj Sunamganj Kishoreganj	• Very low performance on nutrition, health outcome, gender, and poverty indicators • Complementarity and integration opportunity with USAID (SHOUHARDO) activities • Critically vulnerable to nutrition shocks due to frequent floods.
North-West (char)	Kurigram Gaibandha Rangpur Joypurhat	• Low performance on nutrition, health outcome, gender, and poverty indicators • High prevalence of early marriage • Complementarity, and integration opportunity with EU multisectoral collaboration and SHOUHARDO • Ethnic minority concentration • Critically vulnerable to nutrition shocks due to frequent river erosion and displacement.

[2] USAID Agriculture and Food Security. https://www.usaid.gov/bangladesh/agriculture-and-food-security

Zone of Influence	Shariatpur Faridpur Madaripur	• Moderately low performance on some nutrition, health, outcome, gender, and poverty indicators • Opportunity for complementarity and better integration with other USAID activities (Feed the Future) • Geographically vulnerable areas with high river erosion.

Activity goal and objectives

The overall goal of CNHA is to sustainably impact the nutrition and health outcomes of women and children in their first 1,000 days. The activity will strive to achieve its goal by contributing to the following result areas:

Result 1: Strengthened community health systems to deliver nutrition, family planning, and health services.

Result 2: Improved household (HH) nutrition and health behaviors.

Result 3: Enhanced leadership and governance for improved nutrition.

Result 4: Resilience of communities and households to potential nutrition shocks increased.

Purpose, Approach, and Questions in the Equity Gap Analysis

Inclusive Development is an equitable development approach built on the understanding that every person, of all diverse identities and experiences, is instrumental in the transformation of their own societies.[3] Inclusive Development Analysis is an analytic tool that helps to map the context in which marginalized people exist. The analysis suggests 1) identifying, understanding, and explaining gaps that exist between persons or certain population groups and the general population and to consider different impacts of policies and programs; 2) identifying structural barriers and processes that exclude certain people from fully participating in society; 3) examining differences in access to assets, resources, opportunities, and services; and 4) lead to specific recommendations on how to include population groups left behind in activities and design the activities to close equity gaps.[5] In other words, inclusive development analysis is an equity gap analysis.

CNHA's equity approach is responsive to excluded groups and will ensure health systems approaches and activity interventions target, reach and benefit marginalized communities and the ultra-poor[4]. The results of the equity gap analysis help CNHA develop customized strategies to develop interventions and action plans for PLW, adolescent mothers and marginalized populations including ethnic and

[3] USAID DCHA/DRG/HR. 2018. Suggested Approaches for Integrating Inclusive Development Across the Program Cycle and in Mission Operations: Additional Help for ADS 201. USAID Learning Lab. https://usaidlearninglab.org/sites/default/files/resource/files/additional_help_for_ads_201_inclusive_development_180726_final_r.pdf

[4] Ministry of Health and Long-Term Care, Ontario. 2018. Health Equity Guideline, 2018. https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Health_Equity_Guideline_2018_en.pdf

religious minorities, women with disability and third gender persons[5] in alignment with USAID's vision and guidance for equity and inclusion[6] and CARE's Good Practices Framework[7] on Gender Analysis.

The results of the analysis serve to strengthen the integration of equity measures throughout the related health and nutrition services, selecting advocacy agenda to adopt equity measures within the existing health system (upstream, midstream, and downstream) and adoption of behaviors and empowering marginalized communities to break cultural and structural barriers that limit their participation and advancement in accessing public services and resources. The equity gap analysis is being used by project staff to refine and adapt program activities considering target groups and marginalized communities; to share key information, needs and gaps in CNHA target areas with government stakeholders; to inform target communities of key findings and to promote equitable participation; and to inform the program's learning agenda.

The key objectives of the equity gap analysis were to:

- Identify equity gaps, both in access to quality health services and nutrition and health outcomes using high quality data and assessment tools,
- Identify system gaps, bottlenecks, and root causes that contribute to health and nutrition disparities among different population groups,
- Identify specific opportunities, enabling factors, and best practices to address equity gaps at the local level through health systems strengthening and community engagement.

The overall questions posed to be answered by the equity gap analysis were:

1. Among CNHA's target populations, are certain groups facing poorer health or nutrition outcomes or being excluded from nutrition, MNCH, FP, or hygiene/WASH services?

2. Are there equity gaps for nutrition, MNCH, FP, and hygiene/WASH outcomes?

3. If there are equity gaps, why are these groups facing poorer health / nutrition outcomes or being excluded from services and what barriers are they facing?

4. How can these equity gaps and barriers be addressed through interventions?

The final outputs from the equity gap analysis helped CNHA to develop programmatic considerations that:

a) identify existing equity gaps, and contextual opportunities relevant to activity objectives/impacts

b) include specific interventions to close those equity gaps,

c) monitor equity gaps, and the impact of interventions on a continuous basis, and

[5] The term third gender is legally recognized in Bangladesh as intersex people (informally known as hijras). However, the term third gender has also been used as an umbrella term for people designated as male at birth with feminine gender identity. We use the term third gender and included intersex hijra and transgender persons (people born male who later identify as female) aligned with CNHA's target group of women.
[6] https://www.usaid.gov/inclusion-and-equity
[7] CARE International Gender Network. 2012. Good Practices Framework: Gender Analysis. https://genderinpractice.care.org/wp-content/uploads/2019/12/GEWV_gender-analysis-good-practices_2012.pdf

d) be flexible and adaptive to challenges and performance.

Methodology

Since national surveys indicate inequity in health and nutrition outcomes and utilization of health services, the CNHA equity gap analysis sought to validate whether similar inequities exist in the proposed
target areas, discover any additional ones, and to explore the root causes. Results are being used for tailoring project activities to sustainably ensure service coverage and engagement of marginalized populations.

CNHA used the following steps from USAID guidance to conduct the equity gap analysis:

1. Identify the equitable results we want to achieve

2. Identify differential results among population groups

3. Identify the reasons/root causes of those differential results

4. Tailor interventions to address equity gaps

5. Monitor progress

6. Adaptively manage

I. Identify the equity results we want to achieve by Activity Result

A CNHA equity committee discussed each of the Activity Results in relation to equity. This led to formulation of equity objectives or outcomes being articulated for each Result. The complete list is found in Annex A. These equity outcomes serve to guide plans for the analysis and the resulting action plan to enhance planned activities to better ensure equity.

2. Identify differential results among population groups

The Bangladesh Demographic and Health Survey (BDHS) and Multiple Indicator Cluster Survey (MICS) have consistently identified inequity in health and nutrition outcomes. Other national studies[8] have revealed inequity in health and nutrition service delivery in several ways affecting different groups. Some major papers have used causal analysis to assess the association of inequity in health and nutrition with policy, geographic access, ethnicity, poverty, and other factors[9,10,11,12]. To determine whether inequities exist in the CNHA target areas, icddr,b as part of the CNHA team reviewed secondary quantitative data that was disaggregated by wealth quintile, geographic location, gender, maternal characteristics, religions,

[8] https://www.researchgate.net/publication/378527552_Health_Equity_in_Bangladesh_A_Comparative_Review_and_Recommendations_for_Policy_and_Practice

[9] Khanam, M., Hasan, E. Inequalities in health care utilization for common illnesses among under five children in Bangladesh. *BMC Pediatr* **20**, 192 (2020). https://doi.org/10.1186/s12887-020-02109-6.

[10] Mahabub-Ul-Anwar M, Rob U, Talukder MN. Inequalities in maternal health care utilization in rural Bangladesh. Int Q Community Health Educ. 2006-2007;27(4):281-97. doi: 10.2190/IQ.27.4.b. PMID: 18573752.

[11] Hasan MM, Uddin J, Pulok MH, Zaman N, Hajizadeh M. Socioeconomic Inequalities in Child Malnutrition in Bangladesh: Do They Differ by Region? Int J Environ Res Public Health. 2020 Feb 8;17(3):1079. doi: 10.3390/ijerph17031079. PMID: 32046277; PMCID: PMC7037734.

[12] Kundu, S., Das, P., Rahman, M.A. et al. Socio-economic inequalities in minimum dietary diversity among Bangladeshi children aged 6–23 months: a decomposition analysis. Sci Rep 12, 21712 (2022). https://doi.org/10.1038/s41598-022-26305-9.

and disability. Ultimately, the data from the most recent MICS in 2019 was the most sufficiently disaggregated for further analysis related to four key indicators: wasting in children under five, exclusive breastfeeding, at least one antenatal care visit, and use of a modern family planning method.

3. Identify the reasons/root causes of those differential results

To validate the equity disparities found in the analysis of the MICS 2019 data in the target areas and to further understand root causes related to the inequities, CNHA conducted stakeholder consultations in different geographical zones of the target areas. The focus groups included young mothers, mothers-in-law, and husbands separately and were inclusive of the ultra-poor in different subgroups in the target areas. The key informant interviews were conducted with a range of government health personnel, third gender and disabled persons. Government health officials were interviewed for their perspective on health and nutrition inequity and provided recommendations for addressing the gaps.

4. Tailor interventions to address equity gaps

Key CNHA staff participated in a two-day workshop to review the findings of both the secondary data and the stakeholder consultations. Working groups then used the findings to tailor the CNHA activities for each Result to increase equity through health systems strengthening and community participation.

5 and 6. Monitor Results and Adaptively Manage

The same working groups that tailored the interventions proposed indicators which were then synthesized into two measurable indicators for monitoring results through the annual surveys. Subsequent discussion led to the Adaptive Management Plan which will be continually updated based on contextual lessons learnt and project activities.

Findings and Recommendations from Equity Gap Analysis

Secondary data results

To identify inequity in health and nutrition, CNHA looked at data from the MICSs, doing additional analysis to disaggregate data by the CNHA operating areas. Data came from these key indicators:

1. Use of a modern method of family planning
2. Women having at least one ANC visit during the most recent pregnancy
3. Wasting among children under five years
4. Children under six months receiving exclusive breastfeeding

For comparative analysis, Survey data was disaggregated by wealth index, sex, place of residence, religion, disability, and age of the mother. Data from the MICS 2012 was compared with data from the more recent MICS 2019, and while some equity gaps narrowed, overall, the gaps remained for all groups. In addition, we further analyzed MICS 2019 data for performance on these key four indicators for the particular geographies of CNHA (haor, coastal, northwest, and zone of influence clusters detailed in Annex F) by wealth index, religion, disability, and education.

Use of Modern Contraception

Since use of modern contraception was found by MICS 2019 to be inversely associated with wealth quintile, the characteristics that show inequity are religion, area of residence, disability, and age of woman.

Non-Muslim women are more likely to use modern contraception. Women with disabilities are much less likely to be using a modern contraceptive. Adolescents are more likely to be using contraception. The disaggregated differences are shown in Tables 2-3 in Annex B. Among mothers with disabilities, only 47.7% reported using modern contraceptives, significantly lower than the 59.5% reported by mothers without disabilities. Educational attainment also plays a role, with those with higher secondary education and above showing lower usage (53.7%) compared to those with primary education (61.3%). The wealthiest quintiles consistently showed lower contraceptive use compared to poorer quintiles; for instance, the poorest quintile reported 63.1% usage, while the richest quintile reported 53.9% (Table 3).

At Least One ANC Visit with Medically Trained Provider during the Most Recent Pregnancy

The data show the biggest disparities in this indicator are by wealth index and geography. Women in the highest wealth quintile are almost twice as likely to have one ANC visit compared to those in the lowest wealth quintile (Table 4 in Annex B). Within CHNA's working areas, the coastal cluster reports lower wealth inequity in ANC coverage (61.8% coverage among poorest compared to 92.4 richest quintile) whereas the gap in ANC coverage by wealth quintile in other clusters ranges from 43.3% to 94% (Table 5 in Annex B). In the Northwest cluster, Non-Muslim women report much lower ANC coverage (40.9% compared to the 66.4% among Muslim women) while Muslim women report lower ANC coverage at 64.3% compared to non-Muslim women at 85.9% in the Zone of influence cluster (Table 5). Educational attainment also influenced coverage, with those having higher secondary education and above showing the highest coverage (87.7% to 92.9%), while those with pre-primary or no education had the lowest (31.8% to 46.5%) (Table 5).

Children under Six Months Receiving Exclusive Breastfeeding

In looking at the practice of exclusive breastfeeding, disparities are found in religion, area of residence, disability, and age of mother. Non-Muslims are shown to be more likely to practice exclusive breastfeeding, but the sample size is small as is the sample of mothers in the Hilly Lands. Children with disabilities are much less likely to be exclusively breastfed. Adolescent mothers are less likely to breastfeed. See Table 6 in Annex B.

Analysis by sex of the child showed boys ranging from 51.3% in the Zone of Influence (ZoI) to 79.5% in the Northwest, while girls ranged from 63.8% in ZoI to 71.8% in the Northwest. Wealth disparities were evident, with the poorest households exhibiting rates from 56.4% in Haor to 73.7% in the Northwest, contrasting sharply with the richest households at 45.0% in ZoI to 79.6% in the Northwest (Table 7) Differences were also notable by religion, mother's disability status, maternal age, and education level, emphasizing the complex interplay of factors influencing exclusive breastfeeding practices across regions surveyed.

Wasting among Children under Five Years

The data on wasting clearly revealed inequities as shown in Table 8 in Annex B. There is a significant difference by child's sex (10.44% among boys versus 9.17% among girls), but the higher prevalence among boys regardless of other characteristics is commonly found in many countries, so is not particular to Bangladesh.

The largest inequity in wasting is found between the two lowest wealth quintiles (11.8% in lowest and 11.5% in lower) and the other wealth quintiles (9.3% among middle, 8.5% among higher, 8.0% among highest). There is also significantly more wasting among those with disabilities (13.7%) compared to those without disability (9.8%). It is notable that there is less wasting among children of adolescent mothers than children of non-adolescents. The difference by area of residence and religion were not significant.

Table 9 in Annex B shows a further analysis of 2019 data on wasting. Compared to the national average wasting rate of 9.8% in the 2019 MICS, CNHA's Northwest region had the highest prevalence of wasting for both boys (10.8%) and girls (10.7%). Children from the poorest households had the highest wasting prevalence (11.8%), with rates decreasing as wealth increased: poor (11.5%), middle (9.3%), richer (8.5%), and richest (8.0%). Children born to mothers with disabilities had a higher prevalence (13.7%) compared to their counterpart (9.8%). Mothers' educational attainment inversely related to wasting rates: pre-primary or none (12.6%), primary (11.1%), secondary (9.5%), and higher secondary or above (7.0%).

Conclusions of secondary analysis

The secondary data on wasting is the most revealing on inequity and, perhaps, the most useful because it measures a discrete nutrition outcome rather than a practice. Practices such as seeking ANC from MTPs and use of modern contraceptives may measure access, but other factors are involved such as beliefs, mobility, knowledge, and motivation. For wasting, the two lowest wealth quintiles, are those most affected indicating inequity. Because of sample sizes, MICS does not disaggregate by ethnicity although the data is collected.

The major difference in seeking ANC by wealth quintile also points to the inequity facing the ultra-poor women. All four indicators (wasting, ANC by MTP, exclusive breastfeeding, and modern contraception) identify PwD as experiencing worse outcomes. The adolescent mothers are not as disadvantaged as

might be expected, outperforming older mothers in use of modern contraception, and having fewer wasted children.

Findings from stakeholder consultations

CNHA conducted 33 focus group discussions and 12 key informant interviews in the 3 clusters (haor, coastal, zone of influence) shown to have the highest equity gaps based on secondary analysis. Annex C contains additional details on respondents included in consultations.

Manta family, Patuakhali Cluster. All photos taken with consent and permission.

Analysis

For purposes of analysis 33 consultations, 12 KIIs, 2 stories collected from the sub-districts in each cluster were combined since the data was identifiable by group and, thus, did not also need to be analyzed by sub-district. This made it possible to analyze the findings by each of the three clusters or by comparing groups and geographic areas when important. Key results are presented below by each of the three domains described in the methodology section.

After the initial visual review and compilation of the data, analysis was conducted using NVIVO software which identified key themes across the data. The analysis included differentiation by cluster, geographic area, and groups. Data was grouped by pre-determined domains related to CNHA results.

Limitations

It was feasible to identify only a very limited number of disabled women or third gender people within the CNHA target population of pregnant and lactating women and women with children under two years. In the cases of people living with disabilities, it was evident they lack health care, but this is due to decisions by family members. Neither group was asked questions about Domains 2 or 3.

Discussion of Findings

The findings are presented organized by the three domains. At the end of each domain, there is a summary in bold of the key findings for that domain.

Domain 1: Accessing CC or UHFWC services (CNHA Result 1)

In general, women and men of the minority groups seem less aware of the services available at the Community Clinics (CC) than the ultra-poor Muslims.

Men knew much less about CCs, and few reported using the services. They say the hours are not convenient because they are working during that time and some who had gone were not comfortable with a female CHCP. The Manta, who spend all day working out on the rivers, are unable to access services due to the limited hours of CC operation.

Few minority women groups interviewed in the hills of Netrokona had ever availed of CC services. The barriers they mentioned included poor roads for travel, especially bumpy for pregnant women, a lack of

confidence in the skills of the CHCPs, and the presence of male CHCPs in about half of the CCs in Kishoreganj Cluster. Respondents mentioned that at CCs they were mostly attended by male CHCPs rather than HAs/FWAs.

Men's group, Madaripur Cluster. All photos taken with consent and permission.

A few respondents across clusters mentioned that they must bear the costs of purchasing medicines from outside CCs as CCs are routinely stocked out of needed medicines.

Muslim women in the Haor area said they find the limited hours of the CC a barrier, and the presence of male CHCPs. They mentioned the lack of time CHCPs must provide counseling, and some thought CCs do not provide services to women who are not pregnant. They said that they are sometimes treated poorly by the CHCPs. The Muslim women in this group were the only women in the study who said they need permission from the husband or mother-in-law to seek health care.

Mothers-in-law in the Haors mentioned that during the rainy season, mud and flooding make travel to the CC or any health facility nearly impossible. Women in the coastal area and the lower caste of Hindus (Namasudra) in the Char also mentioned distance as a barrier to accessing services.

Low-caste Hindu (Namasudra) women, Madaripur Cluster. All photos taken with consent and permission.

The Rakhine respondents included under the coastal Patuakhali cluster reported they face stigma from the community and the health workers, which prevents them from utilizing the CC or UHFWC . This manifests in the conduct of CHCPs towards them, being made to wait longer, and being called names or spoken to harshly. Some Bengali Muslim women and women from the fishing community in the Chars also mentioned lack of respect from the CHCPs. Core team members interviewed concurred that CHCPs need more training in respectful care and interacting with women from different ethnic and social backgrounds.

Out of four married adolescent girls consulted, two reported to know they can get contraception from the CHCP or FWV. The other two married adolescent girls interviewed seemed to know nothing about contraception.

The six third gender persons interviewed in Kishoreganj and Patuakhali had faced very poor conduct by government and non-government health workers when they sought treatment at upazila or district level. They go to private doctors and are charged more because they are perceived to be rich. The four interviewed in the coastal area reported these same issues.

Among participants in all groups in all clusters, the preferred option of health care is to go to village doctors, homeopaths or quacks. The village doctors charge far more than the but are always readily available and listen to the patients. The village doctors dispense any needed medicine, providing advice for free. While CC services are free, some respondents mentioned that CHCPs asked them for 5 to 10 Taka contribution for CC.

According to the groups in the different areas, the government policy of providing a partial dose of medicines at the CC with the patient instructed to purchase the rest outside is a strong deterrent to utilization of the CCs. People interviewed feel they should be given the full course because it is inconvenient (time, distance) to go find the rest.

Across all groups of women interviewed in all regions there is a strong preference for home deliveries with a local traditional birth attendant. The women said birthing is a private matter, they are more comfortable at home, and often mentioned they are supported at home by their mother or other family member. Some women in all clusters mentioned that the CCs don't have appropriate conditions for deliveries including lacking running water or any water. However, women in all regions said they do go to the UHFWC or a government hospital in the case of delivery complications. A few seek upazila health complexes and private clinics in this case.

In summary, the inequities in service coverage by CCs were reported due to the following:

- **Lack of knowledge in the communities of services offered, financial contribution to maintain structure, hours of operation.**
- **Lack of respectful care by CHCPs, particularly towards ethnic and religious minorities and the low socio-economic groups and third gender persons.**
- **In some regions, geographical barriers of distance, poor roads and floods were mentioned by ethnic and religious minorities.**
- **Other factors mentioned, such as lack of confidence in CHCP skills, poor conditions at CCs, preference for CHCPs of the person's own gender, and preference for traditional providers were not different between the poor of the ethnic and religious minority groups and the poor Muslims.**

Domain 2: Household decision-making, women's mobility, women's leadership, social norms

There is variation between minority groups and between those groups and the Muslims in relation to household decision-making and males engaging in housework. The Christian groups and Hajong in the north reported more involvement of women in making routine financial decisions and in women's autonomy to go to the market or take a child for health care. Women do consult the men before

making purchases. In the study areas the women from Garo community mostly stayed at home and men are the main income earner for the family and major decision makers. The Rakhine women in the coastal area also have more autonomy in going places and making purchases. In one Muslim group, the women said they could decide to take a child for care but go in the company of another female family member or neighbor. In the Muslim men's group in another region, the men reported making all decisions.

While none of the women were asked if they control money of their own, it emerged in questions about participation in other platforms, that a very large majority across all districts participate in savings groups. This would indicate that they have control over some money to make their regular savings payments.

The Rakhine are the most egalitarian with men and women sharing both household and non-household work. Most Muslims and Hindus said men should never engage in household work, that it is only for women. The lower-caste Hindu (Namasudra) men said they provide some help in the household, but they get teased by their peers. In the Hajong group, men also do some work in the household. Some Muslim women in the Haor and Coastal clusters reported their husbands will help with heavy lifting or fetching water when the woman is pregnant.

Both men and women across all clusters feel that using a family planning method is the responsibility of the women. Men help by purchasing contraception in the market. None of the groups expressed rejection of using family planning, however Muslims expressed concern that using FP before having the first child might make a young woman infertile.

In the groups that were questioned, food distribution follows the traditional pattern of men being served first as well as the largest portion, and sometimes, the highest quality food. The different cultures justify this because the men must do the heavy labor, reinforcing the belief that their energy requirements are higher. Women hold most tightly to this tradition saying they do it out of respect or love. A recently published study shows that, even with this supposed unequal distribution, for the general Bangladeshi population women and men are eating proportional to their energy requirements and both men's and women's diets in rural Bangladesh are sub-optimal in terms of nutrients[13].

Among those interviewed there was little or no understanding of the additional nutrient needs of pregnant women who often get the smallest portion. However, the Rakhine, Garo women reported that pregnant women are sometimes given more or special food, including occasional fruit or fish. Muslim women report receiving special food when they visit their parental house.

In summary, there were few findings in this domain contributing to inequity in health outcomes:

- **Women's mobility requiring permission from their husband is prevalent among the ultra-poor Muslims.**

[13]Coleman FM, Ahmed AU, Quisumbing AR, Roy S, Hoddinott J. Diets of Men and Women in Rural Bangladesh Are Equitable but Suboptimal. Curr Dev Nutr. 2023 Jun 2;7(7):100107. doi: 10.1016/j.cdnut.2023.100107. Erratum in: Curr Dev Nutr. 2023 Aug 31;7(9):101993. PMID: j7396059; PMCID: PMC10310464.

- **Across all groups, men are responsible for decisions about major purchases, but in some minority groups women can make decisions about food purchases, taking children for health care, and more.**
- **Unequal food distribution in the household is common across ethnic groups and is tied strongly to the belief that men need more energy because they do heavy work. There is a lack of knowledge of increased energy needs of pregnant and lactating women.**

Domain 3: Participation in social safety nets and platforms (linked to Results 3 and 4)

In general, few people in the entire study had adequate awareness of available safety net programs. In both Muslim communities and among the Rakhine, some households are receiving various benefits such as old age pension, widows, or disability allowance. Women in different regions who have some knowledge of certain programs said they would have to bribe officials to receive the benefits. Some of the Rakhine receive benefits from the Vulnerable Group Development Fund and some Muslim men received Trading Corporation of Bangladesh cards from Union Parishad. They did not mention about Dustho Bhata. The Manta and fisheries groups reported receiving an allocation of rice during the off-season of fishing which is insufficient to meet their family needs. None of the women reported receiving the pregnancy allowance.

In contrast, literally everyone is part of a community savings group or engaged with a large micro-finance group such as BRAC or Grameen. They reported resorting to these savings or to a loan to pay large medical expenses or deal with some health or nutrition shock. This seems to be a predominant strategy for resilience. In the case of a health shock, some others report taking loans from other family members or selling cattle or assets.

Participation in community groups is very limited. Most of those interviewed had little or no knowledge of the groups related to the CCs. Some said the CSG is not functional. Since Muslim women cannot leave the house without permission, they feel they cannot participate in such committees , they are not aware about the benefits of participating in different committees like CSGs. The members of Core Team and CSG who were interviewed said it would require major awareness raising among the ethnic and religious minorities groups to get them to participate and that quotas may need to be set for their participation.

In summary, there is little participation of minority or ultra-poor Muslim groups in government safety net programs due to lack of knowledge of eligibility and perception of bribes required. Neither do these groups participate in CC-related platforms, again due to lack of knowledge but also lack of interest. An important positive finding is the high level of participation in savings groups, which contributes to resilience.

Tailoring CNHA Interventions to address Equity Gaps and Findings

Health Systems Strengthening

Manta woman, Patuakhali cluster, Galachipa upazila. All photos taken with consent and permission.

The USAID MOMENTUM Project has found that the most effective means of increasing equity through health systems strengthening is building capacity of front-line health workers (CHCP, FWA, HA) to provide respectful, dignified, and person-centered care that is responsive to the needs of various populations[14]. In collaboration with government counterparts, CNHA will adapt existing government training modules to include this level of care.

1. Sensitize Core Team members (management committees comprised of local government first- and second-line supervisors of frontline health workers providing supportive supervision, mentoring, and coordination support at district and sub-district levels) on respectful care, equity understanding based on EGA and cultural understanding so that they may impart these concepts to front-line health workers through training, mentoring, and supportive supervision.

2. Integrate the concepts of respectful care into nutrition and other thematic training modules building on existing respectful care content from maternal health modules e.g. the Shukhi Dampati Apps and e-learning module on FP methods include contents on respectful care. Include attention to provider bias that may exist against poor and ultra-poor groups, ethnic and religious minorities, people with disabilities, and third gender people into the overall training of frontline workers.

3. Ensure service quality through supportive supervision by the Core Team with special attention to attitudes and behavior of health workers towards ethnic minority and ultra-poor groups.

4. Introduce the Community Scorecard (CSC) for monitoring accountability between CC and CG or CSG, including representatives of ultra-poor communities, ethnic and religious minorities, people with disabilities, and third gender people in the CSC activity. This includes communication and understanding of service hours between community and CHCP, with hours publicized and posted and discussion of solutions to concerns such as absenteeism, infrastructure limitations, drug shortages, etc.

Improving access to and conditions at Community Clinics

5. Ensure health services for Manta and other floating communities by nearest CC at specific hours/days as they are completely excluded from the CC and UHFWC services.

[14] https://usaidmomentum.org/what-we-do/increasing-access-and-equity/

6. Link CSGs, CGs, and core teams with Upazila and Union government committees to advocate for infrastructure improvements including roads. Link CC and CSG with local disaster committees to solve transport of patients and/or CC staff in times of flooding.

7. Support Core Teams and CGs to advocate with the union parishad government that each CC has running water supply and sanitary latrines.

8. Advocate with core teams and national government stakeholders to recruit female CHCP where there are vacancies and arrange specific days when female CHCPs are available for ANC and other services for women. For geographies with FWAs positions filled, advocate for additional days/time for FWAs (all female), particularly in CC with no female CHCPs.

9. Promote regular visits by FWAs to pregnant and lactating women and families from ethnic minority and ultra-poor communities, those with disabilities, and third gender communities.

Community Level Engagement

Administration of Community Clinics (CCs) and awareness raising and referral for nutrition and health are the responsibility of the CG and the CSG, respectively. The government has delineated their roles and responsibilities; therefore, community engagement is vital for these groups to support quality health and nutrition service delivery with equity.

Revitalization of the CGs and CSGs to promote CCs

1. Include ethnic and non-Muslim ultra-poor women during reformation of CG, CSG and advocate government to set their inclusion as a selection criterion of CG, and CSG membership (in communities with substantial populations of ethnic and religious minorities).

2. During training of the CSGs and CGs, include a complete explanation of services, charges, hours and policies to enable members to explain these well to the population of the service area.

3. An official function of the CSGs is to promote utilization of the CCs. Emphasize this role during orientation and strategize with them how they can reach each household, including male members, with information on CC services. In areas with significant ultra-poor groups, CSGs may utilize annual campaigns to promote CC services.

4. Family welfare assistants will promote CC services and explain policies during courtyard sessions; whereas health assistants will integrate CC information into the Expanded Programme on Immunization site sessions.

5. Include ethnic or religious minorities in the CG and CSG with this specified in the CC Standard Operating Plan. Representation should be proportional to the census of groups in the service area.

Addressing social norms that hinder equity

6. Plan an SBC focus on reaching men to increase their understanding of the health, nutrition, and family planning needs of their wives, adolescent girls, and children (including postpartum family planning, long-acting and permanent methods where appropriate). Digital methods may be useful for individual contact.

CNHA will explore supporting FWAs to conduct interactive courtyard sessions designed for men only to enable them to ask questions and feel support from peers .

7. Engagement of men in discussion of family planning and use of contraception.

8. Engage religious leaders to promote care-seeking behaviors and joint decision-making in households.

9. CSG members and Health Assistant (HA) or Family Welfare Assistant (FWA)-led courtyard or other sessions will include mothers-in-law and other household decision-makers to learn about nutrition and health care needs of different family members.

10. Introduce Social Analysis and Action (SAA)[15] by training selected CSG members to facilitate in their communities. Include community reflection and analysis on the following topics: a) stigma towards ethnic, religious, or social minorities, b) Muslim women's need for permission to leave home or decide on her and her child's health care, c) intra-household food distribution relevant to needs of pregnant and lactating women and giving males preference for quality and quantity of food. Integrate plan for risk mitigation and prevention of gender-based violence (GBV) when addressing these social norm changes.

11. Part of SAA's approach is internal staff reflection on challenging gender and social norms. CNHA can integrate regular reflections on equity, diversity, and inclusion for its staff to address personal attitudes in addressing social norms.

Enhancing resilience of ultra-poor and marginalized groups towards health and nutrition shocks

1. Orient CSGs on the eligibility requirements of government safety net programs which they can share with ultra-poor groups and the eligible general population.

2. Ensure that CHCP and FWA have adequate knowledge to tell each poor pregnant woman about how to access the maternal allowance.

3. Involve the local government committees in discussing equitable access to the safety net programs and monitoring participation of minorities and marginalized groups.

4. Link CGs and CSGs with local disaster committees to make readiness plans for continuity in health services and access to nutritious foods in all seasons including during emergencies.

5. Through private sector engagement, increase access of remote and isolated populations to quality inputs (Moni Mix, fortified foods, etc.) including exploration of partnership with Social Marketing Company and others.

6. Coordinate with savings groups and faith-based organizations and churches for outreach to ethnic minorities to promote setting aside emergency funds in case of health shocks that households can access instead of selling productive assets.

The complete Action Plan for Interventions, Responsibilities, Implementation Details, and Time Frame is included in Annex E.

[15] https://www.care.org/our-work/health/strengthening-healthcare/social-analysis-and-action-saa/

Monitoring Progress

Through multiple data sources, CNHA will monitor progress in key areas of inequity. On a regular quarterly basis, project data and DHIS-2 data will be used for routine quarterly monitoring. Higher-level outcome indicators will be collected through annual surveys. Illustrative indicators that can be considered for equity are below.

Aligned with CNHA's MEL plan, illustrative outcome indicators that can be collected from annual surveys include:

Access: 1) Percentage of population from lowest wealth quintile that received any nutrition services from targeted CC; 2) Percentage of population from lowest wealth quintile received any family planning services from targeted CC

Disaggregated where possible by: Ethnicity; Person with Disability (PwD), Adolescent mother, Education status, Religion, Geographic location

Numerator: Number of women from lowest wealth quintile surveyed who received any nutrition services.

Denominator: Number of women in lowest quintile included in survey

From routine program data, illustrative indicators include:

Participation in platforms and institutions: Percentage of CGs & CSGs revitalized with inclusion of members representing marginalized groups

Disaggregated where possible by: Ethnicity; Person with Disability (PwD); Adolescent mother; Religion; Ultra-poor (wealth quintile); Education

Source: Program data

As part of its quarterly reports, CNHA will also report disaggregation where available for all indicators. Further details on the numerators and denominators of these indicators and their application can be found in Annex E and CNHA's MEL Plan.

Adaptive Management

CARE and its consortium partners will organize a review and reflection meeting on a quarterly basis at the district and consortium partner level to critically review and reflect on the ongoing key interventions' progress, equity indicator results, output indicator progress, key successes, learning questions, context of activities and emerging risks, opportunities to collaborate, challenges, learning and the way forward for the upcoming quarters. This will be a part of an internal monitoring process to review and reflect on program progress and achievements, examine the changing operational context, and make any adjustments to the Activity's operational approach and interventions, including those aimed at improving equity, as part of adaptive management. This reflection platform and open dialogue serves to not only inform diverse teammates about each other's work and the relationship of their work to achieving activity results but also creates a forum for shared decision-making and further planning and

adaptations. The MEL team will take the lead in organizing review and reflection meetings at districts and with the consortium organizations. All consortium members and CNHA's Senior Management Team will participate in the consortium organization-level review and reflection meetings.

Similarly, monthly program management team meeting reviews will reflect on the ongoing program and next steps. Monthly program meetings will help to guide and provide regular inputs to the districts. CNHA will also regularly discuss with the USAID team and employ an adaptive management approach so that program adaptations can be made to address issues that arise. This input will be used for program and MEL adaptations as relevant, including periodic updating of equity-related actions and of the SBC strategy, as applicable.

Annex A. Expected equity outcomes by CNHA Results

CNHA Result 1: Strengthened community health systems to deliver nutrition, MNCH, FP, health services

- *Equitable access to FP, MNCH, nutrition, and hygiene, and health services at CC and UHFWC levels; those with poorer health and nutrition outcomes or those who are excluded from care receive equitable access to services*
- *Equitable participation and inclusion in Community Group (CG), Community Support Group (CSG), nutrition committees*
- *Service providers provide special attention to those with poorer health and nutrition outcomes or those who have been excluded from care*

CNHA Result 2: Improved household (HH) nutrition and health behaviors

- *Participation in household decision making and use of finances for nutrition, hygiene, and FP behaviors*
- *Support from household members in seeking care and practicing healthy nutrition, FP, and hygiene behaviors*
- *Community support to address social norms affecting optimal nutrition, FP, and hygiene behaviors (e.g. maternal nutrition, child feeding, healthy timing and spacing of pregnancy)*

CNHA Result 3: Enhanced leadership and governance for improved nutrition

- *Linkages to social safety net support; leadership and participation of excluded groups in social safety net platforms*

CNHA Result 4: Resilience of communities and households to potential nutrition shocks increased

- *Linkages with multi-sectoral support services for improved resilience to nutrition and climate shocks*

Annex B. Additional Supporting Info from Secondary Data Analysis

The following tables show data on equity disparities as documented in MICS 2019.

Table 2. Use of Modern Contraception between 2012 and 2019 Bangladesh MICS Surveys by category

Characteristics	Modern method of contraception (%)			
	Overall			
	2012		2019	
	n	%	n	%
Wealth index				
Lowest	5092	63.2	5770	63.1
Lower	5249	63.6	6403	64.4
Middle	5189	61.3	6073	58.7
Higher	4794	56.1	5959	55.3
Highest	4684	52.5	5879	53.9
Religion				
Muslim	22370	58.8	26998	58.4
Non-Muslim	2638	63.3	3087	62.8
Area of residence				
Plain land	24747	59.2	29671	58.9
Hilly lands	261	59.6	415	59.5
Person with disability				
PWD	702	47.7	702	47.7
Non-PWD	28930	59.5	28930	59.5
Type of mother				
Adolescent mother	811	65.8	1064	64.5
Non-adolescent mother	24197	59.0	29021	58.7

Table 3. Use of Modern Contraception in 2019 MICS survey in four clusters of Bangladesh covered by CNHA by category

Characteristics	Use of modern contraceptives (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	Zol
Wealth index					
Poorest	63.1	66.3	58.0	63.8	56.6
Poor	64.4	64.7	64.0	65.4	61.2
Middle	58.7	60.8	55.8	61.9	54.1
Rich	55.3	58.0	50.6	62.0	50.2
Richest	53.9	53.5	48.2	55.1	51.6
Religion					
Muslim	58.4	63.8	56.1	63.2	55.2
Non-Muslim	62.8	58.6	59.9	63.6	57.0

Characteristics	Use of modern contraceptives (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	Zol
Person with disability among the mothers					
PWD	47.7	56.3	50.2	62.0	27.4
Non-PWD	59.5	64.0	57.1	63.8	56.2
Type of mother					
Adolescent mother	64.5	70.4	59.5	64.9	59.5
Non-adolescent mother	58.7	62.9	56.5	63.2	55.1
Education					
Pre-primary or none	58.2	59.8	56.8	61.2	53.6
Primary	61.3	65.4	58.5	65.5	59.3
Secondary	59.3	63.3	56.1	65.1	55.6
Higher secondary and above	53.7	60.2	51.0	57.5	46.1

Table 4. Antenatal Care Seeking (at least one Antenatal Care Visit with a Medically Trained Provider) between 2012 and 2019 Bangladesh MICS Surveys by category

Characteristics	ANC (%)			
	2012		2019	
	n	%	n	%
Wealth index				
Lowest	630	34.4	969	49.6
Lower	693	43.2	1151	66.6
Middle	905	59.4	1358	77.7
Higher	1018	72.0	1588	87.4
Highest	1418	90.0	1840	95.1
Religion				
Muslim	4225	58.0	6347	75.3
Non-Muslim	438	65.8	559	74.1
Area of residence				
Plain land	4633	58.9	6842	75.7
Hilly lands	31	38.3	63	44.9
Person with disability (PwD)				
PwD			72	72.8
Non-PwD			6693	75.3
Type of mother				
Adolescent mother	576	62.2	987	79.1
Non-adolescent mother	4087	58.2	5918	74.6

Table 5. Antenatal Care Seeking (at least one Antenatal Care Visit with a Medically Trained Provider) in 2019 MICS survey in four clusters of Bangladesh covered by CNHA by category

Characteristics	At least one ANC (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	Zol
Wealth index					
Poorest	49.6	61.8	43.3	45.7	44.5
Poor	66.6	67.7	63.2	69.8	56.6
Middle	77.7	82.9	70.5	71.8	69.3
Rich	87.4	88.8	86.5	82.7	80.7

Characteristics	At least one ANC (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	Zol
Richest	95.1	92.4	92.1	94.9	94.0
Religion					
Muslim	75.3	70.7	63.8	66.4	64.3
Non-Muslim	74.1	79.9	68.2	40.9	85.9
Person with disability among the mothers					
PWD	72.8	72.4	49.9	0.0	57.0
Non-PWD	75.3	71.5	64.2	64.5	65.4
Type of mother					
Adolescent mother	79.1	72.9	69.9	68.1	84.1
Non-adolescent mother	74.6	71.2	63.5	63.6	62.7
Education					
Pre-primary or none	46.5	57.7	39.1	40.1	31.8
Primary	63.0	56.9	58.1	55.8	43.7
Secondary	79.9	74.7	76.5	66.5	74.0
Higher secondary and above	92.9	93.8	92.1	90.9	87.7

Table 6. Exclusive Breastfeeding between 2012 and 2019 Bangladesh MICS Surveys by category

Characteristics	Exclusive breastfeeding (%)			
	Overall			
	2012		2019	
	n	%	N	%
Sex of the child				
Boy	550	56.7	798	63.6
Girl	579	57.7	741	64.1
Wealth index				
Lowest	266	59.6	349	67.2
Lower	268	62.5	272	64.0
Middle	200	53.8	273	62.0
Higher	179	54.6	312	64.3
Highest	207	54.4	330	61.8
Religion				
Muslim	1041	56.8	1398	63.4
Non-Muslim	89	60.3	143	68.8
Area of residence				
Plain land	1118	57.0	1518	63.7
Hilly lands	11	76.4	21	78.7
Person with disability (PwD)				
PwD			11	49.3
Non-PwD			1483	64.2
Type of mother				
Adolescent mother	168	56.9	268	62.0
Non-adolescent mother	951	57.3	1267	64.2

Table 7. Prevalence of Exclusive Breastfeeding in 2019 MICS survey in four clusters of Bangladesh covered by CNHA by category

Characteristics	Exclusive breastfeeding (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	Zol
Sex of the child					
Boy	63.6	69.8	54.7	79.5	51.3
Girl	64.1	68.1	64.0	71.8	63.8
Wealth index					
Poorest	67.2	68.8	56.4	73.7	65.6
Poor	64.0	85.2	54.4	81.6	52.6
Middle	61.6	68.0	67.5	66.2	58.9
Rich	64.3	41.0	52.6	78.5	45.0
Richest	61.8	69.6	70.8	79.6	52.7
Religion					
Muslim	63.4	68.7	57.8	77.5	56.5
Non-Muslim	68.8	75.4	69.0	63.7	80.4
Person with disability (PwD) among the mothers					
PWD	49.3	61.7	100.0	76.4	0.0
Non-PWD	64.2	69.4	60.1	76.4	59.2
Type of mother					
Adolescent mother	62.0	61.7	53.8	81.0	45.1
Non-adolescent mother	64.2	70.4	60.4	75.3	59.9
Education					
Pre-primary or none	55.6	70.5	46.4	81.1	60.6
Primary	63.8	79.1	62.0	67.1	53.3
Secondary	64.4	58.4	63.8	84.3	61.6
Higher secondary and above	65.6	91.0	54.4	66.4	48.2

Table 8. Wasting Prevalence between 2012 and 2019 Bangladesh MICS Surveys by category

Characteristics	Wasting (%)			
	Overall			
	2012		2019	
	n	%	n	%
Sex of the child				
Boy	1037	10.4	1196	10.4
Girl	838	8.8	968	9.2
Wealth index				
Lowest	548	11.7	553	11.8
Lower	439	11.2	552	11.5
Middle	347	9.6	379	9.3
Higher	295	8.5	361	8.5
Highest	231	6.6	350	8.0
Religion				
Muslim	1730	9.6	1976	9.8
Non-Muslim	165	9.7	188	10.1
Area of residence				
Plain land	1846	9.6	2111	9.8
Hilly lands	29	13.3	29	9.1
Person with disability (PwD)				
PwD			40	13.7
Non-PwD			2075	9.8
Type of mother				
Adolescent mother	135	11.3	141	8.6

Non-adolescent mother	1724	9.60	1995	9.93

Table 9. Wasting Prevalence in 2019 MICS survey in four clusters of Bangladesh covered by CNHA by category

Characteristics	Under-5 Wasting (%)				
	Overall	CNHA working areas			
		Coastal	Haor	Northwest	ZoI
Sex of the child					
Boy	10.4	10.5	9.8	10.8	8.8
Girl	9.2	8.8	9.4	10.7	8.3
Wealth index					
Poorest	11.8	12.1	11.1	13.7	10.7
Poor	11.5	6.2	9.6	9.1	9.5
Middle	9.3	9.3	9.2	11.6	7.6
Rich	8.5	4.6	8.6	7.8	7.8
Richest	8.0	9.6	5.9	4.4	3.4
Religion					
Muslim	9.8	9.8	10.1	10.3	8.7
Non-Muslim	10.1	8.5	5.6	16.0	4.0
Person with disability among the mothers					
PWD	13.7	8.7	7.5	0.0	12.7
Non-PWD	9.8	9.8	9.6	10.7	8.4
Type of mother					
Adolescent mother	8.6	9.7	5.0	15.2	3.8
Non-adolescent mother	9.9	9.6	9.8	10.5	8.7
Education					
Pre-primary or none	12.6	7.5	11.5	14.9	13.4
Primary	11.1	11.9	10.1	11.1	10.8
Secondary	9.5	9.7	7.7	10.1	6.2
Higher secondary and above	7.0	6.3	10.4	7.1	9.1

Annex C: Stakeholder Consultations

CNHA conducted stakeholder consultations in the 3 clusters (haor, coastal, zone of influence) shown to have the highest equity gaps based on secondary analysis. The team purposely selected the two upazilas in each cluster with the highest concentration of excluded populations. (These numbers were obtained by cluster teams from existing government rosters from community clinics and union parishads). The table below shows the geographic coverage, the groups and individuals interviewed during the stakeholder consultations for equity gap analysis.

Area	Groups Interviewed	Consultations Conducted
Kishoreganj Cluster, Tahirpur and Derai Sub-districts	Ultra-poor Women from remote areas included: ● Garo and Khasia Christians (ethnic and religious minority) ● Hajong indigenous group (ethnic minority) ● Bengali Muslim women ● two third gender people ● Hindu religious minority	11 group consultations: - 2 FGDs with ultra-poor women from remote communities, ethnic and religious minorities -2 FGDs with ultra-poor men from remote communities, ethnic and religious minorities - 2 FGDs with mothers-in-law and sisters-in-law of ultra-poor women from remote communities, ethnic and religious minorities -1 FGD with ultra-poor Bengali Muslim women from remote communities - 2 group consultations with core team members - 2 group consultations with CSG, CG, UDCC members 5 KIIs: 1 with CHCPs; 2 KIIs with third gender people; 2 KIIs with married adolescents; 1 story with married adolescent
Coastal Patuakhali Cluster, Kalapara and Galachipa Sub-Districts	Ultra-poor Women from coastal areas were included: ● Rakhine (ethnic minority) ● Manta (low-caste Muslims) ● Adolescent girls ● Third gender people ● Christian religious minority ● Hindu Religious minority ● Bengali Muslim women	11 group consultations: - 2 FGDs with ultra-poor women from remote communities, ethnic and religious minorities -2 FGDs with ultra-poor men from remote communities, ethnic and religious minorities - 2 FGDs with mothers-in-law and sisters-in-law of ultra-poor women from remote communities, ethnic and religious minorities -1 FGD with ultra-poor Bengali Muslim women from remote communities - 2 group consultations with core team members - 2 group consultations with CSG, CG, UDCC members 5 KIIs: 2 with CHCPs; 2 with third gender persons; 1 KII with married adolescent 1 story with CHCP
Char/ Madaripur / zone of influence cluster, Gosairhat and Damudya sub-districts	Ultra-poor Women from char areas were included: ● Namasudra caste: Women from low-caste Hindu (communities, ● Fishing community ● Bengali Muslim community	11 group consultations: - 2 FGDs with ultra-poor women from remote communities, ethnic and religious minorities -2 FGDs with ultra-poor men from remote communities, ethnic and religious minorities - 2 FGDs with mothers-in-law and sisters-in-law of ultra-poor women from remote communities, ethnic and religious minorities -1 FGD with ultra-poor Bengali Muslim women from remote communities - 2 group consultations with core team members - 2 group consultations with CSG, CG, UDCC members 2 KIIs: 1 with CHCP; 1 with married adolescent

Annex D. Additional Supporting Information from Stakeholder Consultations

The table below shows recommendations from CGs, CSGs, core teams, Union Development Coordination Committee (UDCC) members CHCP provided during equity consultations

Consultations with CSGs, CGs, UDCC members, CHCPs, core team members

Cluster: Hilly and Haor Kishoreganj Cluster (Tahirpur and Derai Upazilas)

Members of CGs, CSGs, UDCCs were interviewed together in a group:

- The members of CG, CSG and UDCC mentioned that they are not aware of the availability of medicines, but they have an idea of the nature of services at the CC. "Sometimes they refer patients, and they are back due to insufficient medicine."
- Detailed information on the availability of medicine may help them to refer to the community to visit CC because medicine is insufficient at CC. They emphasize that disrupted and poor road conditions make it very difficult to carry pregnant women to the CC or other service points. They mentioned that CHCPs provide partial antibiotic tablets to patients which is harmful for their health, and that CHCPs are not aware of the harm; and there is no specific guidance to proper use of antibiotics provided by CHCPs.
- **How can we ensure excluded women's access to CC and CG, CSG, UDCC groups?** According to the CG, CSG and UDCC group, community awareness can increase participation of excluded women in CCs. The CSGs can help increase awareness in communities. Capacity building training on how to participate and communicate actively in different committees could be helpful for CSGs. The government can arrange conveyances for the excluded persons to ensure representation in CGs, CSGs and set quotas for the leadership positions. They also added that government stipend for education could be an option for the extremely poor and ethnic boys, not only girls.

Saida Begum, female CHCP, Dhalchanpur CC (KII):

- The number of CCs is smaller compared to the requirement, "I treat 40-45 patients every day, I arrive by 10:00am and leave by 3:00pm"- Saida Begum, female CHCP, Dhalchanpur CC. There is a need to support CHCPs for them to provide quality service.

Views of Core Team:

- The members of the Core Team mentioned that poor people visit CCs. The CCs provide treatment for all, though the demand for medicine is high compared to the insufficient supply. The government provides 28 types of medicines and almost 30% of people visit CCs regularly though medicines are not sufficient for all.
- In general, 5% of deliveries happen at CC level, the percentage is less because almost 50% of CHCPs are male. They mentioned that male CHCP are not acceptable to deal with deliveries and they are unskilled to provide delivery services. CCs are also not well equipped as there is no running water, delivery kit, sufficient TBAs, or trained FWAs, HAs.
- Health care providers conduct counseling on child health, breast feeding, communicable and non-communicable diseases. The referral system does not function well specifically for complicated cases of pregnancy.
- They added that community involvement through CSG and CGs is limited. The group mentioned that mostly educated, motivated women come to the sub district and District level hospital for normal delivery. Through ensuring ANC, maternal death can be reduced. The group viewed that a reduced number of FWVs and FWCs has constrained family planning services. Women are major users of family planning methods and contraceptive pills and injections are popular methods among women.
- Answering 'Why is FP user rate low among men?' they said that there is a common belief that men will be weaker (physically and sexually) if he goes for a permanent contraceptive method. Men are not comfortable using condoms, they are not comfortable with female FWV and are not at home during daytime when FWVs visit homes. Besides, FWVs visit a small number of households.
- To improve service quality and increase PLW visits to the CC, the group recommended activating the CSGs and engaging them to raise community awareness, update pregnancy lists regularly, and follow up for regular checkups. Revive community skilled birth attendant (CSBA) created by NGOs, install closed circuit TV to monitor CCs, and initiate non-judgmental supportive supervision of CHCPs.
- They said motorcycles are used to transport pregnant women to Upazila health complex or district hospitals which is difficult for them.

How can we ensure inclusive service? The Core Team suggested to incorporate the topic on how to deal with PLW from diverse groups during training of CHCP, FWA, HAs

How can we improve women's leadership from diversified communities? Responding to this question CG, CSG, and UDCC members viewed that women's capacity for leadership could be developed. They suggested setting a quota for women leaders, convening women for discussion, and selecting leaders among them. The major leadership qualities that can be used for selection include being educated, vocal, can speak with logic, enthusiastic, and those with experience in voluntary roles in the community (collaboration with UP, different committees, NGO clubs, sanitation clubs, community development and awareness raising)

Consultations with CSGs, CGs, UDCC members, CHCPs, core team members

Cluster: Hilly and Haor Kishoreganj Cluster (Tahirpur and Derai Upazilas)

How can excluded groups be connected with safety net support to face various shocks? The CSG group said that the government can ensure safety net support for eligible persons, create ward-wise extreme poor population list, and engage ward committees accordingly to distribute safety net support.

Consultations with CSGs, CGs, UDCC members, CHCPs, core teams
Cluster: Coastal Patuakhali District: Kalapara & Galachipa

CG, CSG, UDCC members:

- Under the coastal areas CG, CSG UDCC viewed that CC is overcrowded by patients. CCs provide medicine only for 3 days because it has been decided by the government. Women, including PLW, and children receive primary treatment and medicine for general diseases.
- Identifying the challenges, this group mentioned that CCs are not equipped for delivery and a sizable number of CHCPs are not trained on 'community skilled birth attendant' (CSBA) courses provided by the government, an essential criterion for safe delivery. On the contrary, FWCs are equipped with delivery kits, oxygen and BP machines, cylinders, weight machines, etc. In general, 200-250 pregnant mothers live around their community and there are 4-5 deliveries every month on average in the FWC.

Why are the women seeking delivery support from FWC reducing? Responding to this question the group said, both CHCPs and FWVs ask money for delivery service which puts pressure on poor pregnant mothers; in addition, lack of health education, fear of outside delivery, poverty, and social stigma discourages them from visiting FWCs. "Allah will support us because babies are given by Him" Rahima Akter, UP member, Kalapara. They also observed that Hindu and Christian women from nearby locations visit CCs. They also assumed that Rakhine men in Kalapara upazila may use the natural method of family planning because they have fewer numbers of children.

CHCP Rehana Pervin, CHCP, Galachipa and Piyara Begum, Kalapara:

- CHCPs viewed that poor and extremely poor women visit the CCs with general complaints like fever, cold, allergy, or suffering from worms. In general, 10-15 pregnant women visit CCs, with ethnic women visiting less. On average, they provide treatment to 40-45 people daily. They provide zinc, iron, B complex to the pregnant women and provide counseling for rest, taking nutritious food, i.e. milk, egg, fruit, vegetable. Sometimes they attend home deliveries. In general people call traditional birth attendants at home. Sometimes they call trained CHCPs when the case gets more complicated, "I was called to attend a delivery case, her perineum was wounded badly, I stitched it immediately" -Rehana Pervin, CHCP, Galachipa.
- They said a good number of CHCPs, FWVs did not receive the CSBA (Community Skilled Birth Attendance) training, and women will never agree for delivery even for physical check up by a male CHCP. Insufficient medicine, space for delivery, and lack of delivery kits are the common challenges to provide quality services at the CC. FWAs also said HAs only sit two days at CC, so FP service gets disrupted. They also face problems due to lack of CC maintenance and person's support.
- They also mentioned Rakhine was the earliest community in this area. The community believes that something bad will happen if they deliver outside of the home, "hospital means Caesar [C-section]" – Piyara Begum, Kalapara. The CHCPs suggest to pregnant mothers to deliver at FWC or CC which is not convincing to them.
- For CHCPs to be credible and respected among patients, they said that good behavior and patience are the key qualities CHCPs need to have.
- **To increase excluded women's participation in CC**: The members said that the government provides an allocation for extremely poor Bengali women called "Abashon." This includes government housing allocation for extremely poor Bengali women. The group members suggested that these women could be engaged in CG/CSG groups. They said that excluded women feel shy to attend CC or any community livelihood program. Increasing their participation in CC and CSG motivational programs can be initiated for them, and they may discuss inclusion issues with other committees
- Recommendations from CHCP: Arrange CSBA training for service providers, increase the number of supporting people, and ensure continuous community awareness to build up ownership to maintain CCs.

Core teams:

- In general, 5% of deliveries happen at CC level. The rate is like that of CC or UHFWC in coastal areas except for a few numbers of UHFWC where delivery rate is higher (i.e. 10-12 deliveries per month).
- They also viewed that local people are less interested in joining CG, CSG meetings due to lack of ownership. They seek individual benefit. "Is there any snacks arrangement?" asked Shafiqul Islam, Medical Technologist, Expanded Program on Immunization. There is a lack of ownership among the community. "People who don't own CCs, not interested in paying the electricity bill, on the other hand they actively participate in repairing the Mosque." They also mentioned that shortage of medicine compared to the growing population, lack of support for door-to-door/home visits are some of the challenging areas. They suggested to engage Upazila Nirbhaya Officer (who is the chief executive officer of the upazila) because all staff follow their instruction.

Consultations with CSGs, CGs, UDCC members, CHCPs, core teams
Cluster: Coastal Patuakhali District: Kalapara & Galachipa

- **How can we ensure inclusive service?** They suggested inviting all diverse communities, identifying ethnic women with leadership quality to work for the community. Appoint community volunteers to motivate ethnic women for visiting CC and UHFWC; and to initially arrange area-based discussions to include them in different committees accordingly.

Participation in platforms: The groups from coastal areas said that excluded groups do not want to engage with mainstream activities and they are not interested in interacting with the Muslim community. The group added that CC, CSG, UDCC are not active in most of the areas. Reviving the groups, orientation of their roles and responsibilities, and the benefit of inclusiveness would be the options for re-activating these groups. Furthermore, motivational meetings, courtyard meetings, counseling to the diverse populations are required . They suggested selecting those excluded women who can provide time for the community and have voluntary work attitudes and acceptance by the community.

Consultations with CSGs, CGs, UDCC members, CHCPs, core teams

Madaripur Char Cluster, Districts: Gosairhat & Damudya

- **In the Char** area there are insufficient numbers of CCs creating problems to cover for the patient load. To ensure inclusive service, some of the members of CSG emphasized that all people have equal rights to get medicine from CCs, there is no preference for the poor people. They added, FWV is not active in their community. The FWC attends to the patient when they bring references from UP members or village police, and she mostly provides services to the community for a fee.
- **Why is the participation of excluded communities low in CSG?** Responding to this question the group said that they are less educated, and they are not interested in joining CSG because they are the income earners for their family. To ensure participation of excluded groups they suggested to make them aware of maternal health, find out active women with the ability to motivate other women in their community to visit CCs. The group recommended organizing regular meetings of CSG and providing training to develop their communication and motivation skills.
- **CHCP**: Afroja Yesmin, CHCP Goshairhat Upazila under Char area said that it is difficult to arrange meetings with CSG because there is no budget for refreshment. Another challenge is that the members of CSG bring medicines from CCs without any complication or consultation. Due to lack of ownership by the community, CHCPs struggle to repair the CCs since the community people do not want to bear the costs for repair. The community thinks that CC is a government institution, and they will maintain it. Insufficient human power is another problem; the CHCPs provide all sorts of services including cleaning the CC and distribution of contraception. They also mentioned that trained CHCPs provide home delivery services and work on data entry in the register books.
- **How could a CHCP be credible and respected among the patients?** The CHCP said that time management, counseling skills, and providing equitable services for all patients is key. The CHCP mentioned that the excluded groups (barber, blacksmith, potter) live in distant areas from the CC and they visit the sub-district Health Complex.

Core team:

- In char areas, there is an insufficient number of CCs to cover for the whole community.
- **How to improve the service quality and increase PLW visits to the CC?** - need to arrange training, increase community awareness regarding the service nature of CC, FWC, and motivational sessions are necessary for mothers and sisters-in-law.
- **How can we ensure inclusive service and participation in different committees?** Initially arranging area-based discussions and accordingly including them in different committees, the arrangement of snacks would be a better option to ensure their participation. The views of Core Team are similar to Haor, char and coastal area to ensure inclusive service and participation. In addition, they added, training in motivational skills, better communication and an overall idea of health and family planning would be helpful for the CSG and new members from excluded groups.

How does a chairperson make a safety net recipient list? Answering this question, a chairman said that UP members make the recipient list for allowance and verify with the government criteria through village police, and sometimes discusses with local people. He receives a limited number of safety net allowances which is not sufficient for all. He spends a health related budget for sanitation (tubewell, latrine).

Annex E. Action Plan for CNHA Equity Gaps and Interventions

Equity gaps	Interventions to reduce equity gaps	Monitoring indicators	Time frame
IR 1/ Domain 1 (Accessing CC or UHFWC services)			
Ethnic and religious minorities are less likely to seek MCHN services for themselves or their children due to: - Lack of clarity on services offered, fee structure, hours of operation - Lack of respectful care by CHCPs towards ethnic and religious minorities (e.g. Rakhine and Manta communities in coastal Patuakhali cluster, members of fishing community in Madaripur char cluster) Married adolescents mostly excluded from FP services	**Community Engagement**: As CSGs are activated, CNHA union facilitators will support active members of the CSGs as champions. 1. Union facilitators will build the capacity of active CSG members to conduct small group discussions in their communities, including with ethnic and religious minority groups as well as women with disabilities who may not be accessing services. 2. Union facilitators will support CSGs in their social mapping exercise and action plans to identify households with pregnant and lactating women, children who have been identified as underweight or malnourished at clinics, ethnic and religious minority households, adolescent mothers, and persons with disability. The union facilitator will support CSG champions to incorporate outreach to these groups through small group discussions. 3. During these small group sessions, the CSG champions will discuss key messages identified in CNHA's SBC Strategy. These champions will also provide information on services, charges, operating hours of CCs and policies. 4. **Community Groups**: As CHCPs serve as the member secretary of Community Groups, CNHA included a session on respectful treatment of ethnic and religious minorities into the CG/CSG orientation manual (GOB has a combined orientation module for both groups). **Advocacy**: 5. CNHA will advocate with CBHC for inclusion of ethnic or religious minorities in the membership of CSGs within the TOR for CSGs. Representation should be proportional to the census of groups in the service area. 6. CNHA will advocate with CBHC to include this session within the standard orientation module for CGs/ CSGs. **Frontline Health Workers**: 7. Upazila-level core teams (which are comprised of supervisors of health workers) will provide monitoring and supportive supervision to FWAs for household outreach to pregnant and lactating women, married adolescents, and families with children under two years from ethnic minority and ultra-poor communities and women with disabilities, including registration, documentation and follow up of households with ethnic and religious minorities and households with malnourished or underweight children. 8. Upazila-level core teams will provide monitoring and supportive supervision to HAs to integrate information about CC services into EPI sessions and increase outreach of EPI sessions to include ethnic and religious minorities. 9. **Core teams**: As CNHA is activating core teams that are not functional, once activated, core teams meet monthly. During these monthly meetings, CNHA's advocacy and training managers (supported by cluster coordinators) will add micro-dosed sessions on value clarification and respectful treatment of minority groups. CNHA advocacy and training officers (supported by cluster coordinators) will advocate with core teams (which include supervisors of frontline health workers) for FWAs, HAs, and FWVs to monitor and provide supportive supervision on outreach and respectful treatment of ethnic and religious minorities tailored to the specific context (e.g. Manta communities in Patuakhali cluster, etc.)	Aligned with CNHA's MEL plan, we will monitor indicators at the output, process, and outcomes levels such as: Parent Indicator at the outcome level: Percentage of population from lowest wealth quintile that received any nutrition/ family planning services from targeted CC (Equity) Disaggregated: - Indigenous/Adivasi - Person with Disability (PwD) - Adolescent mother - Education status - Religion - Geographic location As described in our MEL plan and the monitoring section, this data will be collected through CNHA's annual survey. The denominator will be those women who are sampled for the survey that are in the lowest wealth quintile. Out of that numerator, the denominator will be those women in the lowest wealth quintile who are accessing services. MEL Plan Indicator: GNDR-80 Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations. Disaggregation: - Male (GNDR-8a), - Female (GNDR-8b) Source: Project MIS Frequency: Quarterly	Year 3-5

	10. **Accountability**: In each district, CNHA will pilot the use of Community Scorecard (CSC) by core teams to monitor accountability between CCs and community members, including ultra-poor women, ethnic and religious minorities, people with disabilities, and third gender people. CNHA's district manager will facilitate the interactions and monitor based on practical indicators that can be integrated into the core team's action plan. We will discuss this concept further with government counterparts and with USAID.	Number of supportive supervision visits conducted by core team for CHCPs Source: Project MIS Frequency: Quarterly	
Ultra-poor women who have visited CCs mentioned that: - Essential drugs are not always routinely available; - CCs are often in need of repairs; - Female CHCPs are not often available. (Pregnant and lactating women indicated that they prefer to receive care from female providers.)	11. **Community groups** are designated as the management committee of CCs including to ensure the management, operations, and maintenance of CCs. CNHA cluster teams will activate CGs. During their monthly meetings, CNHA's cluster teams will encourage the discussion and addressal of key issues such as repairs and drugs. 12. On a quarterly basis, CNHA's cluster teams will support the inclusion of community groups in core teams' monthly meetings for joint action planning and resolution of issues such as drug availability and repairs. These quarterly sessions may include the Upazila Nirbhaya Officer to help resolve issues as needed. 13. **Core teams**: As core teams include supervisors of CHCPs and FWAs, CNHA project managers will advocate that core teams ensure availability of female CHCPs for ANC and other services for women where female CHCPs are available. CNHA will also advocate for additional days at clinics for FWAs, particularly in CC with no female CHCPs. **14. Advocacy**: Where female CHCPs are not available, CNHA will advocate at national level with CBHC for recruitment of female CHCPs based on specific data of where female CHCPs are currently posted within CNHA's areas.	% of CG monthly meetings that include action plans for identified problems Denominator: Number of monthly meetings conducted by CGs Numerator: Number of monthly meeting minutes that include action plans Source: CG Meeting Minutes Frequency: Quarterly monitoring checklist	
IR 2/Domain 2: Household decision-making, women's mobility, women's leadership, social norms			
Women delay seeking support from outside the home for health, nutrition due to husband's permission. Women feel discouraged to participate in different committees without permission of husbands.	15. **Community Engagement**: Once CSG groups are activated, CSG groups will meet bimonthly. Aligned, during these bimonthly meetings union facilitators will conduct micro-dosed sessions on social norms including women's mobility and decision-making aligned with CNHA's SBC strategy and build capacity of CSG champions on this content. 16. Within SBC messages, integrate messages for CSG champions targeting husbands on health complications (premature birth, low birth weight, malnutrition, anemia) of poor nutrition of pregnant women and malnourished children and the necessity of equitable food distribution for women's and girls' health. 17. CSG champions will conduct small group sessions in their communities with key messaging on women's mobility and decision-making for care seeking. Union facilitators will support male CSG champions to conduct small group discussions with men and female CSG champions to conduct small group discussions with women. 18. **Innovation**: In addition, the partnership innovation fund coordinator will work with district teams to circulate the opportunity for small grants under the partnership and innovation fund as a pathway for localized solutions to address these barriers. 19. **Advocacy**: CNHA will advocate with CBHC, NNS and IPHN to include training content on the importance of male and family engagement on the health of mothers and children.	Percentage of husbands in 1,000 days HHs who have knowledge on the importance of healthy timing and spacing of pregnancy (HTSP) Disaggregated: -Wealth -Ethnicity -District -Upazila Source: Annual survey Denominator: Number of husbands in 1000-day households included in sample Numerator: Number of husbands in 1000-day households included in sample with knowledge on the importance of healthy timing and spacing of pregnancy (HTSP)	Year 3-5
IRs 3&4/Domain 3: Participation in social safety nets and platforms			
Little participation of government safety net programs by the ethnic groups, due to lack of knowledge on eligibility, less connection with union parishad, and perception of	20. CSG champions will connect with union parishad secretaries who maintain union-level lists for social safety net eligibility to ensure plan for linkages for ethnic and religious minorities, women with disability 21. CNHA district manager will sensitize Core Team and Union Parishad, UDCC, DNCC, UNCC members and advocate to include excluded communities in receiving safety net support.	**RESIL-1** Number of host government or community-derived risk management plans formally proposed, adopted, implemented, or institutionalized with USG assistance [IM-level].	Year 3-5

bribes required to receive government allowance			
In Sylhet (Haor areas), PLWs feel discouraged/risk visiting the CC, FWC, health complex during flooding time due to poor road and other communication.	22. CHNA union facilitators link CSG champions to meet with ward and union disaster committees to ensure plan to link for safety net distribution to remote households and explore potential for link with savings groups and include addressing geographic constraints in their planning (i.e. road repair/construction, allocate funds for arranging boat/ambulance). 23. CNHA union facilitators will support CGs to engage with local Government Institutions to improve road conditions and involve the upazila and union disaster management committees (UDMC) and local elites for repairing/constructing roads and other options through advocacy at local level.	**RESIL-1** Number of host government or community-derived risk management plans formally proposed, adopted, implemented, or institutionalized with USG assistance [IM-level]. Disaggregated: - Type: Government (RESIL-1a) - Type: Community (RESIL-1b) Source: Project MIS Frequency: Annually	Year 3-5