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Poverty, Protection and Exclusion in Rural Bangladesh

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Acronyms and Abbreviations

CFPR-TUP	Challenging the Frontiers of Poverty Reduction-Targeting the Ultra Poor
PESP	Primary Education Stipend Programme
SSNP	Social Safety Net Programmes
VGD	Vulnerable Group Development
VGF	Vulnerable Group Feeding
UP	Union Parishad
UNO	*Upazila* Nirbahi Officer
MP	Member of Parliament
BRC	Birth Registration Card
KII	Key Informant Interview
FGD	Focus Group Discussion
IDI	In-Depth Interview
IPT	Interactive Popular Theatre

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Abstract

Social protection is one of the key strategies of fighting against long-lasting and intergenerational poverty in Bangladesh. The concept has significantly evolved both in scale and scope in recent times. Targeted pro-poor interventions in public services and safety net programmes have been scaled up. However, access to institutions is an issue of grave concern especially for poor people. Although, recent years have witnessed almost 100 per cent school enrolment, drop out rate is still high especially among the ultra poor children. Advocacy is BRAC's latest tool to address the critical issues of accessibility and utilisation of resources by the ultra poor. Looking at social protection interventions through the conceptual lens of 'social exclusion', this study seeks to understand how and why the poorest face constraints in gaining access to public services and entitlements, and why the ultra poor children discontinue regular schooling and drop out from primary education. Built on a mixed method approach, the study identifies a number of important mechanisms through which the poorest are excluded from their entitlements. There are a number of mediating processes through which they are included, but allegedly often in the elites' terms and conditions. Besides, the study highlights a number of critical factors that force children to discontinue schooling.

1. Introduction

Social protection is one of the key strategies of fighting against persistent and intergenerational poverty in Bangladesh. The concept has significantly evolved both in scale and scope in recent times. Particularly, the targeted pro-poor interventions in public services and safety net programmes have been scaled up. However, though the pro-poor social protection programmes have largely been successful in improving the economic well-being of extreme poor households, they were very effective in linking these households with regular government and non-government services. These services (e.g. health, education) are essential for the poor to sustain and build on their economic achievements, and get out of the cycle of poverty and social exclusion that they are trapped in. Advocacy is BRAC's latest tool to address the critical issues of accessibility of the ultra poor households to different public services.

Looking at social protection interventions through the conceptual lens of 'social exclusion', this study seeks to know the ultra poor's level of access to public services, constraints in accessing the services and reasons behind the ultra poor children's dropping out of primary education. Based on a combination of quantitative and qualitative approach, the study diagnoses the ultra poor's level of access to public services, and identifies a number of important mechanisms through which the poorest are excluded from their entitlements, and also a number of mediating processes through which they are included.

1.1 Impressive achievements but daunting challenges

Bangladesh's success in poverty alleviation drew global attention. By reducing its ultra-poverty rate from 34.3% in 2000 to 17.6% in 2010, the country has strongly responded to the number one target of Millennium Development Goals (MDG) of halving extreme poverty rate (BBS 2010). In the health indicators such as life expectancy, fertility rate, and infant and under-5 mortality rate Bangladesh performed better than other South Asian countries (Chowdhury *et al.* 2013). Bangladesh has also been able to widen the access to primary education. Besides, gender equity in both primary and secondary education has been achieved well before the year 2015 as set in the MDG (World Bank 2013). Due to constant agricultural growth which was largely contributed by the small holders; the country could successfully emerge from the shadow of famine and hunger (Hossain and Bayes 2009).

However, on the flip side, poverty is still widely prevalent. The official statistics reflect that the people living below poverty line are about 26 million people, or 6 million families (BBS 2010). About 41% of children under the age of five suffer from moderate to severe malnutrition which is a leading cause of stunting for the said age group (Hubbard 2003). Country's malnutrition rate is still one of the highest in the world. Due to poverty, many children are dropped out from the school at the early

age, and about 5 million children are bypassed schooling because of the inability of the vulnerable households to enrol their children (World Bank 2013). The major challenges, which include, among others, eradication of extreme poverty by 2022 and attainment of universal healthcare by 2032, are daunting and multifaceted.

1.2 Social protection discourse: from 'protection' to 'transformation'

Social protection is usually known as the typical European social system which addresses the risks and vulnerabilities of the poor and near-poor households, and implemented through the publicly-mandated policies and programmes (Babajanian and Hagen-Zanker 2012). Nowadays, while many European welfare states are slimming down public funds for social protection, the need for and practice of social protection measures are growing exponentially in developing world. Barrientos and Hulme (2009) perceives this as a 'silent revolution'.

During the mid-2000, the concept of social protection has evolved from the conventional crises-centred protectionist approach towards more development focused system built on the promotional approach, which implies that social protection must not only meet the basic needs of the people, it should also develop the capacity to breakout from poverty and promote long-term well-being (Rahman and Chowdhury 2012). Lately, the social protection system had started to receive more distinctive views which underlined the significance of transformative potential of the social protection, and highlighted the broader goals of equity, social justice and empowerment. This concept advocates that social protection should be able to empower the poor and protect their rights (Sabates-Wheeler and Devereux 2008). This may include addressing regulatory frameworks that protects against discrimination, sociocultural issues that heighten women's vulnerability, or customs and behaviours that generate stigma.

1.3 Social protection in Bangladesh

The concept of social protection system has advanced extensively in Bangladesh. This has progressively attained the centrality in the national poverty reduction strategy. The concept has been gradually transformed over the past few years, and expanded to integrate strategies to tackle heterogeneity in vulnerability, prioritise underprivileged geographic locations, combine interventions protecting basic level of consumptions among poor and poorest households, facilitating investment in human capital and other productive assets, and generating income with the aim of exiting from the persistent and intergenerational poverty (Kabeer and Mahmud 2009; Rahman and Chowdhury 2012).

However, its significance in the policy framework of Bangladesh should not be seen exclusively as an effect of international donor discourse, but as a political process whereby the welfare responsibilities of the state have come into sharper focus (Rahman and Chowdhury 2012). Consequently Bangladesh has been experiencing a steady scaling up of targeted pro-poor interventions in public services and safety net programme.

1.4 Institutions, inaccessibility and drop outs

There are evidence that social protection interventions can address the causes of exclusion and reach socially marginalised groups if designed efficiently (Kabeer 2008). Access to institution, however, is an issue of grave concern. A DFID funded study focused that the quality of institutions and governance are the prime influencing factors that will determine the success of poverty reduction in Bangladesh (Duncan, *et. al.* 2002). A BRAC initiated study has identified the practice of corruption in the beneficiary selection process and in the distribution of safety net benefits (Hossain and Zahra 2008).

Rahman and Islam (2002) projected how patron-client relation is reworked out through the operation of social safety nets within the context of local government institutions. Research also reveals practical issues such as, unavailability of ultra-poverty related data or lack of coordination among different ministries/departments, duplication of efforts, wastage of limited resources etc. which can critically influence the accessibility of the poorest to their 'entitlement social transfers' (Khatun *et al*. 2011). An ethnographic study of a public hospital offers deep insight into the social hierarchy and incidents of everyday physical and structural violence that take place in public health service delivery institutions in Bangladesh (Zaman 2005).

The manifesto for the extreme poor reminds us that active and constant measures are required to overcome the constraints that the poorest face in getting access to services. Remarkably, the social protection programme in education sector is less known for corruption or inefficiency; instead, it is widely credited for impressive enrolment rate.

However, school drop out remains as an issue that concentrates among the ultra poor population group. The baseline survey data of BRAC's ultra poor programme reflected that, while the enrolment rate among the 6-10 years aged boys of the ultra poor households does not differ greatly with the enrolment rate among the non-poor (74% against 89%), but the corresponding proportion among 11-15 years aged boys indicates a pattern of drop out (38% against 79%) among boys from extremely poor households (Sulaiman 2009).

1.5 BRAC's response and overview of APUP project

BRAC has been working vigorously in the critical frontiers of local governance, both at supply and demand sides, in the form of capacity development of duty bearers and service providers at one hand, and nationwide grassroots campaign among right holders through community based organisations like *Polly Shomaj* on the other hand. Advocacy is its latest tool to address the critical issues of accessibility to public services and minimizing school drop-out among the ultra poor. BRAC Advocacy for Social Change has introduced a new project titled Advocacy for Access Promotion of the Ultra Poor (APUP) which has already been translated into action in Naogaon, Rangpur, Sunamganj and Khulna in 2013 for a period of two years with the aim of promoting enabling environment for the ultra poor in accessing government services

(Health, Education, Livestock and SSNPs) and enhancing regular attendance of the ultra poor children in primary education.

The aim of this project is to mobilise relevant stakeholders for enhancing regular attendance of the ultra poor children in primary education and increasing accessibility of the ultra poor to public services. This is a pragmatic effort to reduce the ultra poor drop-out rate from schools and to facilitate their access to different services. The project is operating in above mentioned four districts from 2013 to 2015. Advocacy programme works in those areas where CFPR-TUP (Challenging the Frontiers of Poverty Reduction-Targeting the Ultra Poor, initiated in 2002) programme[1] exists.

1.6 Project implementation strategy

The project is being implemented by disseminating reports about the current situation of the ultra poor in regard to the public services in the projected areas to relevant stakeholders as a means of raising awareness. Arranging meeting with policymakers and relevant stakeholders to increase participation and accountability among relevant duty bearers, and to sensitize them about rendering special attention to public service delivery for the ultra poor is another vital component of the implementation strategy. Building awareness among the ultra poor communities, school management committees, school teachers and broader community people by arranging follow up meetings, Interactive Popular Theatre (IPT) shows etc. to minimise gap between public services and the ultra poor. And thereby, reducing school drop-outs has also been treated as an inseparable constituent of the strategy.

1.7 Expected outcomes of the project

Expected outcome of the project is to engage relevant duty bearers and policy implementers at the national and sub-national level to give special attention, and thus become more responsive to the schooling of the ultra poor children. The outcome of the project is also intensifying government services related to education, health, livestock and SSNPs for the ultra poor. Another expected outcome of the project is to advice the ultra poor communities about the importance of regular schooling, and existing public services related to health, livestock and SSNPs.

[1] For further details of the CFPR_TUP programme please see Ahmed *et al.*, 2009.

2. Objectives and analytical framework

Keeping in mind BRAC's intention to explore why the ultra poor remain unable to access Government services, this study has been conducted to address very specific research questions. Along with the objectives, a conceptual framework has also been presented in this chapter.

2.1 Objectives of the study

The broad objective of this study is to analyse the current situation and identify major obstacles of the ultra poor in accessing public services (Education, Health, Livestock and SSNP).

Specific objectives: To achieve the above mentioned broad objective, the study aims to answer some specific research questions:

1. What are the levels of accessibility of the eligible ultra poor to different government services (education/health/livestock/SSNP)?
2. Why and how do the poorest face constraints in getting access to public services and their entitlements?
3. What are the mediating processes through which the poorest get access to public services and their entitlements?
4. Why do the ultra poor children discontinue regular schooling and drop out from primary education?
5. What is the level of knowledge and awareness about the importance and eligibility criteria of different services among both service receiver and implementer?
6. What are the limitations that the service providers face and what would motivate duty bearers to facilitate better services towards the ultra poor?

2.2 Conceptual framework: exclusion from protection

In this study, 'social exclusion' has been used as an analytical framework through which we intend to know the ultra poor's level of access to public services, constraints in accessing the services and reasons behind the ultra poor children's dropping out from primary education. The study critically diagnoses the ultra poor's level of access to public services and identifies a number of important mechanisms through which the poorest are excluded from their entitlements, and also a number of mediating processes through which they are included.

2.2.1 Concepts of social exclusion and multi-dimensional poverty

'Social Exclusion' emerged as a concept from the European policy discourse during the last decades of 20th century to identify why some groups do not benefit equally from the state services, or remain deprived (Silver 2007a). The application of the concept began after the 1994 Social Summit focusing on the issues of poverty, inequality and social justice in the context of developing countries. Since then different forms of disadvantage have been identified across the developing world and conceptualised in various ways in different disciplinary domains (Kabeer 2006).

Simultaneously, there has been a growing understanding among scholars and practitioners that the causes, manifestations and consequences of poverty are multidimensional. The heterogeneity within the category of poor and the intersection of resource deficits with other kinds of inequality in extreme forms of poverty were also identified. Poverty and inequality are also viewed by the researchers as an effect of historically developed economic and political relations, social categorization and identity formation such as gender, physically challenged or ethnic minorities etc. (Mosse 2010).

2.2.2 Integrating insights from different paradigms of exclusion

Given that the characterisation of poverty has progressed considerably from earlier income-based approaches to a greater recognition of its multidimensionality, Kabeer (2006) explains what else the concept can add to the understanding of poverty. She argues that the analytical value addition of the concept lies in integration of insights from different paradigms of disadvantage. Even though poverty is increasingly recognised to be a multi-dimensional phenomenon, it nevertheless continues to be causally interpreted within economic theories. In this respect, disadvantage is an outcome of what they have. Income or assets measurement based analysis of poverty as in resource-based paradigm gives rise to a 'vertical' model of inequality (Stewart 2000).

Sociological paradigm, on the other hand, pays greater attention to identity-based forms of disadvantage. The identity in question may relate to distinct and bounded groups of people who are characterised by their distinct cultural practices and shared way of life. Caste, ethnicity and religion are examples of such group identities. Here disadvantage originates from *who they are*, or rather, *who they are* perceived to be. Processes of cultural devaluation through the construction of identity by dominant sections of society can serve as powerful tool of exclusion.

Group-based disadvantages give rise to what Francis Stewart calls a 'horizontal' model of inequality where the inequalities in question cut across economically defined strata and differentiate the ability of different groups and categories within society to access valued resources and opportunities (Stewart 2000).

There is another dimension to social exclusion which may not be fully captured by the interplay between economic deprivation and social discrimination, which is the spatial

one (*where they are*). Spatial disadvantage may be caused by the remoteness and isolation of a location which makes it physically difficult for its inhabitants to participate in broader socioeconomic processes. The spatial dimension of exclusion is not entirely disconnected from its resource and identity dimensions since it is usually culturally devalued and economically impoverished groups that inhabit physically deprived spaces (Kabeer 2006).

The integration of insights from different paradigms of disadvantage allows the analysis of economic deprivation to intersect with the aspects of group identity, cultural devaluation and social discrimination. In other words, poverty cannot be adequately defined by very low income alone but can include various forms of exclusion and marginality from basic services (health, education, water etc.), labour and credit markets, citizenship claims, and agreed-upon human rights provisions (Mosse 2010). The extreme poor are not 'just like' the rest of the poor, only poorer or poor for longer, but are additionally disadvantaged by 'who they are' and 'where they are' aspects which set them apart from the rest of the poor. Silver (2007b) defines social exclusion:

> *'A dynamic process that precludes full participation in the normatively prescribed activities of a given society and denies access to information, resources, sociability, recognition, and identity, eroding self-respect and reducing capabilities to achieve personal goals'.*

2.2.3 Exclusion from protection

Social exclusion, though, occurs at global, national and local levels, Kabeer (2006) explicitly contemplates, the real value added to the concept lies at the meso-level, in analysis of institution. According to her:

> ***'****Social exclusion has to be seen as an institutionalized form of inequality, the failure of a society to extend to all sections of its population the economic resources and social recognition which they need in order to participate fully in the collective life of the community. The analysis of social exclusion is thus concerned with institutional rules, relationships and processes through which resources are distributed and value is assigned in a society, focusing particularly on the mechanisms by which 'access' and recognition is granted or denied'.*

The social exclusion concept can significantly contribute to the analysis of social policy. First, it captures an important dimension of the experience of the certain groups of being 'locked-out' of participation in social life. Second, a focus on process of exclusion is a very useful way to think about social policy because it draws attention of disadvantage through the active dynamics of social interaction, rather than through anonymous processes of impoverishment and marginalisation. Babajanian and Hagen-Zanker (2012) advocate that the concept of social exclusion is a useful lens for researching and analysing the performance of social protection interventions.

3. Methodology

In addressing the research questions mentioned earlier, both quantitative and qualitative techniques have been applied in this study. Quantitative study deals with respondents' household level information mostly related to the status and perception of their access to different public services, and reasons behind exclusion from these services. Using this technique, an attempt has been made to find out the state of the access of the ultra poor, and the problems and potential remedies in accessing public services from the viewpoint of right holders/service receivers only. Qualitative technique has been designed to explore the research objectives through collecting data from both service receivers and providers.

Thus, employing these quantitative and qualitative techniques, this study provides a detailed situational analysis of the ultra poor in accessing public services prior to the intervention. After two years of intensive intervention, the impact of the programme will be studied. For any impact assessment, it needs to control for the counterfactuals i.e. what would have happened if the intervention did not take place. To control for the counterfactuals in the quantitative survey, the non-participant households from the similar communities in other districts have been surveyed as well.

3.1 Sampling technique and sample size

3.1.1 Quantitative

As stated earlier, the project operates in 120 unions of 20 *Upazilas* of four Districts- Naogaon, Rangpur, Sunamganj and Khulna. It is to be noted that Advocacy programme operates in those areas where CFPR-TUP programme exists. The programme, albeit, operates in four districts, particularly in this study, two districts (Khulna and Sunamganj) from two geographic regions have been selected at the first stage of the sampling and randomly selected10 unions from each of the intervention district. From each of the unions two villages have been drawn randomly.

Eighteen ultra poor households from each village were surveyed. Considering that one of the basic objectives in this research is to assess the impact of the advocacy programme after two years of intervention, the same number of households from other two districts have also been surveyed where CFPR-TUP programme exists, but no advocacy intervention takes place. To represent the comparable areas, two districts (Shariatpur and Moulvibazar) close to intervention districts of Khulna and Sunamganj were purposively selected. Following the similar procedure used in intervention areas, 18 ultra poor households from each village of these districts as comparison have been brought under survey. Thus, in order to comply with the study objectives, in total 1440 households from intervention (CFPR-TUP + Advocacy

project) and non-interventions (only CFPR-TUP project) areas have been surveyed. Our quantitative analyses have been conducted based on the whole sample. A brief of these discussions have been presented in the following figures:

Figure 1. Sampling and sample size (Intervention group)

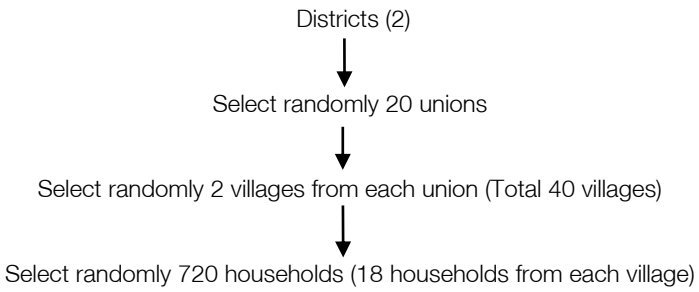
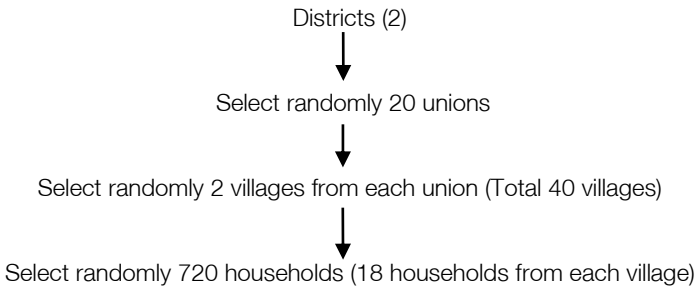


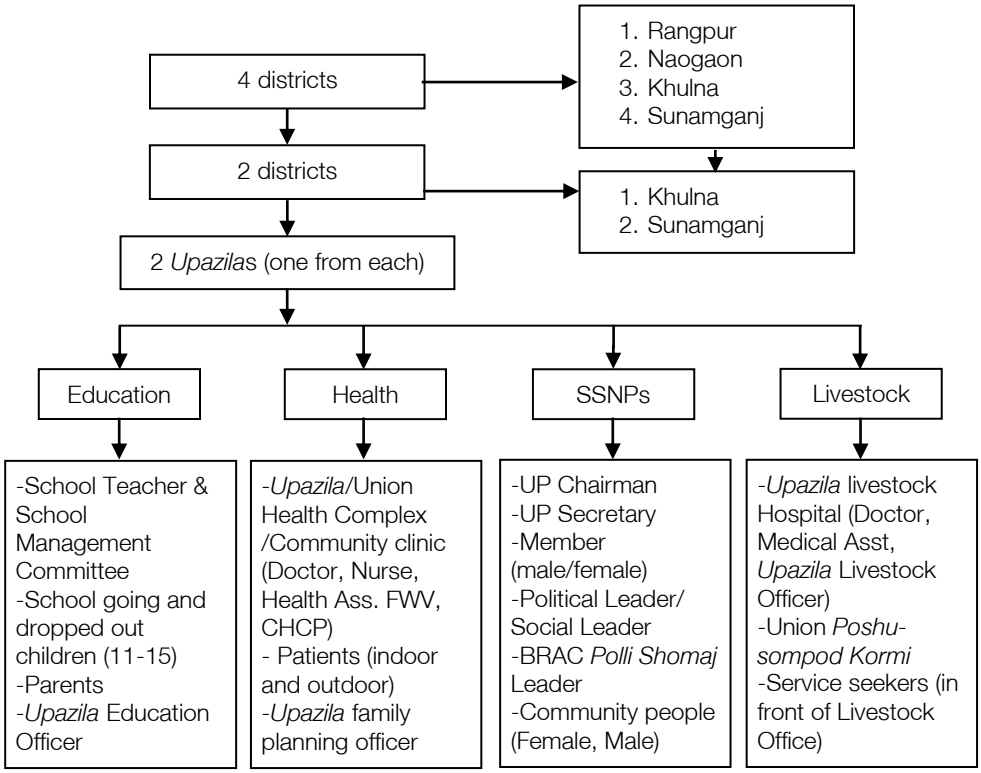
Figure 2. Sampling and sample size (Non-intervention group)



3.1.2 Qualitative

A detailed qualitative research, covering all stakeholders (both recipient and provider level), has been conducted in this study. After identification of relevant stakeholders (Annex Table A 1) related with each of four services, a representative sample have been chosen in each area of service (education/health/livestock/SSNP).The idiosyncratic characteristics (Annex Table A 2) of each area of intervention, based on socioeconomic, cultural, vulnerability, ethnographic and geographical diversity are properly analysed, and to capture the multidimensional varieties, two *upazila*s are chosen. Due to resource constraints, the study team, was not able to collect qualitative data from the north-western region. In this research, for the sake of generating qualitative data and information, different individuals and group have been selected from each component of the study for in-depth interviewing, group discussion and case studies for each of the intervened sampling area. Following figure shows the different stakeholders that have been interviewed:

Figure 3. Qualitative sampling design



3.2 Data collection and quality control measures

The Research and Evaluation Division (RED) of BRAC has conducted the survey during October-November, 2013. A total of 46 research assistants have been recruited to collect the quantitative and qualitative data. A five day long in-house training to the specifics of the questionnaire along with field testing has been provided to the research assistants to ensure efficient, unbiased and professional capture of primary data from the respondents. A semi-structured questionnaire has been used to collect information from the respondents to attain the objective of the study. The questionnaire contains regular demographic information seeking questions, close-ended (Yes/No) questions to capture certain basic information, close- and open ended questions to get information related to the ultra poor children's education and access of government services such as health, livestock, and social safety net programmes.

To maintain overall quality of the data, research assistants were strictly instructed to survey no more than four households per day, and all the completed questionnaires were cross-checked every day. In addition, random regular spot checks on the interviews were conducted by each team supervisor, field manager and survey coordinator.

3.3 Data management and analysis

The collected data ware rechecked and edited for removing inconsistency, wrong recordings and coding in the field. Before data entry, the filled up questionnaires were further checked by a separate Data Management Unit based in BRAC Head Office in Dhaka. After recording all data, distributions and ranges were examined for consistency, and extreme values and outliers and necessary corrections were made in case of entry errors. Then, the cleaned data were analysed using STATA (version 12).

3.4 The limitations of the study

Quantitative survey was conducted only among those ultra poor households who were the members of BRAC's Targeting Ultra Poor Programme (TUP). The large number of sample size helped to identify many and multifaceted dimensions of social exclusion that this populace most often experience in their lives. Nevertheless, as the non-TUP households were not the subjects of survey, some of the dimensions and extent of outcomes of social exclusion might remain underexplored. Still and all, extensive qualitative fieldwork was conducted among the non-TUP ultra poor members in order to capture their views and experiences of social exclusion. While extensive quantitative and qualitative research were conducted to explicitly understand the views of right holders, information from service providers were elicited mainly through qualitative methods such as In-depth Interview, Key Informant Interview, Focus Group Discussion and Observations.

4. Demographic characteristics

To have a definite understanding of the characteristics and status of the ultra poor households, this section analyses the characteristics of the ultra poor household members, their employment status, financial characteristics and access to basic facilities. This analysis is basically about the households under quantitative survey.

4.1 Characteristics of household members

The characteristics of household members have been presented in Annex Table A 3. The Table shows that average household size of the ultra poor is 4.43 and 26% of the household members whose age greater than 6 years are able to read and write. Results indicate that about three fourths of the ultra poor households have at least one working age male member while almost all households have at least one working age female member. In the analysis to determine the number of working age male and female members in the ultra poor households, the study found no male working members but more than one working age female members in each of the ultra poor household. It could be due to the fact that one of the targeting criteria of CFPR-TUP programme is that there must be at least one working age female members in the households.

Survey data shows that, over four-fifth of the ultra poor households have at least one member working as day labourer while around one fourth households have at least one member aged 11-17 years working as day labourer. Per capita annual income of the ultra poor household is estimated to BDT 13,382. In addition to the analysis of household members' characteristics, households head's characteristics have also been analysed (Annex Table A 4) as it directly or indirectly affects the whole family. From the data it has been found that 63% household heads are male and average age of the household head is 44 years. Nearly 12% of the household heads can read and write while an average year of schooling of the household heads are less than two years. More than 52% of the ultra poor household heads' primary occupation is day labouring while a very few proportion of household heads are engaged in farming (8%).

4.2 Primary occupation of the working aged male and female members

To get a quick understanding of the status of the ultra poor households, it is worth to have a look on the employment status of the working age group. The research highlights that most of the ultra poor male members are engaged in wage employment (46%) which is their self-reported primary occupation, while 18% are engaged in non-firm self-employment (Table 1). On the other hand, for females, it is found that household chores is their primary occupation (54%) for most of the working age females, while more than 26% are engaged in wage employment. A

very few working age male (10%) and female (4%) members are self-employed farmers.

Table 1. Primary occupation of the working male and female members aged (15-65 years)

Employment status for the working age group	Male (%)	Female (%)
Farm self-employment	9.70	3.83
Non-farm self-employment	17.58	1.79
Wage employment	46.10	26.28
Business	5.84	1.89
Service	9.99	2.15
Student	4.45	4.91
Housemaid	0.80	2.61
Begging	0.66	1.07
Household chores	-	53.58
Others (unemployed)	4.89	1.89

4.3 Self-perceived food security and economic condition

To understand the food security status of the ultra poor households, the respondents were asked to rate their households identifying this households to a particular category considering all the sources of income and items of expenditures during last one year of the study. About 21% of the households rated they faced a high food deficiency and 44% households faced moderate or occasional food deficit (Fig. 4). Surprising enough, only about 7% household enjoy the food surplus and 28% households are at optimum/break-even situation. Aggregating the first two catagories, it can be said that about 65% of the ultra poor households faced food deficit to different extents. Moreover, regarding the economic condition of households, 48% of the respondants reported that their households' economic condition has improved during the last two years prior to the study while about 10% households' economic condition has been deteriorated during same period (Fig. 5). About 42% households' economic condition during the period remained unaltered.

4.4 Physical structure of the households

The study also seeks to observe the physical structure of the households' main house and the materials used in wall and roof (Annex Table A 5). Results show that nearly 71% households have built the wall of their main house by the semi durable materials like wood, bamboo, jute stick, mud etc. and 27% have built by tin-coated iron sheets. Only about 2% households have built the wall of the main house by brick and cement. In case of roof, 88% households have built the roof of the main house by tin-coated iron sheets while about 12% households have made the *kacha* roof (inferior and cheap materials like straw, mud etc.) like straw, soft plastic sheet etc. In the construction of houses, the use of *kacha* materials symbolizes extreme poverty in village.

Figure 4. Self-perceived food security of the households

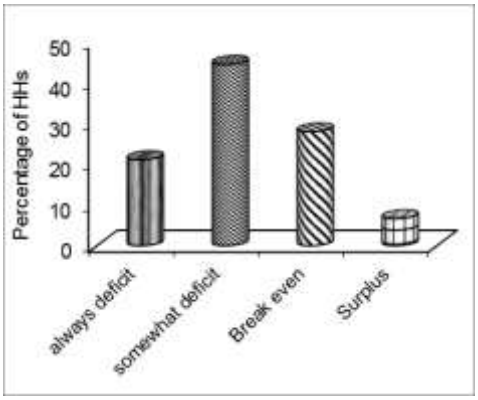
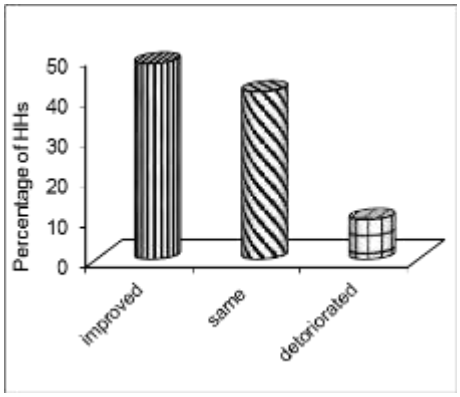


Figure 5. Households' economic condition during the last two years



4.5 Households' access to basic facilities and practices

The study makes it explicit that about 97% of the ultra poor households drink tube-well water, while 73% households of the same category use tubewell water for cooking purpose (Annex Table A 6). Only 59% of the ultra poor households, however, have the access to arsenic-free water. Data indicates that merely 16% households have access to electricity and 4% can afford to use solar panel as a source of energy. It is also observed that only 19% households are using sanitary latrine with water seal. About 83% households reported that they use soap after defecation and 97% wear sandal while using toilet.

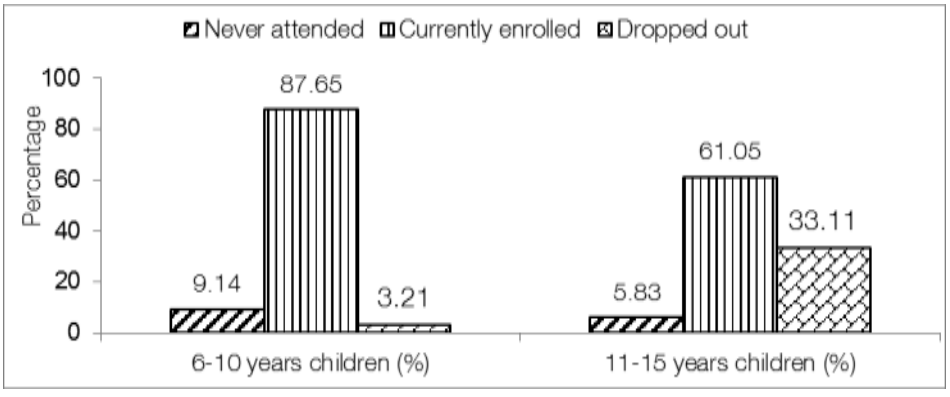
5. Results and discussion

5.1 Education

Education is an important sector where social protection has paved the way for improving the lives and livelihoods of poor people in Bangladesh. The Primary Education Stipend Programme (PESP) has been one of the key instruments to achieve inclusive primary education in Bangladesh currently reaching 7.8 million children per annum, drawn largely from poor households with cash incentives to reduce schooling cost (DPE 2013). To reduce the increasing school drop-out rate among girl students, Female Stipend Programme was introduced at the secondary level. Gradually, boys from underprivileged households were also included into Secondary Stipend Programme. Recently, Female Stipend Programme has been extended up to higher secondary level. Apart from pro-poor and gender-focused stipend programmes, school fees have been abolished and text books are distributed free of cost. Along with the government, a number of NGOs also work for inclusive education. All these sincere efforts ultimately led to remarkable achievement in primary enrolment in rural Bangladesh. Although Bangladesh has made impressive progress in increasing enrolment in primary education and achieving gender parity in both primary and secondary education, exclusion of the ultra poor children still remains an alarming issue.

The quantitative findings reflect that around 88% of the ultra poor children within the age of 6-10 years are currently enrolled in school while 9% of them never attended school and more than 3% have dropped out (Figure 6). On the other hand, 61% of the ultra poor children within the age of 11-15 years are currently enrolled in school while 6% of them never attended school and 33% have been dropped out. The drop-out rate is higher at the secondary level, the study reports.

Figure 6. Schooling status of the ultra poor children



There are three stages of exclusion of the ultra poor children from mainstream formal education. These are: enrolment, irregularity and drop out which the current study named EID model of exclusion of the ultra poor children from schooling. The discussion below explains this model and the status of poor Bangladeshi children.

5.1.1 First and foremost stage of exclusion: enrolment

Although primary enrolment is impressive to some extent in rural Bangladesh for the last decades, there still exist some exclusive reasons hindering the access to formal educational institution by the marginalised ultra poor children. Three basic exclusionary instruments that operate in this stage are discussed below:

Poverty: Poverty impedes children of the ultra poor households in continuing education. The quantitative results show that average costs of education for the ultra poor students in primary and high school for the year prior to survey were BDT 1338 and 3086 respectively (Table 2). Primary and secondary students' education costs were about 10% and 23% of per capita income respectively. Around 30% of primary and 49% of high school students are taught by private tutors where a major cost is also involved. Through qualitative exploration, it is perceived that potential cost of books, stationeries, private tuition, school uniform etc. remained as factors for exclusion of the ultra poor in enrolment and continuing schooling.

Table 2. Educational cost and status of having private tutor

Education cost and status of having private tutor	Primary students	Secondary students
Cost of education for the year prior to survey	1338	3086
% of per capita annual income	10.10	23.06
Students having private tutor (%)	29.86	48.69

Awareness: On one hand, poverty hinders accessing education by the ultra poor children, while on the other hand, the ultra poor parents' low level of awareness about the need of basic education deteriorates the situation further. Parents are still unaware about the primary enrolment age of children; consequently, more than 27% of 6-year old children are not enrolled into school yet (Annex Table A 7). Similarly, qualitative data indicate that compulsory birth registration card (BRC) in getting admission into primary school also acts as a means of exclusion since some of the ultra poor guardians are not aware of preserving it. In addition to these, it is mentionable that only 12% of the ultra poor households' heads can read and write, and their average years of schooling is only 1.03 (Annex Table A 4) which can be a strong reason behind such unawareness.

Geographical exclusion: Although average distances of the nearest primary and secondary school for children of the ultra poor households surveyed are 0.61 and 1.72 km respectively, in some cases, children of remotest areas have to travel about

3 km for primary and 10 km for secondary school on foot (Annex Table A 7). The qualitative findings leads to argue that along with geographical location, infrastructural barrier is also excluding children from enrolment, as the school authorities at times fail to accommodate all the students seeking enrolment. Quantitative findings show that around 8% students were not enrolled because of the denial of admission by the school authorities (Table 4).

5.1.2 Second stage of exclusion: irregularity

Even after publicity of the slogan 'Education for All' which resulted in the impressive enrolment for the last decade and a half,' Quality of Education' remained a big challenge. The situation further went downhill due to some irregularities at home and at school.

Irregularities at home: Though the ultra poor children's irregularity at school is more or less related with poverty, lack of awareness of their parents and some other factors cannot be ignored. These are given below:

- **Spatial constraints at home:** From qualitative exploration it has been observed that, in most of the ultra poor households, there is only a single room, especially in the *Haor* areas, and there prevails no healthy environment for study by the school going children. Moreover, watching television in the same room, frequent visitors and guests also hinder study at home.

- **Caring responsibilities to younger siblings:** Large families with infants require assistance from the school going children in taking care of their younger siblings, particularly the girls need to support their mother.

- **Helping in family task:** At only 9-10 years of age, children are expected to do domestic works and help parents in household chores. Normally, the girls help their mothers and boys help their fathers at work.

- **Lack of tutor at home:** Absence of tutor at home creates problem for some students to complete the home work. As mentioned earlier, only few students can afford private tutor, and average years of schooling of the ultra poor adults is very low, it is often tough for the students to complete the school homework. So, inability of completing the homework may also lead to irregularity.

Irregularities at school: Quantitative findings show that 43% students of the ultra poor households were absent at least one day in the week prior to the survey. Reasons behind irregularities at school are:

- **Hours of schooling:** Full day schooling makes children hungry. It is difficult for the ultra poor children to buy or arrange food during tiffin hours. This is one of the reasons for irregular schooling as either they do not go to school or take a half day off.

- **Distance and transport:** As the distance from home to school constrains children to enroll in the school, such difficulties can also cause irregularity at school as most often students have to walk to school (Annex Table A 7). Irregularities increase further during adverse weather condition or poor transportation facilities. Particularly during rainy season, irregularities increase due to poor transportation system.

- **Security and group absence:** From qualitative information it has been observed that security is one of the key concerns for female students as they are afraid of harassments on the way to school. In order to avoid such situation, female students prefer to go to school in a group. However, absence of one or two of the group members at times makes the group absent.

- **Disincentive generated from non-inclusion in stipend:** It is well known that all the students cannot be covered under the stipend programme. Non-inclusion under the coverage of stipend works as a disincentive for excluded students which lead to irregularity in some cases. Qualitatively, it has been perceived that in a family if there are two students and of them only one receives stipend, then the other one becomes irregular, discouraged either by himself/herself or by the family. Besides, some students and guardians complain about the irregularities in selecting beneficiaries for stipend.

- **Fear at school:** Fear of Mathematics and English, and fear of corporal punishment is also a reason of irregularities. In addition to these, failures or repeated failures in a class, resulting readmission discourage students as well as family to continue regular schooling.

- **Family priority of education:** It is a very crucial factor that hampers children's regular schooling. In the social context of Bangladesh, especially in rural the ultra poor households, children work as helping hands to their parents. The study also found that parents mostly decide who should go to school and who should help the family. In most of the cases, a child who is skilled in helping family works is likely to be taken away from education.

5.1.3 Third and final stage of exclusion: drop out

Drop-out is the outcome of irregularities and some other socioeconomic constraints. At this final stage, five dimensions of exclusion from education have been identified. These are discussed below:

Poverty: About one-fifth of all Bangladeshi children between the ages of 5 to 14 years work in the agricultural sector where the households' of poorest quintile share 50% of family income by child workers which reflects how poverty compels children to work (Salmon 2005). Amin *et al.* (2004) also identified that the child labour is more noticeable among the poorest households. Under this dimension the following factors are associated with higher drop-out.

- **Household size:** From quantitative analysis it appears that average household size of the ultra poor is 4.27 (Annex Table A 3) where minimum and maximum size varies from 1 to 12. There is a positive correlation between drop out and household size. Drop-out rate is high in case of large sized households, for both primary and secondary level of education (Table 3). This might be due to the fact that children of large sized the ultra poor households are more vulnerable, and in most of the cases they are forced to involve in earning activities which eventually compels them to drop-out.

Table 3. Schooling status of the ultra poor children based on household size

Indicators	Household members ≤4	Household members (5-7)	Household members ≥8
6-10 years old children (%)			
Never attended	7.69	10.13	8.06
Currently enrolled	89.49	86.59	87.9
Dropped out	2.82	3.28	4.03
11-15 years old children (%)			
Never attended	3.47	6.58	10.62
Currently enrolled	64.52	59.78	54.87
Dropped out	32.01	33.64	34.51

- **Myopic attitude:** Investment for future is undermined by the immediate needs. Parents usually discount potential future return of education at a high rate. The opportunity cost of education is very high as a child can earn 200-250 Taka per day by working as a day labourer. Quantitative findings show that 9% students dropped out due to earlier involvement with earning activities. It is also noticeable that around 25% households have at least one child of 11-17 years of age working as a day labourer (Annex Table A 3).

- **Unaffordable cost:** Increasing cost of higher education is leading to higher drop outs. As mentioned earlier, in enrolment, households had to bear around two times higher cost for secondary school students compared to that of primary school students. Around 43% of the students dropped out from school because their parents could not afford the cost of education (Table 4).

- **White collar job versus agricultural employment:** The perception of the ultra poor households that is captured through qualitative exploration is the aspiration for a white collar job, and hierarchical position in society both in scale of status and money is an incentive to spend time in receiving education. But that requires long term education which may not be possible for the ultra poor. About 5 or 6 years of education with the assistance from the government does not make any sense to many of the ultra poor parents because eventually the children will have to involve in earning for the family. In case of female child, it does not matter since in most of the cases they cannot earn during this age.

Spatial: Qualitative result indicates that livelihood of a significant fraction of the ultra poor households depends on temporary/seasonal migration especially those who live in *Haor* or seasonally vulnerable areas. In Khulna, some households migrate temporarily to brickfields areas with whole family. During this time, students are out of education for a long time, which leads to permanent drop out. It is also perceived that two other factors such as long distance and seasonal breakdown of transportation system cause discontinuation of schooling, and eventually dropping out permanently. Distance to secondary school, at times, is more than that of primary school, which is another reason for dropping out. However, quantitative findings show that only about 0.30% students dropped out due to distance to school (Table 4).

Social: Under this dimension the following factors are associated with higher drop out.

- **Early marriage:** Child marriage is still prevailing in rural Bangladesh even though a large scale campaign has been launched against it. In addition to arranged marriage, at times, through the use of cell phone and other technologies children develop romantic relationship at an early age and eventually get married leading to drop-out from studies. However, quantitative findings show less than 1% students dropped out due to marriage (Table 4).

- **Insecurity:** As students have to travel 5-10 km long way for school either on foot or by local transport, female students remain vulnerable to insecurity in some situations. This fear of insecurity on the way to school is also a reason for dropping out by some female students in rural Bangladesh.

- **Peer pressure:** As the drop out rate is higher within the ultra poor society, many school going children become negatively influenced by the ones not going to school. Due to such peer pressure, some students start to keep them away from school.

- **Competence:** Unwillingness to study is one of the major reasons for dropping out as quantitative result reflects that more than 36% of the students dropped out due to their unwillingness to study (Table 4). Along with this, any kind of disability, either physical or mental is also a reason for dropping out. About 2% of the ultra poor students dropped out due to disability. Qualitative finding indicates that failure to qualify public examinations, such as PSC, JSC is another reason for dropping out.

- **Institutional:** Compulsory school uniform acts as a paradox. On one hand, school uniform is a symbol of beauty, unity, nondiscriminatory social class, and more importantly, a security for female students from any kinds of harassment, but on the other hand, it may exclude the ultra poor to get access to school being unaffordable. It has been mentioned earlier that 43% students dropped

out due to parent's inability to bear the cost, such as annual/monthly fees, school uniform, private tuition, books and stationeries.

Table 4. Reasons of school drop-out

Reasons of school drop out	Per cent
Due to early marriage	0.3
Due to distance	0.3
Unaffordable	42.94
Refusal by the institution to admit	7.73
Involvement in earning	9.21
Due to work at home	1.34
Unwillingness to study	35.96
Disability	2.08
Illness	0.15

5.2 Health service

Health services and modern medicines are beyond the reach of more than one billion people across the globe (Carr D 2004). Generally, people in Bangladesh have limited access to public healthcare services, particularly in the rural areas, and the main indicator of this spatial exclusion in healthcare is the lack of access to health services for the women, rural people, and the poor (Werner 2009). In rural Bangladesh, three types of basic institutions have been working to provide healthcare services as a measure of public protection for the poor community. These are Community Clinics located at the ward level, Union Health and Family Welfare Centres (UHFWC) at the union level and *Upazila* Health Complexes (UHC) located at *upazila* level. Apart from these, there is a district (*sadar*) hospital in every district of Bangladesh to provide basic healthcare services.

Community Clinics provide limited health facilities at the furthest and hard to access areas. It is basically intended for promoting health education (on health, nutrition and family planning), health promotion and treatment of minor ailments, first aid, and identification of emergency and complicated cases to establish an effective referral linkage with the higher facilities, i.e. UHFWC and UHC for better treatment. The UHFWC primarily provides outpatient services for the rural people. The staff of UHFWC also organises outreach activities, home visits by the community health workers like family welfare visitor and arranges satellite clinics at the community level. In every *upazila*, there is an UHC which provides inpatient and outpatient care, primary healthcare, family-planning services, and other preventive healthcare services to the local population.

This section analyses the status of health seeking behaviour of the ultra poor along with identifying the mechanisms through which the ultra poor are being excluded from public health services.

5.2.1 Vernacular meanings of diseases

It has been found that poor people classify diseases into two broad categories such as: physical illness and evil wind. Physical illnesses are also perceived in two different forms. The illness which leads to physical inability to work, move and eat is considered as a serious one. It differs from the other physical illnesses which do not hamper the usual human activities.

A female indoor patient of Sunamganj *Sadar* hospital expressed her intellect, *"we can comprehend diseases either as 'evil wind' or 'physical sicknesses' by observing the symptoms. If a patient speaks incoherently, feels severe pain in abdomen and talks after pressing nose, then the disease is emanated from evil wind".* Moreover, a patient of evil wind wanders over here and there doing insane activities, she added.

Another male respondent Sanjib said, patient experiences different types of nightmares if evil wind attacks.

5.2.2 The prevalence of illness

It is essential to know the disease pattern and health seeking behaviour of the ultra poor households to provide required health support, and to encourage them to visit the government health centres when needed. The health service providers also should be motivated to make the services more pro-poor. The quantitative findings show that around 29% of the ultra poor households had at least one member with sickness during the past 15 days prior to the survey (Table 5). They mostly suffered from fever (42%), physical pain (27%) and respiratory illnesses (16%).

Table 5. Prevalence of illness and types of diseases suffered by the HH members

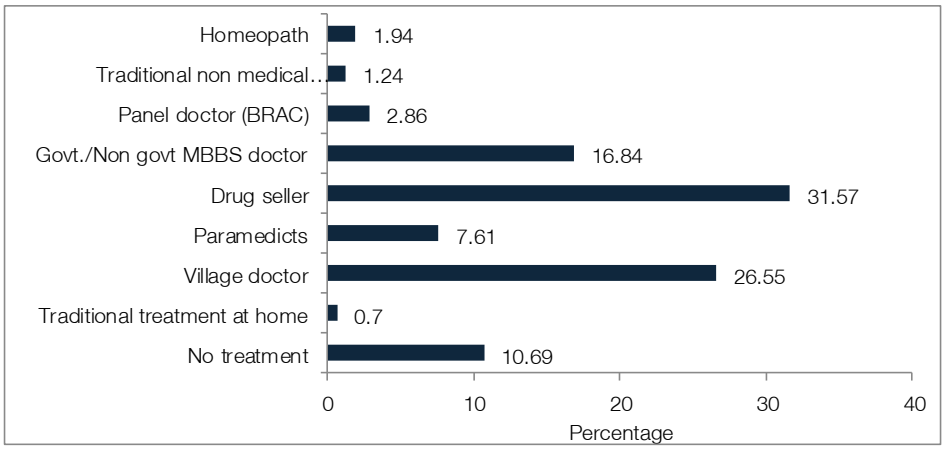
Types of diseases	%
At least one member was sick during past fifteen days prior to the survey	29.10
Type of illness	
Respiratory disease	16.30
Fever	42.04
Diarrhoea	3.72
Gastric/Ulcer	0.38
Cardio vascular disease	2.05
Physical pain/problem	27.47
Skin disease	3.62
Jaundice	0.76
Others	3.62

5.2.3 Health seeking behaviour

According to Hausmann-Muela *et al.* (2003), health seeking behaviour typically refers to the action taken by the households in case of any illness within the family members. In this section, the households' main health seeking behaviour is analysed in terms of their action taken in case of any illness of their members. The majority of the ultra poor patients (more than 80%) visit non-medical practitioner in case of health issues (Fig. 7).

Results also show that more than half of the surveyed the ultra poor patients seek treatment from village doctors and local drug sellers (27% and 32% respectively) which reflect a clear lack of awareness and understanding for receiving appropriate treatment. The treatment by traditional healers, however, seems to be low these days, which accounts for less than 2%. A considerable percentage of the ultra poor households (11%) do not or cannot avail treatment during illness. In addition to these quantitative findings, the qualitative results indicate that treatment at hospital is associated with high cost in terms of medicine, diagnostic test etc. They prefer village doctors as they do treatment on credit contrary to the institutional healthcare providers. Through in-depth-interviews, it was also captured that traditional healers are cheaper options for the ultra poor. There is also a strong perception that 'evil wind' related diseases can only be cured by traditional healers, known as *Kabiraj.*

Figure 7. Main treatment of illness received by the ultra poor



5.2.4 Access to health services

The quantitative findings shows that the respondents have visited public health service providers more than three times during the last one year prior to survey, either for themselves or for any members of the household, where more than two-third of them have visited *upazila* hospital and community clinics (Table 6). This may be due to the proximity of these health service providers from their households. Majority of

the households receives prescription and medicine from there and more than 86% report that they are satisfied with the existing services (Annex Table A 8). The main self-reported reasons mentioned by those who are not satisfied with the existing services or situation provided by the healthcare providers are that they have to spend extra money (46%) and have to wait for a long time (26%) to receive the services. Along with these, respondents' perception regarding what should be done to improve the services has also been assessed. Around 32% of the ultra poor expect better health services from the providers, while 24% feel that they do not need to spend extra money.

Table 6. State of visits to the health providers

Indicators	%
Number of visits to the government health centre either for self or for any members of the household during last one year	3.50
Access to health services	
Union health centre	16.43
Health and family welfare centre	3.17
Upazila Hospital	30.64
Medical college hospital	3.07
Sadar hospital	13.83
Community clinic	32.66
Others	0.19

5.2.5 Exclusionary mechanisms in accessing health service

A range of factors that are constraining the ultra poor to seek institutional health services have been identified through quantitative and qualitative analyses. As mentioned above, the ultra poor households face difficulties in accessing government health services specifically as they have to spend extra money and have to wait for long time, other two major categories of exclusionary mechanism have been identified from qualitative findings in accessing health services where one of them is self-exclusionary and the other is institutional.

Self-exclusionary mechanism: Basically, this mechanism is based on the perception of the ultra poor which are discussed below:

- **Maternal care:** Ms Shila Rani Das, family welfare assistant of Gourarang union of Sunamganj *Sadar upazila* expressed that, "still there is a widely-held belief among the ultra poor that consumption of sufficient amount of food and iron tablet can increase the size and weight of the baby which may need costly surgery during childbirth". Such beliefs discourages the ultra poor to avail these vitamins and multi-nutrients during pregnancy, and seeking services from formal institutions during childbirth.

- **The idea about vaccine:** Some of the ultra poor parents mistakenly equate Tetanus Toxoid Vaccine for adolescent girls with birth control vaccine. This

belief may stem out from the fact that the healthcare providers at the community level sometimes provide both types of vaccines. At times, this makes parents unwilling to let their daughters being vaccinated.

- **Birth control:** It has been observed that the ultra poor male members do not like to use permanent or periodical birth control methods due to the perception that these are harmful for their body. Some female members have also shared that, as the male are the main earning members, they prefer to use birth control method by themselves instead of their husbands.

- **Family tradition:** The qualitative research found that due to family traditions, people do not like to take pregnant women to hospital during childbirth.

> Rujina Begam was a pregnant woman. At the time of her delivery, her mother-in-law did not allow her husband to admit her into hospital as no child of their family was ever born at a hospital. It is a family tradition. Moreover, they think, a child will have no affection for home/elder members of family if he/she is born at a hospital.

Institutional exclusionary mechanism: Under this exclusionary mechanism, five major indicators have been identified that exclude the ultra poor in accessing the public health services.

Financial constraints

- **Cost:** On the one side, treatment at a hospital is associated with a huge cost in terms of medicine and diagnosis etc. which excludes the ultra poor in accessing institutional health services. On the other side, treatment from informal institution is more popular among the ultra poor as village doctors allow treatment on credit contrary to institutional health providers. Similarly, traditional healers are cheaper option for the ultra poor. There is also a strong perception that 'evil wind' related diseases can only be cured by traditional healers.

- **Opportunity cost:** Physical ability to work is the main asset of the ultra poor. Staying at a hospital for the household's earner either as a patient or a companion means loss of potential income, such perception leads to exclusion from health services.

> Sanjib (55) is an indoor patient of respiratory disease at Sunamganj *Sadar* hospital. He is a rickshaw puller and only earning member of his five-member family. Previously, he got admitted into hospital for the same diseases but had to leave before completion of treatment as his family was under the threat of hunger. He is satisfied with government's free treatment and food for indoor patient, but seeking treatment for a prolonged period is impossible for him. Now, he had to readmit for the same diseases.

Institutional versus communal treatment: From quantitative findings it has been observed that most of the ultra poor seek treatment from non-medical practitioners. The reasons behind this have been identified through qualitative exploration. Close proximity, provisions of having medicines and consultation, friendly behaviours and services in credit imply that village doctors are more popular among the ultra poor patients.

Geographical exclusion

Distance: Majority of the rural ultra poor households are located quite far from health institutions though on an average it is less than 3 km (Annex Table A 8). The distance becomes harder during the wet season. People from *haor* areas suffer from this problem more acutely. In some remote areas, transport is a vital need. Response to emergency health crises during night is more problematic due to lack of transportation facilities.

Absence of companion: According to the quantitative results, around 44% of the patients needed companions to commute to hospital (Annex Table A 8). The patients, who do not have close relatives to accompany, face difficulty in accessing health services from institutions located far from their dwellings. Furthermore, qualitative results indicate that even if they have close relatives or family members, in most of the cases that do not work out due to the risk of losing potential income.

> *"In case of female patient, one male member has to be there as a consort because female patient cannot manage everything alone. So, the attendant cannot involve himself in earning activities, and ultimately he is terminated, and entire family remains under the threat of hunger."* said a female patient at Sunamganj *Sadar* hospital.

Gender sensitive conservatism: The qualitative study reflects that insufficiency of female doctor and male nurse is one of the reasons behind unwillingness to seek treatment from hospital. As it is seen that female patients feel comfortable to receive treatment from UHFWC/CC since service providers are mostly female.

Attitudinal exclusion: Around 36% of the ultra poor households reported that they find a difference in delivering health services to the rich and poor, where more than half of them mentioned that the service providers do not pay attention, or at times neglect poor people (Table 7). More than 45% mention that rich people do not have to wait for the services, receive more attention and better service. Hence, reasons like elite bias service delivery, nepotism/familiarity, hierarchical attitude, and money driven efficiency are found to discourage the poor patients to avail the services.

Table 7. Ultra poor's perceptions/attitude about health service providers

Indicators	Per cent
Perceived difference in delivering health service among the rich and poor	35.81
Ultra poor's self-perceived difference	
Don't pay attention/neglect poor people	50.65
Speak less	1.95
Need to spend much time	1.3
Rich people don't have to wait, receive more attention and better service	45.13
Provide quick service to the known people	0.97

Resource paucity: Qualitative findings show that service providers also face some constraints such as scarcity of resources, both physical and human resources to make services more pro-poor. Doctors intend to work in the cities, and nurses prefer to live with their families. So, irregularities, absence and transfer of both doctors and nurses are common in *upazila* health complexes. Laboratory assistants and other technical assistants are also inadequate. Sometimes, technicians are not available to conduct any diagnostic tests. Availability of inpatient accommodation is also limited, so most of the time patients have to be admitted without allocating a seat. It is also mentionable that security of female nurses is not adequate.

5.3 Social Safety Net Programmes (SSNPs)

As various types of SSNP have already been mentioned in the introduction section, it is almost clear that SSNPs now have much more focus on poverty reduction and employment generation from being mostly relief oriented. There has been a gradual shift from food to cash based programmes in response to the high leakage associated with the former, like Food for Work is replaced by the Cash for Work and so is 'Food for Education'. SSNPs are distributed mainly through the channel of local government institutions which are Union Parishad (UP) chairman, member and female member.

The major SSNPs in Bangladesh can be divided under three broad categories: (i) Programmes for disadvantaged groups like the elderly, widowed, disabled etc; (ii) Programmes to cope with natural disasters and other shocks; (iii) Employment generation programmes. All types of SSNPs are designed for most vulnerable groups like women, destitute, elderly people, widow, disable, seasonally distressed working aged poor, pregnant and lactating mother, disaster affected people, freedom fighters etc.

Notably, SSNPs have a deliberate intention to meet the need of vulnerable women by directing some programmes especially for women and some others are designed in such a way that the eligibility criteria would include a large number of women. In this

section, an analysis has been made on the current status of the ultra poor in accessing the SSNPs and reasons behind their exclusion in accessing the services.

5.3.1 Vernacular meanings of safety net

Safety net has evolved significantly in scale and scope. Crises period food relief has turned into longer term integrated measures with promotional goal. Policy approach has shifted from aid towards right. However, the vernacular meanings of safety net have not changed much. Poor hardly perceive safety net benefits as their entitlement. Some major safety net programmes are well known by their acronyms such as Vulnerable Group Development (VGD) and Vulnerable Group Feeding (VGF). Yet, the majority of the ultra poor seem not very aware of a range of other benefits and their eligibility criteria. Ultra poor identify benefits with 'card' or 'wheat' (*gom*) and immediately associate them with the UP Chairman and Members through which such resource are usually distributed. However, the data shows that the providers also demonstrate limited understandings of different safety net programmes.

5.3.2 Status of receiving services and the mediators

The quantitative findings highlight that about 76% of the ultra poor households received SSNPs in last one year (Table 8) while 77% of them received VGD/VGF services and a very small proportion received widow (9%) and old age (11%) allowances. In addition to the status of receiving SSNPs, respondents were also asked to report who helped them to get the services. Results indicate that 44% of the ultra poor received the services with the help of their local UP chairman/member while 18% received the support with the help of school teacher.

Table 8. Status of receiving SSNPs and types of SSNPs

Indicators	Per cent
Received SSNP in last one year (% of hhs)	76.01
Type of service (% of receiving households)	
VGD/VGF	76.81
Widow allowance	8.58
Old aged allowance	10.52
Others	4.09
Who helped to get to the service (% of receiving households)	
Relative	7.21
Neighbour	15.6
Respected person in the village	15.2
Political leader (chairman, member)	43.71
Teacher	18.28

5.3.3 Perception regarding beneficiaries' selection

In this section, an attempt has been made to capture the respondents' self-perception regarding whether the beneficiaries are selected properly. Around 49% of the respondents disagreed that beneficiaries are selected properly. Though, a very few of the ultra poor completely agreed or disagreed about the issue, only 38% report that they agreed that beneficiaries are selected properly (Table 9). However, from qualitative exploration, it has been observed that the service providers have limited understandings of different safety net programmes. Most of the cases, the service providers do not even know the basic criteria in selecting beneficiaries for the services.

Table 9. Perception regarding proper selection of the beneficiaries

Opinion	%
Completely agreed with proper selection	5.18
Agreed with proper selection	38.27
Disagreed with proper selection	48.82
Completely disagreed with proper selection	7.73

5.3.4 Change in selection process

Recipient selection process has shifted from being relatively decentralised to a more centralised one. According to the new rule, representatives of the Member of Parliament (MP) and UNO (*Upazila* Nirbahi Officer) have been included into the recipient selection committee. To some extent, it has reduced the roles of local governance institutions. On the other hand, ruling party members are found to play a vital but informal role, like a parallel local government, in selecting the recipients.

5.3.5 The mediating processes in accessing safety net

In Khulna, one of the UP Chairmen says, *"Corruption doesn't exist in targeting, because people who have received benefits in my area come from destitute, vulnerable or extreme poor households. They are all eligible to get the benefits"*. Though a fair number of the ultra poor households have been receiving SSNPs, the important question is how they are granted resources and at what costs.

Political clientelism: Though it seems to be well known, qualitative assessment also found that political affiliation is one of the key avenues through which the ultra poor access benefits. Affiliation, association or relation with both local and national party political actors has been proven important in this regard. At the ward level, UP Members tend to distribute safety nets to her/his political clients. The poor from the areas or families (*bongsh* or *goshthi*) with significant vote bank are more likely to avail benefits. It signifies how the distribution of and access to safety net programmes are shaped by the political system at local level.

Moral responsibility: The discourse of moral responsibility for the most destitute members operates within the community and shared by the local elites. Though qualitative data indicates that people who do not have any possession or relation seem to be prioritised for selection, it depends on the availability of safety nets.

Connections: Kinship and localism are vital avenues to access safety net. A higher percentage of the ultra poor households report that they came to know about the SSNPs from chairman/member (58%) or school teacher (33%) (Annex Table A 9). Data also shows that around 36% of the ultra poor did not receive any SSNPs in the last year due to not having good relation with chairman/member which shows a clear lack of moral responsibility.

Bribe: The practice of bribing in accessing safety nets, especially, in the occasional programmes such as Food for Work, Road Maintenance Programme, and Hundred Days Employment Generations is prevalent. Quantitative result shows around 25% of the ultra poor who did not receive any SSNP in last one year report that they did not get the services as they did not pay any bribe (Annex Table A 9). However, through qualitative investigation it has been perceived that the illicit practice has declined in case of major safety net programmes, such as Vulnerable Group Development (VGD) and Vulnerable Group Feeding (VGF). It may be due to the increasing campaign and awareness regarding these two programmes.

Patron-client relations: Benefit providers are at times found to practice clientelism while distributing the safety net benefits. It appears to be vital for the aspiring people to involve with a group in order to receive benefits.

Time consuming process: A great deal of time has to be spent for lobbying to be enlisted in safety nets, and the acquiring that through the Union Parishad office. Oftentimes, it may take the full day for a poor labourer to avail the service, compromising her/his working hours and income for the day.

Allocated versus real amount: The recipients often complain that in reality they receive much less than the amount allocated for the safety net. The quantitative findings show that around 66% of the ultra poor households know about their entitled amount for the services, while only 49% of them receive their full entitled amount (Table 10). In regard to this, the study indicates that providers do not deny the claim, but tend to justify this practice by pointing out the facts that they also had to pay bribe for getting the safety net benefits sanctioned from the *upazila* level, and even the government provided transport allowance does not cover the actual cost.

Table 10. Level of knowledge of the ultra poor about the entitled amount

Indicators	Per cent
Know about entitled amount for this service (Yes-1; No=0)	65.60
Receive full entitled amount (Yes-1; No=0)	48.95
Faced problem in getting/accessing the service (Yes-1; No=0)	3.01
Type of problem (for those who face problem in accessing the service)	
Had to pay bribe	32.61
Had to change political mind/opinion	2.17
Had to request the chairman/member several times	65.22

5.3.6 Exclusion from the safety net

Usually, the poor who do not have strong social capital or connection, are not aware of the eligibility criteria, do not have any access to local political structure, do not have the capability to pay bribe, do not want to surrender themselves in the patron-client networks are more likely to remain deprived. Different components of social exclusion affect each other creating a barrier of insecurity that ends up in numerous deprivations which leads to different types of exclusions, and eventually forces to a misery in living standards that increases the risk of poverty. All the respondents irrespective of receiving the SSNP or not, were asked to report the reason behind the exclusion of some the eligible ultra poor. They have highlighted some basic reasons like political influence, bribery, insufficient allocation, and refusal to accept indecent proposal by the providers etc. (Table 11).

Table 11. Self-reported reasons behind the exclusion of the eligible ultra poor from SSNPs

Reasons for exclusion	% of excluded persons
Political reason	16.47
Bribe	54.72
Politically insignificant family	3.6
Ignorance about the benefit	15.99
Insufficient allocation	2.69
Not accepting indecent proposal	0.72
Others	6.82

5.4 Livestock

Public livestock institutions are providing three types of services related to extension, production and health. Farm registration, vaccination and training are included under extension department. Artificial insemination, breeding are under production department and health department provides curative response to diseases. *Upazila* livestock officer, veterinary doctor, compounder and union livestock workers are

working to provide these services. Only a single livestock office and a veterinary hospital are employed to cover an entire *upazila* which is palpably inadequate.

5.4.1 Vernacular meanings of livestock

Livestock owners are found sensitive to the sickness of their domestic animal. Domestic animals are treated as capital, source of earnings and object of passion to the ultra poor. Sharifa Begum of Paikgacha noted that, *"Humankind can express his/her sufferings but animal cannot. Animal cannot tolerate sickness for a long time. Therefore, we need to take care of animals even if we are in an impoverished economic condition."*

5.4.2 Access to livestock

Ultra poor community is not capable to maintain own livestock in large scale except BRAC-TUP members who received cow or goat from the programme. Since they are unable to buy cow, they mostly rear goat, sheep and poultry.

5.4.3 The prevalence of illness

More than 98% of the ultra poor households have livestock; around 58% of them reported that their livestock was sick at least once during the last year and 34% of them faced demise of their animal (Table A10). *Badla, torka* and *khura* are found to be the most common diseases from which the livestock suffered (Table 12).

Table 12. Types of diseases (Multiple responses allowed)

Name of the diseases	% of cases
Badla	74.83
Diarrhoea	37.97
Golafula	73.57
Torka	54.1
Khura	50.35
Ranikhet	19.54
Chicken pox	7.3
Indigestion	1.74
Don't know	0.21

5.4.4 Treatment seeking behaviour

Only 14% ultra poor households seek treatment from certified veterinary practitioner when their livestock becomes sick, while more than 84% do not get access to any recognised doctors (Table 13). Around half of the surveyed ultra poor households seek treatment from village veterinary doctors and local drug sellers (49% and 16% respectively). However, treatment by the traditional healers seems to be minimal in

this case (less than 1%). Around 17% households get treatment and vaccines from BRAC programmes.

Table 13. Sources of treatment

Sources of treatment	Per cent
No treatment	3.59
Traditional treatment at home	0.36
Village doctor	49.16
Drug seller	15.79
Government/Non-government veterinary practitioner	14.35
Traditional practitioner(*Kabiraj*)	0.24
BRAC	16.51

5.4.5 Constraints in accessing livestock services

As mentioned earlier, public livestock institutions are providing three types of service related to extension, production and health of livestock. A range of factors constraining the ultra poor to seek institutional services have been identified here.

5.4.6 Financial exclusion:

- **Cost:** Seeking treatment from government livestock hospital is expensive in terms of medicine and transportation. Going to hospital with a cow requires van/truck which is costly; it becomes more severe in *Haor* and low-lying areas. Even if it is necessary, more than 39% of the ultra poor households report that they do not go to government veterinary hospital/doctor due to distance, while 28% do not want to go as they need to pay (Table A10). Moreover, people complain that most of the medications has to be bought from outside.

- **Treatment on credit:** Instead of government livestock services, the ultra poor households rely heavily on informal services, such as village doctors who allow treatment on credit contrary to institutional health providers.

- **Opportunity cost:** Physical ability to work is the main asset of the ultra poor. To go to hospital or stay there with the livestock imply a loss of potential income for the household earner.

Asymmetric Information: Government's provision of loan for livestock rearing is not practiced properly. People have not sufficient knowledge about this service. Authority feels discouraged due to high default rate.

Risky investment for poor: Investment in livestock has high risk because of frequent demise of livestock. An about 30% household's experienced demise of a livestock during the last one year prior to survey. Besides, recurrent natural calamities adversely affect the survival of livestock.

Institutional vs. communal treatment: From qualitative findings, it has been observed that the ultra poor prefers village doctors due to their friendly attitude and easy access when needed. As people are sensitive to any diseases of their domestic animal, they prefer treatment from informal institutions like village doctors or drug sellers because of their availability, home visits and follow up services.

Geographical exclusion: Quantitative findings explore that average distance of veterinary hospital is around 8 km. Going to a veterinary hospital with a domestic animal is a difficult job, particularly with a sick animal. It requires transport, such as truck or van. Mostly, people living nearest to a livestock hospital, seek treatment from there.

Elite biased extension service: Extension authority's behaviour is not poor-friendly in some cases. Farm registration, vaccination, and treatment services are better offered to the elites. A female poultry owner of Paikghacha incriminated that she went to a veterinary hospital to seek treatment for her sick poultry. Doctor refused her with the excuse of not having any medicine. When the union parishad chairman arrived and asked to provide medicine it was then given. Doctors come to visit elites' farm and home by a phone call only.

Moreover, nearly 46% of the ultra poor (Annex Table A 10) reported that they observe difference in the delivery of veterinary services among the rich and poor. In most cases better service is provided to the rich (55%), and rich people get more advantage (45%) as well. Remarkably, 14% and 12% of the ultra poor states that they do not go to veterinary hospital even if it is necessary, as the service providers neglect the ultra poor and behave badly.

Constraints of the service providers: Service providers face constraints of scarce resources in terms of manpower, medicine and equipment. Union livestock workers are apparently unavailable to the villagers because they are responsible to cover a large area.

6. Conclusion and recommendations

BRAC Advocacy for Social Change has introduced a new project titled 'Advocacy for Access Promotion of the Ultra Poor' to create enabling environment for the ultra poor in accessing government services pertaining to health, education, livestock and social safety nets. This project aims at mobilising relevant stakeholders to enhance regular attendance of the ultra poor children in primary education, and increase the ultra poor's accessibility to government services. This study diagnoses the ultra poor's level of access to public services, constraints in accessing the services, and identifies a number of important mechanisms through which the poorest are excluded from their entitlements, and also a number of mediating processes through which they are included. To achieve the objectives both quantitative and qualitative techniques have been adopted.

Regarding education services, results indicate that drop out rate is high at the secondary level among the ultra poor children. Ultra poor children's three stages of exclusion such as enrolment, irregularity and drop out from mainstream formal education have also been identified. Findings also show that poverty is one of the tools that impede children of the ultra poor households in continuing education. Potential costs of books, stationeries, private tuition, school uniform etc. remains as an exclusionary tool for the ultra poor to enroll and continue schooling. Ultra poor parents' low level of awareness about the needs of basic education and primary enrolment age of children are also influencing exclusion. The situation is further deteriorated due to some constraints at home and at school. Geographical distance and poor transportation system hinder attendance in school as most often they have to go to school on foot, particularly during rainy season.

In respect of health services, findings indicate that respondents have visited public health service providers more than three times in last one year prior to the survey, either for herself or for any member of the household. More than two-third of them have visited *upazila* hospital and community clinics, and received prescription and medicines from there, and over 86% have reported that they are satisfied with the existing services.

Through these analyses, a range of factors that are constraining the ultra poor to seek institutional health services have also been identified. The self-reported reasons for dissatisfaction with the existing healthcare services are the long waiting time and extra money needed to receive the services. The self-exclusionary mechanisms such as lack of awareness about the services, misconception, family traditions, and institutional exclusionary mechanism such as cost, geographical distance, gender sensitive conservatism etc. are the leading causes which hinders in accessing institutional health services.

While making remarks on social safety net, it is found that about 60% of the ultra poor households have received SSNPs in last one year; on the contrary, 80% of them have received VGD/VGF services and a very small portion have received widow and old age allowances. Findings further show that a significant proportion of the ultra poor have received the services with the help of their local UP chairman/member or school teacher. However, around 49% of the respondents reported that beneficiaries were not selected properly. Though, a very few of the ultra poor completely agreed or disagreed about the issue, only 38% agreed that beneficiaries are selected properly.

However, qualitative information assert that the service providers also have limited understandings of different safety net programmes. Recipient selection process has shifted from being relatively decentralised to a more centralised one. Usually, the poor who do not have solid forms of social capital or connection, are not aware of the eligibility criteria. They do not have any access to local political structure, the capability to pay bribe. They have to surrender themselves to the patron-client networks so that they are more likely to remain deprived.

It is found that around half of the surveyed the ultra poor households seek treatment for their livestock from village veterinary doctors and local drug sellers. Seeking treatment from government livestock hospital is expensive in terms of medicine and transportation. A significant proportion of the ultra poor households do not go to government veterinary hospital or doctor due to distance and potential cost, even if that is necessary.

Moreover, some people complain that most of the medicines have to be procured from outside. Instead of accessing government livestock services, the ultra poor rely heavily on informal institutions as village doctors allow treatment on credit contrary to institutional healthcare providers. Extension authority's conduct is not poor friendly in some cases, but better services are delivered for the elites.

Results also indicate that the ultra poor observe differences in delivering veterinary services between the rich and the poor, where the rich receives better service. Remarkably, some of the ultra poor state that they do not go to veterinary hospital even if it is necessary as the service providers neglect the ultra poor and behave badly.

From the results of this study, several recommendations have emerged for improving and making the services more pro-poor and accessible, which are highlighted below:

6.1 Recommendations on education

National level

- A nationwide campaign that goes beyond "education for all" and emphasises on "quality of education" should be introduced. Also, there is a possibility of cynicism amongst people of apparently ineffective education for the poor people.

- "Food for Education" could be a potential instrument to mitigate irregularities as findings indicate that the ultra poor children do not attend school regularly because they work as helping hands to their parents to meet family needs.
- Security for female students on their way to school needs to be ensured as sometimes they are dropped out from school due to fear of harassment and insecurity of their way to school.

Sub-national (Implementers) level

- Institutional level responsiveness is necessary to ensure sufficient and better pedagogue for English and Mathematics as many rural students find difficulty with these subjects. Besides, teachers may give extra attention to the ultra poor students as most of them cannot afford private tutor.
- Teachers may be trained on the appropriate teaching method depending on the level of students, and on supportive and assuring behaviour to make learning more interesting, pleasant and productive.
- Ensuring transparency and fairness in distributing scholarship (*Upabritti)* to the deserving students by addressing irregularities in the system, which would encourage students to continue schooling.

Community level

- A trio-coordination of parents (especially mother), institution (Teacher and school management committee), and students is necessary. Awareness building among the parents, school teachers, along with school management committee through motivating themselves to encourage students to continue education will be helpful to reduce drop out.
- Develop necessary mechanism to address irregularities that are identified.
- Respective communities should develop a suitable system to ensure security of female students on their way to school.
- Aspiration of white collar job and hierarchical position in society is an incentive to spend time in receiving education, but different constrains, particularly the time and resources required in this regard may not make it possible for the ultra poor, resulting in dropping out. Strong motivation and belief about the long run output and importance of education could play an important role in continuing education and reducing school drop outs.
- Introducing a "notion of shame" with illiteracy may be useful.
- Motivate the school management committee/teachers to take special care to the ultra poor children as they can't afford the additional cost of education of private tutor. Either they can help the students to complete the task at school or teach them at free of cost after school hours.

6.2 Recommendations on health

National level

- As patients and service providers complain that doctor, nurse, lab assistants and even necessary medicines are not available at the health service centre at times, it is necessary to ensure the availability of all kinds of resources to deliver appropriate service.
- Village doctors, in general, are prescribing over drug because of pecuniary incentive of drug companies. Bringing village doctors under quasi-regulation or arranging training for village doctor can mitigate the problem.
- Community clinics should be able to provide better service as these are closely located. It would be easier, especially, for the women to access the services when needed.
- Insufficiency of female doctors and male nurses is one of the reasons of unwillingness to seek treatment from hospital; long run policy for increasing number of male nurses and female doctors is needed.

Sub-national (implementers) level

- In response to attitudinal exclusion, campaign should be launched at the implementers' level to be more responsive to the poor.
- Medicines are supplied to community clinics and UHFWC from *Upazila* Health Complex on a monthly basis by pre-determined amount. But it is seen that some drugs are more demanded by the patients and some drugs are less demanded. The stock of some medicine is depleted within a short time and others remain unused. So, medicine supply to community clinic and UHFWC should be demand-driven.

Community level

- At the community level, perception based awareness campaign related to the issues of maternal care, vaccine, and family planning methods can be launched.
- Findings indicate that poor people do not avail the health services from public hospital due to the fear of excess cost. So, awareness campaign addressing this issue can be organised as intensively as possible.
- Female patients prefer female doctor/nurse and male patients prefer male doctor/nurse which is not always possible to provide. Hence, at the community level motivation is needed about the gender neutral health seeking behaviour.

6.3 Recommendations on social safety nets

National level

- Inclusive citizenship campaign should be diffused from central to grassroots level of implementation. Ultra poor should be able to realise that the entitlements of SSNPs are not provided as a grant; rather it's a right for them.
- Training for local government representatives (training related to the issues of eligibility criteria and distribution mechanism) should be provided as many of them are not aware of the eligibility criteria and other issues of social safety net.
- To make the service more pro-poor, it is better to decentralise the selection process from union to village level. Because, villagers have been pointed out that they know each other's economic condition and vulnerability better and that can be helpful in selecting the eligible recipient. It may also improve the transparency in selection process.

Sub-national level

- The selection criterion and time (when the service is being offered) are mostly unknown to the recipients. It will be better if name of the different safety net services along with selection criterion is displayed at the public places such as at markets, mosques/temples, and at the UP office.
- Maintaining data set of eligible SSNP recipients and introducing selection process through lottery can be a tool for better and transparent selection.

Community level

- BRAC *Polli Shomaj* can play an important role at grass root level of the society to empower the poor community through different types of awareness raising activities.
- Engaging benevolent elites (teacher, religious leader etc.) in mediation process will create a plain bridge between the poor and the service providers. Engaging school teachers in the process will be helpful in the fair selection process.
- Right based awareness campaign can be propagated to the ultra poor community so that they do not hesitate to seek the benefits.

6.4 Recommendations on livestock

National level

- Decentralising livestock service from *upazila* level to at least union level will facilitate the service as distance is one of the exclusionary instruments in seeking service from public livestock centres.

- Community clinic has brought a radical change in the health seeking behaviour of rural poor as it is closely located to their habitat. If this model of service is implemented for livestock that might bring a revolutionary change in the life of poor villagers.
- Nationwide educational campaign on disease prevention can be introduced through different media.

Sub-national level

- Relocating and efficient utilisation of existing human and other resources would minimise the current widespread gap between service providers and potential service seekers. For example, union livestock worker who can play an important role in mediating and providing primary services should be made available.
- Educational campaign on available services will encourage the community to seek services. Because, people are not fully aware of what types of services and at what cost are available in public service centres. For example, government provision of loan for livestock rearing is hardly known to the ultra poor.

Community level

- Incorporate measures to improve awareness at the community level about the symptoms and prevention of common diseases.
- Disseminate information about different public services such as training, loan facilities, vaccination, insemination, treatment through publicising at the popular/common places and service centres so that people are informed and interested to avail the services.
- Sometimes, as poor people are unwilling to seek treatment from public service centres to avoid high cost, it is necessary to implement a system to control the cost of service, and abolish bribing for obtaining the service which will reduce the fear of high expenditure.

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Annexure

Table A 1. Distinguished stakeholders of four broad components APUP works for

Broad compo-nents	Service provider		Service receiver
	Institutional	Personnel	
Education	High school Govt primary school Govt pre-primary school *Upazila* education office	School teacher School management Committee *Upazila* education officer(s)	Ultra-poor HHs Children Female students (high school upabritti)
Health	*Upazila* health complex Union health complex Community clinic *Upazila* family planning office Union council (sanitary services, maternal allowance)	Doctor Nurse Compounder Health assistant Diagnostic test taker Pharmacist	Ultra-poor HHs Male Female Children
Livestock services	*Upazila* livestock hospital *Upazila prani-sompod* office	Doctor (veterinary) Compounder *Upazila* livestock officer Union *poshu-sompod kormi*	Ultra-poor HHs
SSNPs	Different Department & ministry Union council *Upazila* land office (Khas land)	UP chairman UP secretary Member Political leader Social leader BRAC *Polli Shomaj* Leader	Ultra-poor HHs Female Old people School children

Table A 2. Idiosyncratic characteristics of the intervention districts

District	*Upazila*	Union	Idiosyncratic characteristics
Khulna	Paikgacha		South-western district, the most vulnerable coastal area, water salinity, affected by climate change.
Sunamganj	Derai		North-eastern district, *Haor* Area, lower cropping intensity, low infrastructural development, scattered and remote villages
Naogaon Rangpur			North-western districts, seasonal vulnerability due to *Monga*.

Table A 3. Household members' characteristics

Characteristics	
Household size (mean)	4.43
Household member (age>6 year) can read and write (%) (Yes=1; No=0)	25.94
% of hh having working aged male members (Yes=1; No=0)	73.50
Number of working aged male members	0.94
% of households having working aged female members	98.33
Number of working aged female members	1.35
At least one member work as day labourer (% of hhs)	85.95
At least one member aged 11-17 years work as day labourer (% of hhs)	24.26
Per capita income	13,382

Table A 4. Characteristics of the household head

Characteristics	Per cent/years
HH head's sex (male=1; Female=0)	62.52
HH head's age (years)	44.18
HH head's marital status (married=1; otherwise=0)	63.42
HH head can read and write (Yes=1; No=0)	12.44
HH head's education (Years)	1.03
HH head's primary occupation (Day labour=1; otherwise=0)	52.36
HH head's primary occupation (Farming=1; otherwise=0)	8.07

Table A 5. Households' physical structure

Indicators	Per cent
Main material of wall (% of hhs)	
Cemented	1.88
Tin	27.19
Kacha	70.93
Main material of roof (% of hhs)	
Tin	88.39
Kacha	11.61

Table A 6. Households' access to basic facilities

Indicators	Per cent
Drink tube well water (% of hhs)	96.59
Use tube well water for cooking (% of hhs)	72.74
Use arsenic free water (% of hhs)	59.04
Have electricity (% of hhs)	15.99
Have solar (% of hhs)	4.03
Use sanitary latrine (% of hhs)	18.98
Use soap after defecation (% of hhs)	82.68
Wear sandal (% of hhs)	96.73

Table A 7. Education

Indicator	Per cent
Distance from nearest government primary school (km.)	0.61
Distance from nearest government secondary school (km.)	1.72
% of children go to primary school on foot	99.44
% of children go to secondary school on foot	84.98
Schooling status of children of 6 years (%)	
Currently enrolled	73.2
Never enrolled	26.8
Dropped out	1.67

Table A 8. Health service

Distance from nearest Government hospital or health centre (km)	2.34
Type of service or treatment received	
Admitted in hospital and received treatment	7.99
Diagnosis to identify diseases	2.69
only medicine	45.14
Prescription	8.37
Prescription and medicine	24.35
Diagnosis/prescription/medicine	11.45
With whom respondents went to the health service centre	
Alone	56.48
With husband	13.74
Relative	21.04
Friend/neighbour	8.26
BRAC SK	0.1
Other health service provider (SK)	0.38
Happy with the existing situation (Yes=1; No=0)	85.11
if no then why	
Doctor's behaviour was not good	18.06
Other staffs' behaviour was not good	6.45
Had to wait for long time	26.45
Had to spend extra money	47.1
treatment was not good	34.84
Respondents self perception about what would/should be there to get the service properly	
If doctor behaves well/ properly	6.92
If the other staff behave well	5.38
If do not need to wait for long time	20.56
if won't need to spend extra money	23.15
Better treatment	27.95
If they do provide medicine	22.67
If doctors are available	0.1
Free medicine and treatment	2.11
Don't know	1.63

Table A 9. From whom got information about the SSNP services

Indicators	Per cent
Sources (From whom got information about the SSNP services)	
Media	1.7
Chairman/member	58.19
NGO	0.85
Local leader	2.36
Relative/neighbour	2.36
School teacher	32.9
Caretaker (Chawkidar)/village police	1.64
Self-reported reasons of not getting SSNPs	
Didn't know	5.44
I'm not eligible for these services	10.29
Knew but didn't try	10.35
Didn't want to give bribe	24.77
Political reason	16.64
Don't have good relation with chairman/member	30.6
Others	1.9

Table A 10. Livestock service

Indicator	Per cent
Have domestic animal (Yes=1; No=0)	98.26
Domestic animal was sick in last one year (Yes=1; No=0)	58.14
Domestic animal died in last one year (Yes=1; No=0)	34.43
Reasons behind people do not go to government veterinary hospital/doctor even if it is necessary	Per cent
Distance	39.15
Behave badly/lack of well behaviour	11.89
Have to pay	28.16
Neglect	13.91
Doctor remain absent	2.09
Don't know	4.8
See any difference in delivering veterinary service among the rich and poor (Yes=1; No=0)	45.71
Types of difference delivering veterinary service (for those who observed)	% of cases
Provide better service to the rich than poor	54.69
Rich people get more advantage	45.31
Provide quick service to the familiar person	3.13
Provide better treatment if paid more money	1.56