Citizens' Assessment of District Level COVID-19 Responses:

Focus on food-cash assistance and health services for the marginalised groups

LNOB Network, Bangladesh

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The local partners NGOs, CSOs, organisations and networks of different marginalised groups and local staff of nine partner organisations did the toughest jobs – without their extended hands and dedication this would not have been possible. This is last but not the least, our gratitude goes to the marginalised groups namely dalits, ethnic minorities (indigenous peoples), persons with disabilities, sex workers, transgender, people living with HIV/AIDS, elderly people engaged in begging, urban floating people, river gypsies, and people living in hard-to-reach areas (char, haor, hills, islands, forests, etc.) who participated in focus group discussions and reached in consensus to fill in the scorecards.

This study has been conducted under the banner of Leave No One Behind Network Bangladesh and supported by the Robert Bosch Stiftung. The Leave No One Behind (LNOB) Network, Bangladesh, is part of a greater global collaborative, the Leave No One Behind partnership, bringing together international and national civil society organisations (CSOs), civic networks and platforms across five countries. The partnership has the goal to bring about a scalable solution for filling data gaps on marginalised groups in the monitoring and review of the SDGs. The project fosters an inclusive model of SDG monitoring, supporting the collection, analysis and dissemination of community-driven data and giving a stage to the local target groups – helping to make their voices heard and count. The partnership is hosted by the International Civil Society Centre.

All the efforts mentioned above would be meaningful if the end users of this report find it useful.

Executive Summary

COVID-19 pandemic created havoc in the lives of the people of the whole world and Bangladesh was no exception. Due to the nationwide lockdown during late March to June 2020, livelihood, public service delivery and the entire economy were severely disrupted and it affected the people from all walks of life disproportionately. However, the low income groups and the socially excluded and marginalised people were the worst hit of this unprecedented crisis. Even though the lockdown was lifted in late June, the marginalised and vulnerable groups continued to face the acute challenges to meet their basic needs. They also continued to face challenged in accessing basic public services and social safety net support to get back on their own feet. Although the Government of Bangladesh declared many a stimulus packages and safety net support to help the people recover from the economic loss, many people from the vulnerable groups did not get the assistance properly due to the lack of proper targeting and improper distribution mechanism. Due to the lack of preparedness and capacity of the government, the health sector revealed the most unpleasant scenario as the people especially the marginalised people witnessed the worst form of disruption in healthcare services in the public facilities. Concerns also raised in the realm of transparency and accountability in providing healthcare services and food and cash assistance to the people who needed the most during the core period of COVID-19 pandemic.

Leave No One Behind (LNOB) Network, Bangladesh, a coalition of nine civil society organisations, gathered information about the measures taken in all districts on the public healthcare services and food and cash assistance during the COVID-19 pandemic, especially for the marginalised communities, by using citizens' scorecard method. Through this process the Network measured the accessibility and inclusion of the marginalised communities in terms of getting health services and the social safety net packages. This process included a good number of marginalised groups such as dalits, ethnic minorities (indigenous peoples), persons with disabilities, sex workers, transgender, people living with HIV/AIDS, elderly people engaged in begging, urban floating people, river gypsies, and people living in hard-to-reach areas (char, haor, hills, islands, forests, etc.).

The major findings from the analysis of the district-wise scorecard suggest that around half of the districts (28) got low scores (20-40% scores) on an average of all sub-indicators in terms of providing food and cash assistance to the marginalised communities. The districts which got the high scores in terms of food and cash assistance are Jhalokathi (66.33%), Barishal (65.67%) and Brahmanbaria (65.67%). On the other hand, the five low scored districts in the realm of providing inclusive food and cash assistance are Norail (20.00%), Rangpur (20.42%), Nilphamari (22.00%), Feni (25.56%) and Bogura (25.83%).

The analysis of the scorecard on health services during the COVID-19 pandemic suggests that no district got either very low or very high scores. In terms of ensuring inclusive health services Narail (30.18%), Nilphamari (30.18%), Feni (30.91%), Tangail (35.64%) and Munshiganj (35.64%) are the five districts that scored the lowest. On the other hand, the high performing districts in terms providing including health services to the marginalised people include Netrokona (78.18%), Chuadanga (69.82%), Jhenaidah (65.45%) and Chapai Nawabganj (64.00%).

Proper targeting and proper distribution of food and cash distribution among the marginalised groups, timely distribution of food and cash assistance and information sharing about the criteria and entitlements also got less than 50% scores. However, quality of products was certified as moderate as it scored between 60-70%. Regarding the healthcare services in the public facilities the analysis shows that the sub-indicators which got the lowest score among the low scored districts are inclusive information on health, institutional complaint mechanism in health centres, equal opportunity in health centres, action taken against complaints and quality of the health services. Among the high scored districts, the sub-indicators that got low scores are institutional complaint mechanism in health centres and action taken against complaints.

Introduction

1.Introduction

1.1 Background of the citizen's assessment

COVID-19 pandemic affected the lives of people disproportionately and the health sector in Bangladesh felt a massive shock. The lockdown situation declared in late March 2020 to minimise the risk of the spread of coronavirus in communities downsized the basic public service delivery, mobility, and livelihood options of the people. Hence, the people from all walks of life entered into a 'new normal' situation, and gradually the food security and other basic necessities became a serious issue to the people especially of low-income families. These issues brought into some new challenges for the marginalised groups such as persons with disabilities, people living with HIV/AIDS, ethnic minorities, transgender, sex workers, dalits, elderly persons engaged in begging, female-headed households, children, people living in hard-to-reach areas, urban floating people and people living in extreme poverty. They became more vulnerable as the new realities added to their experiences of living with different forms of exclusion in society and facing multiple challenges in accessing public services and resources due to their lower position in the social and political structure.

Although the lockdown situation was lifted at the end of June, the COVID-19 pandemic left some scars in all aspects of people's life. The economic and other essential activities continued to take time to get full pace to help people realise their normal lives and livelihoods. People of low income families from the excluded and disadvantaged communities suffered from shortage of income opportunities and suitable coping strategies. Moreover, other necessary services especially the basic healthcare services struggled to get resources and to set on its own feet due to the increasing trend of coronavirus infections and death rate at the middle stage of the lockdown situation. The people living in the bottom of the pyramid suffered from this unusual state of basic healthcare services.

The Government of Bangladesh allocated some resources and implemented some schemes to tackle the spread of coronavirus and helped people cope with food shortage and other crises. At the initial stage of the lockdown situation, the government provided some social safety net support to the people in need apart from the regular schemes. The government further declared a six-month package for reaching out to 50 lac families in need with monthly support of 2,500 taka. However, there were some concerns raised from different corners of people and discussed in social and mainstream media over targeting the right beneficiaries and maintaining transparency and accountability in the selection and distribution of these supports. Moreover, the capacity of public health service-providing institutions in providing services related to testing and healing corona patients as well as sustaining their regular healthcare services were also discussed in different forums.

Given this situation, LNOB Platform in Bangladesh felt the need to look into whether the marginalised groups got the support from the social security packages as well as healthcare services from public hospitals. The Platform aimed at examining the accessibility of the marginalised groups to the above-mentioned services and providing a district-wise citizen's monitoring report for policy discussion and a reflection in the national budget and 8th five-year plan of the government.

1.2 Objective of the citizen's assessment

The main objective of the citizens' assessment of district-level COVID-19 responses was to assess the level of inclusiveness of the public responses provided to tackle the food and health crises induced by COVID-19 pandemic by using a lens of local marginalised groups. The specific objectives were:

a. To assess the level of inclusiveness from the lens of good governance of the public responses provided to tackle the food and health crises induced by COVID-19 pandemic; and

b. To communicate policy recommendations with relevant stakeholders for ensuring inclusive public planning and budgeting for the marginalised groups

1.3 Expected outputs

This assessment was expected to provide a number of specific outputs:

a. District-wise groups of marginalised communities mobilised for assessing the performance of local public service providing authorities and inclusiveness of services;

b. A district-wise scorecard on the performance of local public service providing authorities developed for comparing among districts; and

c. Major policy gaps and operational challenges of reaching out to the marginalised groups identified for proposing policy recommendations for national budget and 8th five-year plan

02 Methodology

2. Methodology

2.1 Conceptual framework

The citizen's assessment of district level COVID-19 responses on health and cash-food assistance relies on some theoretical knowledge, which includes:

Sustainable Development Goals (SDGs)[1]: Some targets of SDG 1 (No poverty), SDG 2 (No hunger), SDG 3 (Good health and wellbeing), SDG 10 (Reduce inequality), and SDG 16 (Peace, justice and strong institutions) have been followed in developing the theoretical foundation of the citizen's assessment. The following targets guided in developing the indicators for assessing district level inclusive services:

- Implement nationally appropriate social protection systems and measures for all, including floors, and achieve substantial coverage of the poor and the vulnerable
- Ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance
- Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters
- Adopt measures to ensure the proper functioning of food commodity markets and their derivatives and facilitate timely access to market information, including on food reserves, in order to help limit extreme food price volatility
- Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- Provide access to affordable essential medicines and vaccines

1 https://sdgs.un.org/goals

- Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
- Empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status
- Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard
- Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality
- Ensure responsive, inclusive, participatory and representative decision-making at all levels
- Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements
- Promote and enforce non-discriminatory laws and policies for sustainable development

Inclusive institutions: According to Carter (2014), inclusive institutions bestow equal rights and entitlements, and enable equal opportunities, voice and access to resources and services. These institutions are typically based on principles of universality, non-discrimination, or targeted action. Targeted action is needed where some people and groups are particularly disadvantaged, and therefore require differential treatment to achieve the equivalent outcomes[2]. Shookner (2002), outlined five foundational values of inclusion, which applies in wider social aspect, however, is not something that does not include institutions: The values are: social justice (fair distribution of inclusion and resources), valuing diversity (recognition and respect; valuing all contributions), opportunities for choice, entitlement to rights and services, and working together (common interests and relations = basis for action)[3].

2 Carter, B. (2014). Inclusive Institutions: Topic Guide. Birmingham, UK: GSDRC, University of Birmingham (https://gsdrc.org/wp-content/uploads/2015/07/InclusiveInstitutionsTG.pdf)

3 Shookner, M. (2002) An Inclusive Lens: Workbook for Looking at Social and Economic Exclusion and Inclusion, Population and Public Health Branch, Atlantic Region, Health Canada (https://www.allianceon.org/sites/default/files/documents/Workbook%20for%20looking%20at%20Social_and_Economic_Inclusion_Lens%202002.pdf)

2.2 The indicators and pillars of inclusiveness

Three indicators were focused to develop the scorecard and 10-12 sub-indicators were developed to assess the health responses and food and cash assistances in times of COVID-19 pandemic. The main indicators are stated below:

a. **Universality:** Example, universal age-related state pension; universal access to justice or services.

b. **Non-discrimination:** Example, meritocratic recruitment in the civil service; inheritance laws that protect widows' land rights.

c. **Targeted action:** Example, affirmative action to increase the proportion of women political representatives; budget rules that prioritise investment in disadvantaged areas.

The pillars of inclusiveness are[4] :

Access	Access explores the importance of a welcoming environment and the habits that create it.
Attitude	Attitude looks at how willing people are to embrace inclusion and diversity and to take meaningful action
Choice	Choice is all about finding out what options people want and how they want to get involved
Partnership	Partnership looks at how individual and organisational relationships are formed and how effective they are.
Communication	Communication examines the way we let people know about the options to get involved and about the culture
Policy	Policy considers how an organisation commits to and takes responsibility for inclusion.
Opportunities	Opportunity explores what options are available for people from disadvantaged backgrounds

4 https://inclusivesportdesign.com/planning-for-inclusion/7-pillars-of-inclusion-using-commonalities-as-the-start-point-for-inclusive-sport/

2.3 Methods and tools

Community scorecard method was applied in carrying out the citizen's assessment. Community scorecard is popularly used as a social accountability tool. Social accountability, another term for bottom-up accountability, refers to the set of tools that citizens can use to influence the quality of service delivery by holding providers accountable. Scorecard refers to a quantitative survey of citizen satisfaction with public services that includes a facilitated meeting between providers and beneficiaries to discuss results and agree on follow-up actions (World Bank, 2012)[5]. However, if it is a community scorecard (CSC), it is usually led and done by the community. Then, the community scorecards are shared with service providers to hold them accountable. Through this process, citizens are empowered to provide immediate feedback to service providers. Some literature suggest that CSC is a collective engagement of both service providers and users in designing and using the cards. A CSC process involves community meetings in which the performance of public services is discussed among providers, users and other stakeholders and includes self-evaluation of performance by providers, as well as the formulation of an action plan based on scorecard outputs (Joshi, 2013)[6].

In citizens' assessment tool conducted by the LNOB Platform three-indicators and some sub-indicators under each indicator were used to assess the level of inclusiveness of the public responses provided to tackle the food and health crises induced by COVID-19 pandemic. This exercise was undertaken in all 64 districts with 10 selected marginalised groups. 5-10 facilitators from each district were trained to conduct scorecard exercise with at least five marginalised groups in each district. The marginalised groups were selected on the basis of availability in each district. Each group consisted of 10 participants of the same community of marginalised group. Each group discussed and reached in a consensus to score against each of the sub-indicators. Then, the average score collated from each district was analysed to find the best performing districts and divisions. Moreover, some key informant interviews (KIIs) were conducted with relevant government officials involved in COVID-19 responses at the district level.

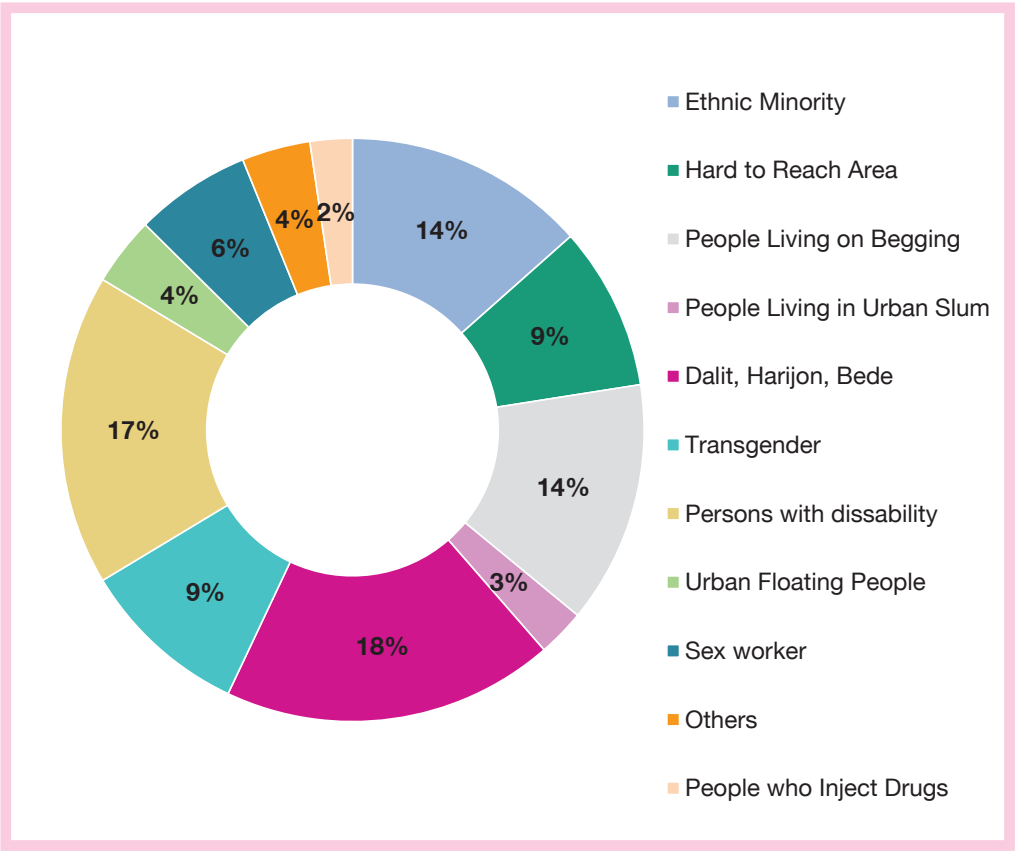
5 "Ringold, Dena; Holla, Alaka; Koziol, Margaret; Srinivasan, Santhosh. 2012. Citizens and Service Delivery: Assessing the Use of Social Accountability Approaches in the Human Development Sectors. Direction in Development; human development (https://openknowledge.worldbank.org/handle/10986/2377).

6 Joshi, A. (2013). The Impact of Social Accountability Initiatives on Improving the Delivery of Public Services: A Systematic Review of Four Intervention Types: Protocol. Unpublished mss. London, UK: Institute of Development Studies.

The following table provides the key methodological processes in brief:

Table 1: The research design at a glance	
Methods	Community Scorecard (CSC) and Key Informant Interviews (KIIs)
Tools	Scorecard and checklist
Indicators	Universality, Non-discrimination, Targeted action
Services covered	Healthcare: Coronavirus and regular diseases Food and cash assistance: Targeting and distribution
Location	64 districts
Scoring at the group level	Five different groups (10 persons in each group) discussed and provide their collective scores against each of the sub-indicators. The facilitators submitted the scores through Google form
District level scoring	Average of scores collated from five different groups
Division level scoring	Average of scores collated from all districts under each of the administrative divisions
Group level facilitators	Grassroots organisations of marginalised communities, local partner NGOs and local staff of LNOB Network members
Groups covered	Dalits, ethnic minorities (indigenous peoples), persons with disabilities, sex workers, transgender, people living with/AIDS, elderly people engaged in begging, urban floating people, river gypsies, and people living in hard-to-reach areas (char, haor, hills, islands, forests, etc.)

Figure 1: Type of marginalised groups covered through the scorecard (percentage of marginalised community-wise participants)



2.4 Analytical framework

The scorecard used five-point Likert scale to analyse the state of inclusion in the districts where 1 was termed as very low/highly dissatisfied and 5 termed as very high/highly satisfied. The scores were converted into percentage to distribute the districts in five categories, which are as follows:

a. Very low scored districts: 0-20%

b. Low scored districts: 21-40%

c. Moderate scored districts: 41-60%

d. High scored districts: 61-80%

e. Very high scored districts: 81-100%

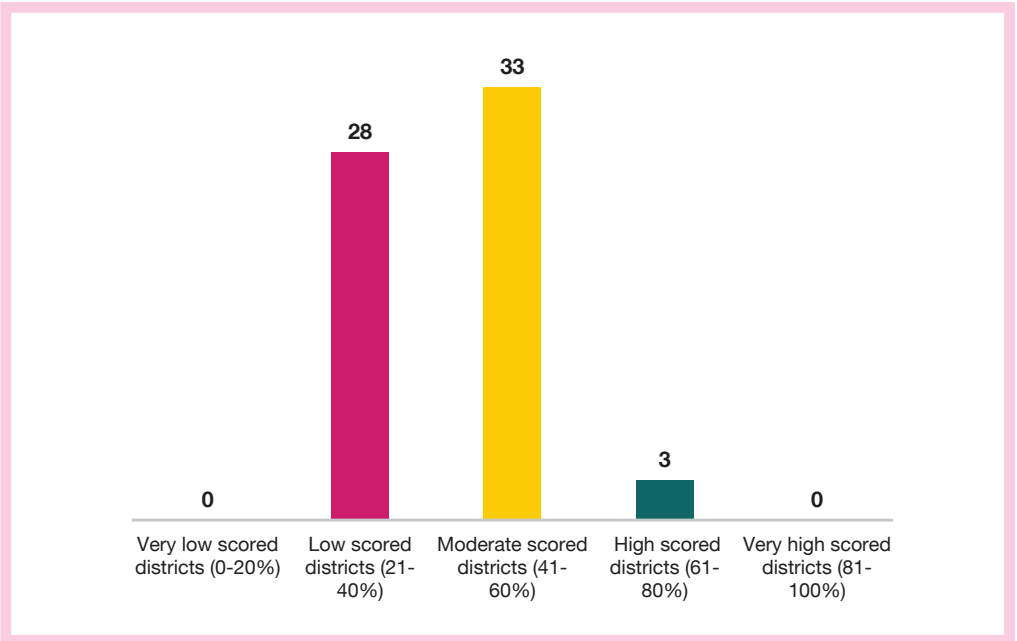
03 Major Findings

3. Major Findings

3.1 Food and cash assistance during the pandemic

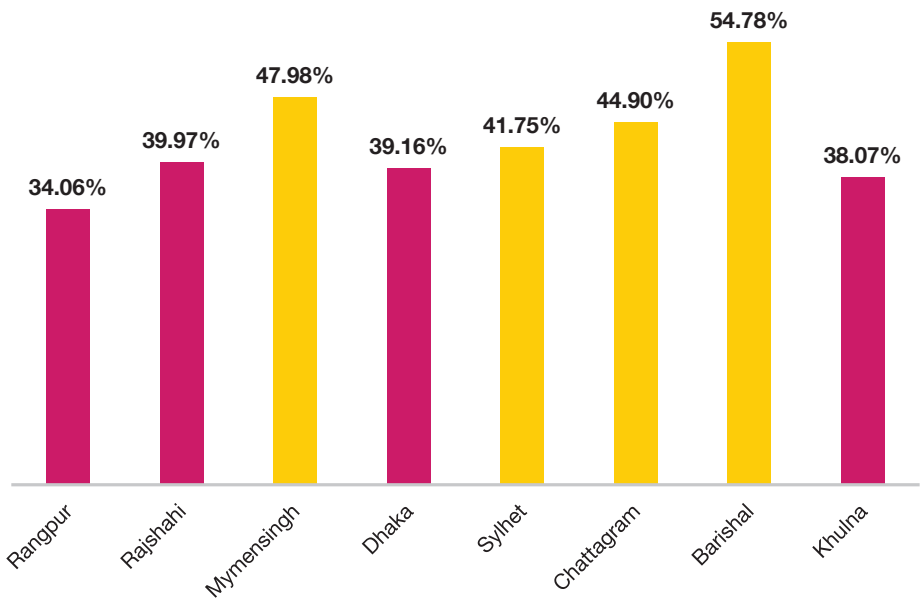
More than half of the districts got moderate scores while many a district got low scores in responding to the marginalised people with food and cash assistance: The scorecard (Figure 2) on the food and cash distribution during the COVID-19 pandemic suggests that no district got very low or very high scores. However, more than half of the districts (33) got moderate score while only three districts got high scores. This is to mention that around half of the districts (28) got low scores (21-40% scores). The districts which got the high scores are Jhalokathi (66.33%), Barishal (65.67%) and Brahmanbaria (65.67%). On the other hand, the five low scored districts are Norail (20.00%), Rangpur (20.42%), Nilphamari (22.00%), Feni (25.56%) and Bogura (25.83%) (See the details in Annex 1).

Figure 2: Distribution of districts based on their scores in food and cash distribution during COVID-19 pandemic (number of districts)



Almost all divisions got less than 50% scores in responding to the marginalised people with food and cash assistance: The division-wise scores show that almost all divisions except Barishal got less than 50% scores in food and cash distribution in terms of ensuring inclusiveness in covering the marginalised population during the COVID-19 pandemic. Four divisions even got less than 40% scores, which include Rangpur (34.05%), Khulna (38.07%), Dhaka (39.16%) and Rajshahi (39.97%).

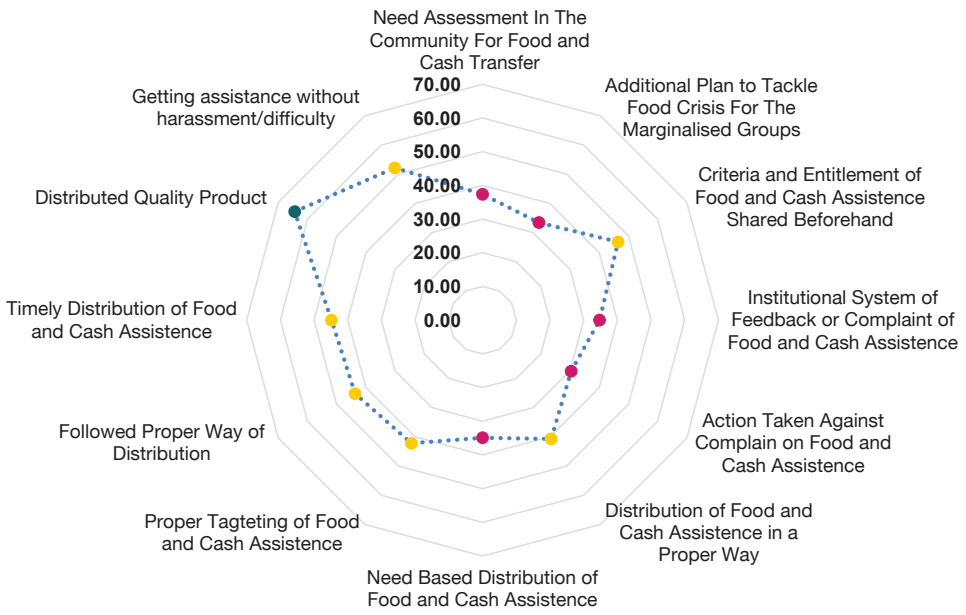
Figure 3: Division-wise scores on the performance of food and cash distribution (percentage of scores)



Participation of marginalised people and accountability mechanisms got poorer scores in food and cash assistance: The sub-indicator-wise national average scores in food and cash distribution show that accountability mechanism in cash and food distribution got the lowest scores. For example, the sub-indicators related to accountability mechanism such as action taken against complaints on food and cash assistance and institutional system of feedback or complaints against food and cash assistance in place got 30-35% scores. Moreover, needs assessment, additional planning for the marginalised groups and needs based distribution of cash and food distribution among the marginalised groups got the poorer scores (34-38%).

Proper targeting and distribution were not satisfactory: Proper targeting and distribution of food and cash assistance among the marginalised groups, timely distribution of food and cash assistance and information sharing about the criteria and entitlements also got less than 50% scores. However, quality of products was certified as higher as it scored between 60-70%.

Figure 4: Sub-indicator wise average scores of food and cash distribution during COVID-19 pandemic

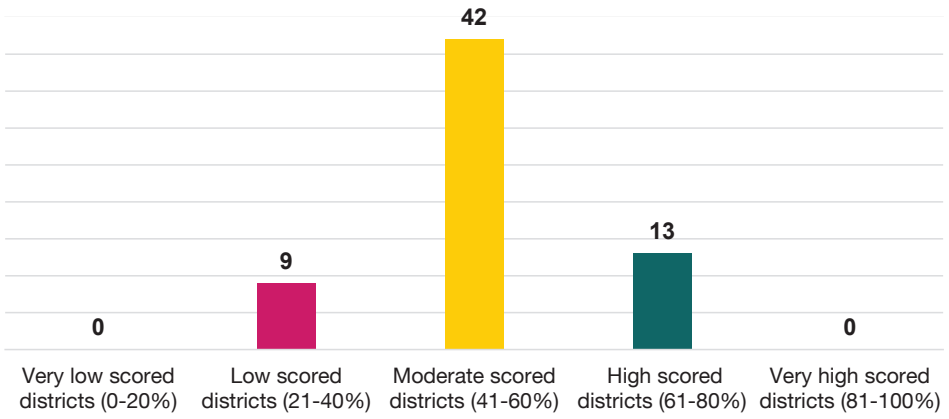


3.2 Health services during the COVID-19 pandemic

Two-thirds of districts got moderate scores while one-fifth got high scores in providing health services: The scorecard on health services during the COVID-19 pandemic suggests that no district got either very low or very high scores. Around two-thirds of districts got moderate scores (41-60%) while only one-fifth of the districts (13 districts) got high scores (61-80%). However, nine districts got low scores (21-40%). In terms of ensuring inclusive health services Norail (30.18%), Nilphamari (30.18%), Feni (30.91%), Tangail (35.64%) and Munshiganj (35.64%) are the five districts that scored the lowest. Gaibandha (36.10%), Rangpur (39.09%), Narsingdi (39.27%) and Thakurgaon (39.39%) also fall under the category of low scored districts in providing health service to marginalised people during COVID-19 pandemic (See the details in Annex 2).

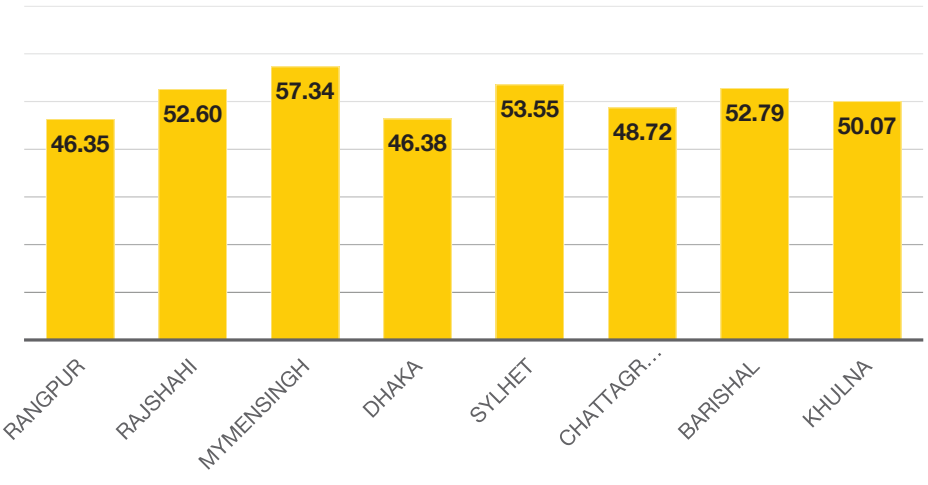
On the other hand, the high performing districts in terms providing health services to the marginalised people include Netrokona (78.18%), Chuadanga (69.82%), Jhenaidah (65.45%) and Chapai Nawabganj (64.00%) (See the details in Annex 2).

Figure 5: Distribution of districts based on their scores in health services during COVID-19 pandemic (number of districts)



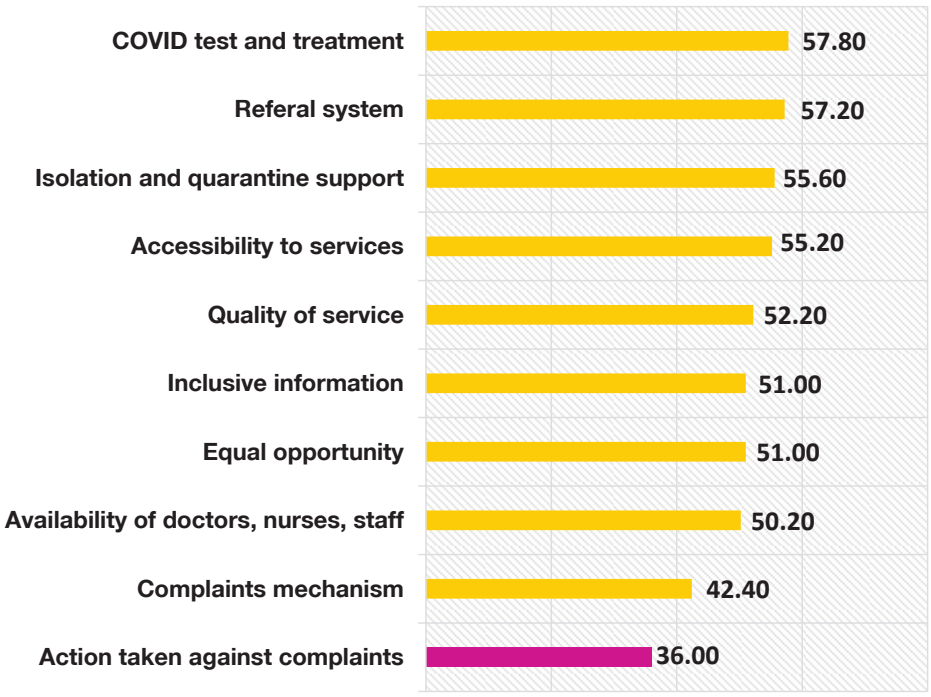
Division-wise scores are around 50% on health related services for the marginalised people: If the scores are distributed according to the administrative divisions, Rangpur, Dhaka and Chattagram divisions got the lowest scores (less than 50% scores) (see the Figure 6). It means that the marginalised people were not satisfied with the health services that they received from the government hospitals during the COVID-19 pandemic. Rest of the five divisions got marginally more than 50% scores in this regard. However. Mymensingh division got the highest scores (57.34%).

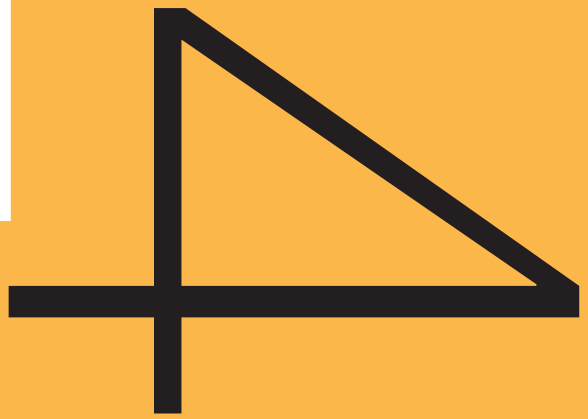
Figure 6: Division-wise scores in health services for the marginalised people



Accountability mechanism, availability of doctors, nurses, information and equal opportunity got very poor scores in providing health services to the marginalised people: The analysis shows that the sub-indicators which got the lowest score among the low scored districts are inclusive information on health, institutional complaint mechanism in health centres, equal opportunity in health centres, action taken against complaints and quality of the health services. The score for these indicators hover around 1-2 (0-40%) which translates to very dissatisfied to dissatisfied. Among the high scored districts the indicators that got low scores are institutional complaint mechanism in health centres and action taken against complaints.

Figure 7: Sub-indicator wise average scores of health services during COVID-19 pandemic





Discussions

4. Discussions

4.1 Gaps in low scored districts

In terms of providing inclusive food and assistance to the marginalised people, the five low scorer districts are Norail (20.00%), Rangpur (20.42%), Nilphamari (22.00%), Feni (25.56%) and Bogura (25.83%). On the other hand, Norail (30.18%), Nilphamari (30.18%), Feni (30.91%), Tangail (35.64%) and Munshiganj (35.64%) are the five districts that scored the lowest in terms of providing inclusive health services for the marginalised people.

Some qualitative inquiries suggest that there were some gaps in providing food and cash assistance to the marginalised people living in these districts when they needed during the pandemic. A group of ethnic minorities in Narail stated that they got only five kilogram rice and one kilogram potato for twice during the lockdown period and no further assistances were given to them during the pandemic. Moreover, no government officials went to their community to assess their needs during the lockdown situation. Some other groups in Narail such as river gypsies, beggar and dalits also brought the allegations that they were not provided with any food or cash assistance during the lockdown. The river gypsies' community expressed that during the lockdown they had to go through starving for days. Even after the lockdown, they failed to get work like they used to get before. The dalit and ethnic minority people who worked in barber shop or worked as rickshaw or van pullers suffered the most as they had to shut their work and at the same time they did not get any food or cash assistance and they had to use most of their savings during the crisis period.

A group of persons with disabilities in Narail complained that they got 10 kg rice only and no other assistance went to their door during the lockdown period. They also argued that they had no special cards for their disability to get the assistance.

A group of dalit community of Narail alleged that they were given hope by the local government representatives that they would be provided with 2,500 taka each as social safety net support and took 50 taka charge from all of them. Photo copies of their national identity cards were also taken from them and asked to open Bkash account so they could receive the money. However, they were not provided with any assistance till the data collection date.

A group of people living in the hard-to-reach area of Rangpur stated that the support of food or any kind of similar assistance was absent in their localities. They also complained about the price hike of essential medicine during the lockdown situation. They also complained that the working doctor in government hospital did not provide proper treatment. Moreover, any type of complain was ignored during that time. A group of persons with disabilities from Rangpur district expressed that they found no treatment

for any severe disease during the lockdown situation. Authority in upazila health complex carelessly referred every patient to the Rangpur Medical College Hospital.

A group of persons with disabilities in Rangpur also expressed of low quality of food assistance that they were provided. They said that they were provided with only three kilogram of rice, however, that was of lower quality. They also alleged that people needed to bribe to get the assistance from members or chairmen of union parishads.

According to a group of an ethnic minority people in Rangpur, they were not provided with any kind of food or cash assistance during the pandemic. They also expressed that the doctors in the government hospitals showed discriminatory behaviour with them. During the lockdown period they were suspected to be the carrier of the coronavirus and therefore, they were avoided when they went to them for treatment.

A group of dalit community people in Rangpur expressed that they did not see any chairman or member of the union parishad to look into their needs during the lockdown situation. A group of senior citizens living on begging also stated that they were provided with no assistance by the chairman or members.

A group of Garo community in Tangail district stated that they were provided with a very less amount of food. In a group discussion, out of 10 Garo people only three people stated that they got the assistance properly.

A group of sex workers in Tangail expressed that they were neglected and harassed when they were asking for health and food facilities during the lockdown situation. Some sex workers did not get any chance to get enlisted in the food assistance as they did not have any national identity card. A group of hard-to-reach char people in Tangail district stated that they did not get food assistance according to their needs and the foods that they were provided with had poor quantity. They further indicated that only the people who had good relation with the chairman and members got the food and cash assistance without any harassment.

A group of senior citizens living on begging in Narsingdi stated that they were provided with five kilogram of rice for twice, which was not sufficient to meet their needs during the lockdown situation. A group of dalit people in Narsingdi informed that they went to the government hospital for treatment but they were referred to the private clinics. However, they could not get the treatment as they did not have money to bear the cost in a private clinic.

However, what the concerned government authorities stated about the services does not match with the lens of the marginalised people. For example, one of the health authorities of Rangpur Medical College Hospital stated that there is no discrimination towards the marginalised communities in terms of providing health services. However, he pointed out some challenges to provide adequate services to the people, which include inadequate manpower, inadequate technology, and management constraints.

Some authorities expressed that the marginalised people are not well aware of the system of taking treatment from the public hospitals. For example, a medical officer at the Barisal Medical College Hospital told that marginalised people had a tendency of not admitting in the hospital rather they preferred to take only outdoor treatment. An executive officer at Sreemangal Upazila Health Complex mentioned that there is a lack of awareness among the marginalised groups about the facilities provided by the health complexes.

An UNO in Nilphamari claimed that with the help of the leader of transgender and dalit community and the president of the Harijan community, the list of food assistance was made and assistance was provided accordingly. However, he agreed that there was not any formal complaint mechanism in place. A concerned official in Rangpur also claimed that food assistance along with cash assistance had been provided in Rangpur district without any discrimination. In Rangpur, the list of the target group was created through the supervision of the UNOs, chairperson, ward members and different political parties. The time, place and date of distribution had been provided to the marginalised people before the distribution. However, she shared the information that there was no system of filing any written complaints. He further informed that the main challenge of distributing food and cash assistance was the absence of proper targeted list of the marginalised groups.

4.2 Good points in high scored districts

As the government is trying to create an inclusive society there is a reflection of it in providing health service and food-cash assistance during pandemic in some of the districts. As perilously the low scored districts were mentioned, so here are some of the high scored districts which implies that they got enough assistance from the service providers and also the level of corruption and deprivation were found to be less in those districts. The districts are Jhalokathi, Jhenaidah, Brahmanbaria, Netrakona and Chuadanga.

A group of hard-to-reach char people in Jhalokathi district informed that during the lockdown they received usual level of treatment from the public hospitals. They had the access to the corona test and there were taken necessary arrangements for their isolation and quarantine on time. The char people in Jhalokathi also claimed to have necessary assistance regarding food from the government. They also mentioned that the amount of food and food quality was good. A group of persons with disabilities in Jhalokathi also got the inclusive arrangements for their health and food services like the char community. The river gypsies also stated that they got some assistance such as medicine and food assistance during the lockdown situation.

A group of senior citizens living on begging in Jhenaidah informed that they got food assistance during the lockdown with a satisfactory amount. A dalit group also stated that they got food assistance during the lockdown and they had the accessibility in the public hospitals as well.

An elderly group living on begging in Bramhanbaria stated that during the lockdown they got some foods and free medicine from the elected members and the quality of food was good. A group of river gypsies in the same district informed that each of their families got one thousand taka before the Eid festival from the local MP. They also got good amount of food assistance during the crisis period. A transgender group in Bramhanbaria also informed that they got good amount of food assistance.

The authority of Jhenaidah Government Hospital stated that they ensure accessibility in different ways. For example, they create separate line for the persons with disabilities, children and women. As they stated there is no discrimination regarding providing health service to the marginalised people. At the front door of the every doctor there is a label that reads “anyone can come to visit them without any appointment”.

A concerned upazila level officer in Jhenaidah stated that both governmental and non-government agencies took necessary and timely steps for the distribution of food and cash. He further stated that with the help of Union Parishads and human rights activists, the food assistance had been distributed in Jhenaidah. They monitored the distribution process. There was a separate box for receiving complaints at the union level. Most of the complaints were about people did not get enough food or the foods got finished.

05 Conclusion

5. Conclusion

The main objective of conducting the score card exercise in all the districts was to bring about the actual scenario of the struggle faced by the marginalised communities during the pandemic in terms of getting health and social safety net packages. The exercise suggests that most of the districts got medium scores in providing food-cash assistance and health services to the marginalised peoples during COVID-19 pandemic. Only a few districts got high scores indicating some good points that the local administration and government in those districts were sensitive towards the marginalised communities. In some cases, they consulted with people and assessed their needs and met them.

However, in most of the cases, the participation of marginalised communities in the needs assessments i.e. consultation with them about their needs did not take place during the pandemic. Moreover, in most of the cases, the accountability mechanism was not in place, which was clearly understood in both of the study focus—food-cash assistance and health services. In absence of the accountability mechanism, the marginalised communities did not have scope to lodge any complaint to any authority. These people are passive by nature, therefore, if the nature of the services and assistances are not inclusive for them by default, it is obvious that they will always be excluded. It is therefore a crying need to help them raise their voice on the one hand and on the other hand, the design of providing the services and assistances should be inclusive especially if they are designed for any emergency situation.

It is now a paramount duty of the government and other stakeholders to thoroughly look into the loopholes and flaws of the system which are excluding the marginalised people from getting the public services and to take proper policies and plans to ensure inclusiveness for all with transparency and accountability.

Recommendations

6. Recommendations

By discussing with the participants of the marginalised communities, the service providers i.e. the government officials, some recommendations have been proposed below for developing inclusive services and assistances for the marginalised communities:

1. A targeted approach for the marginalised and most vulnerable groups should be taken to provide clear, accessible, frequent, gender sensitive, and child friendly health service information and tailored to the dialect of the region. A clear guideline should be disseminated from DGHS to all the community health clinics, Upazila health complex to set up community centric information booth.

2. As there is still stigma while attending patients from marginalised groups such as dalits, transgender, bede, persons with disabilities etc., all health workers should be given sensitisation training and it should be held twice a year to ensure equal treatment for all irrespective of race, sex, age, religion/caste and disability which is the main goal of the Health Policy 2011.

3. The Government needs to focus on developing the capacity of health human resources. There should be recruitment of health workers from the marginalised communities so that availing health services could be more flexible for the marginalised groups.

4. The findings of the report suggest that the accountability mechanism is not well functioning in most of the public hospitals, community clinics and health complexes. There should be district-wise hotline number which will take all the complaints and respond immediately. There should be a monitoring mechanism that will ensure the effectiveness of the hotline.

5. Health card should be introduced for the ease the priority access in health services so that everyone gets the opportunity to avail treatment.

6. Mapping/census should be conducted on floating population/street dwellers, river gypsies and people living on begging and unauthorised sex workers to identify the location and number of these people which will help to organise needed healthcare and other services in a coordinated manner by the public and non-state sectors, complementing and supplementing each other.

7. A nation-wide need assessment of the marginalised groups should be conducted by the Ministry of Social Welfare to identify the ways to address the challenges during and post COVID-period. Since most of the participants of this study reported that no or not sufficient stimulus or cash assistance were given to them or the amount was very negligible, the government should take into account to mitigate their struggle by introducing a welfare package for the marginalised groups. The welfare package can be consisted of age-wise vocational training, cash assistance/ stimulus and sensitisation through media and workshop to the service providers. Also to collaborate with non-state actors and NGOs to reach to these vulnerable groups for bringing them to the mainstream.

Annexure

Annex 1: District-wise scores on food and cash distribution during COVID-19 pandemic

Sl.	Name of districts	Scores (Percentage)
1.	Jhalokathi	67.33
2.	Barishal	65.67
3.	Brahmanbaria	65.67
4.	Netrokona	59.00
5.	Lakshmipur	58.00
6.	Bagerhat	56.33
7.	Cox's Bazar	55.33
8.	Shariatpur	55.28
9.	Meherpur	55.00
10.	Rajbari	54.44
11.	Bhola	54.17
12.	Pirojpur	52.67
13.	Sherpur	52.00
14.	Moulvibazar	51.67
15.	Faridpur	51.33
16.	Chapai Nawabganj	51.00
17.	Khagrachhari	49.44
18.	Patuakhali	48.57
19.	Cumilla	47.50

20.	Kishoreganj	**47.00**
21.	Natore	**46.67**
22.	Rangamati	**46.33**
23.	Rajshahi	**46.25**
24.	Naogaon	**45.33**
25.	Thakurgaon	**45.00**
26.	Chuadanga	**44.00**
27.	Joypurhat	**42.67**
28.	Sunamganj	**42.33**
29.	Gaibandha	**42.14**
30.	Mymensingh	**40.67**
31.	Gopalganj	**40.33**
32.	Barguna	**40.28**
33.	Jamalpur	**40.24**
34.	Panchagarh	**40.00**
35.	Madaripur	**40.00**
36.	Sylhet	**40.00**
37.	Narayanganj	**38.57**
38.	Lalmonirhat	**38.00**
39.	Khulna	**38.00**
40.	Chandpur	**37.67**
41.	Bandarban	**37.33**
42.	Magura	**37.00**
43.	Dinajpur	**36.94**
44.	Gazipur	**36.43**

45.	Chattogram	**36.39**
46.	Jashore	**36.33**
47.	Dhaka	**36.33**
48.	Jhenaidah	**34.67**
49.	Noakhali	**34.67**
50.	Sirajganj	**34.33**
51.	Habiganj	**33.00**
52.	Satkhira	**31.00**
53.	Narsingdi	**29.00**
54.	Kushtia	**28.33**
55.	Kurigram	**28.00**
56.	Pabna	**27.67**
57.	Manikganj	**27.08**
58.	Tangail	**27.00**
59.	Munshiganj	**26.33**
60.	Bogura	**25.83**
61.	Feni	**25.56**
62.	Nilphamari	**22.00**
63.	Rangpur	**20.42**
64.	Norail	**20.00**

Annex 2: District-wise scores on Health Service during COVID-19 pandemic

Sl.	Name of districts	Percentage
1.	Netrokona	78.18
2.	Chuadanga	69.82
3.	Jhenaidah	65.45
4.	Lalmonirhat	64.36
5.	Chapai Nawabganj	64.00
6.	Panchagarh	61.82
7.	Naogaon	61.82
8.	Rangamati	60.73
9.	Cox's Bazar	60.73
10.	Natore	60.36
11.	Sylhet	60.00
12.	Barishal	60.00
13.	Jhalokathi	60.00
14.	Meherpur	59.27
15.	Rajbari	58.18
16.	Sherpur	57.82
17.	Bagerhat	57.45
18.	Bhola	56.82
19.	Khagrachhari	56.67
20.	Madaripur	56.36
21.	Moulvibazar	56.36
22.	Sunamganj	54.91

23.	Faridpur	**54.91**
24.	Narayanganj	**54.29**
25.	Joypurhat	**53.09**
26.	Sirajganj	**52.00**
27.	Dinajpur	**51.82**
28.	Lakshmipur	**51.27**
29.	Pirojpur	**50.55**
30.	Kishoreganj	**49.45**
31.	Chattagram	**48.48**
32.	Kurigram	**48.00**
33.	Brahmanbaria	**47.64**
34.	Jamalpur	**47.53**
35.	Potuakhali	**47.53**
36.	Shatkhira	**46.55**
37.	Noakhali	**46.55**
38.	Bandarban	**46.55**
39.	Sariatpur	**46.06**
40.	Kushtia	**45.82**
41.	Mymensingh	**45.82**
42.	Rajshahi	**45.00**
43.	Jessore	**44.73**
44.	Gazipur	**44.68**
45.	Manikganj	**44.09**
46.	Pabna	**43.64**
47.	Cumilla	**43.64**

48.	Habiganj	**42.91**
49.	Gopalganj	**42.91**
50.	Chandpur	**42.73**
51.	Borguna	**41.82**
52.	Dhaka	**41.45**
53.	Magura	**41.09**
54.	Bogura	**40.91**
55.	Khulna	**40.36**
56.	Thakurgaon	**39.39**
57.	Narsingdi	**39.27**
58.	Rangpur	**39.09**
59.	Gaibandha	**36.10**
60.	Munshiganj	**35.64**
61.	Tangail	**35.64**
62.	Feni	**30.91**
63.	Nilphamari	**30.18**
64.	Norail	**30.18**