



Rapid Assessment of BRAC's Disability Inclusive Ultra-Poor Graduation Program



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Executive Summary

Poverty and disability are significant global concerns, however, tackling them remains a challenge. Poverty and disability interact cyclically, creating a complex poverty trap. Globally, 44 million individuals remain trapped in poverty, while approximately 1.3 billion people face challenges related to disabilities (Baah et al., 2023; Disability, 2023). The “Leaving No One Behind” of the Sustainable Development Goals (SDG) agenda has highlighted the importance of inclusive development for individuals with disabilities within the sustainable development framework.

However, understanding the local contexts relevant to the issue is essential for effectively developing customized solutions—inclusive programs and policies that address the specific needs of people with disabilities—for advancing the agenda. Developing countries face greater challenges in addressing the needs of people with disabilities due to resources and other constraints. While some developing countries have implemented social assistance programs to provide minimal income support, these benefits are often insufficient (Ambati, 2009). Moreover, individuals with disabilities often face exclusion in education and employment, social stigma, and a fatalistic attitude, leading to financial setbacks, perpetuation of the cycle of poverty, and marginalization.

Bangladesh, like other developing nations, faces a significant prevalence of disability, affecting approximately 6.9% of its population (Bangladesh Bureau of Statistics [BBS], 2019). The 2021 National Survey on Persons with Disabilities (NSPD) report reveals a high unemployment rate of about 66% among working-age individuals with disabilities. Additionally, the poverty incidence is higher among individuals with disabilities by 4 percentage points compared to individuals without disabilities (Leonard Cheshire, 2018). This situation places a substantial economic burden on the country, with an estimated annual income loss of around USD 1.2 billion, due to limited educational and employment opportunities for people with disabilities and their caregivers (World Health Organization [WHO], 2011). In response to this issue, BRAC’s Ultra-Poor Graduation (UPG) program¹ designed the Disability Inclusive Ultra-Poor Graduation (DIUPG) program.

The DIUPG program was launched in 2021 with the objective to improve the quality of life for extremely poor individuals with disabilities and their families, assisting them to escape poverty and enhance their social participation. Before its full-scale launch, the program underwent a pilot phase in four districts (Kishoreganj, Rangpur, Mymensingh, and Kurigram) with the assistance of Humanity and Inclusion² (HI).

The program selects ultra-poor households that have at least one person with a disability through a rigorous selection process. The person with disabilities is considered the main program participant, and the entire household benefits from the intervention. Another household member is designated as the caregiver, responsible for providing care to the person with a disability and assisting them in engaging in program activities.

¹ The BRAC UPG program pioneered the graduation approach to poverty reduction in Bangladesh. This comprehensive and time-bound program aims to empower ultra-poor households and provide them with a pathway out of extreme poverty.

² Humanity and Inclusion (HI) was formerly known as Handicap International.

The selected households are divided into Group A and Group B mainly based on their poverty status. Group A receives a full grant package, while Group B receives a partial grant and credit package, requiring them to pay back 50% of the asset value over a specific period (typically 18 months). The DIUPG program provides comprehensive support, including enterprise development training, asset transfer, hands-on training through home and group visits, matched savings, health support (including rehabilitation and psychosocial support), and community mobilization. The program also facilitates access to healthcare, social safety net programs, and connections with organizations for persons with disabilities (OPD). Although the DIUPG program is based on the UPG model, its interventions are customized to specifically focus on persons with disabilities.

As this was the pilot phase of UPG's first disability-inclusive program, BRAC decided that the program should be studied for generating insights and learnings to improve or fine-tune its design for effectiveness. Therefore, the BRAC Institute of Governance and Development (BIGD) collaborated with BRAC UPG program to conduct a rapid assessment of the pilot DIUPG's 2021 cohort.

The main purpose of this study was to gather learnings from the pilot phase to help finalize the program design. An exploratory mixed-method study was conducted to achieve the following objectives: understand the composition and criteria of the target group, examine the process of enterprise selection and matching, identify the appropriate sequencing between health support and livelihood support, understand the caregiver dynamics, explore disability-inclusive graduation criteria, and identify enabling factors and mechanisms.

The qualitative component used in-depth case studies focused on persons with disabilities to capture their diverse characteristics, understand their ecosystem, and gain deep insights into their interaction with the program. The quantitative component included a survey and data collection from program documents³ on a subsample of the participants, consisting of 287 households. The quantitative approach aimed to provide a broader perspective to examine the research objectives. The findings from both components were thoughtfully integrated to obtain a comprehensive understanding of the experiences of ultra-poor households with individuals with disabilities and to gain in-depth insights into the program design.

Overall, the changes brought about by the program appear promising. However, since this was BRAC's first attempt of this kind, it needs to develop further expertise and insights on designing disability-inclusive livelihood development interventions. The study findings underscore the need for a stronger disability lens in program design as mentioned in the key takeaways. It also highlights the importance of shifting away from a household-centric livelihoods approach to one that prioritizes the needs and perspectives of individuals with disabilities within the household.

The following are the key takeaways:

1. **Targeting:** The program should establish clearer selection criteria and instructions for categorizing individuals with disabilities, taking into consideration their disability condition, such as disability type and severity.

³ These are program surveys conducted by the program to select program participants in terms of their poverty and disability status.

2. **Enterprise Development:** The enterprise selection and matching process should address the barriers hindering the participation of individuals with disabilities as nearly 25% are not engaging in IGA. Also, there is need for more customized enterprise development plans that better match the person with disabilities' strengths and weaknesses, instead of providing cow and poultry to majority of the households.
3. **Livelihood Support:** While livelihood support has been successful in lifting households out of poverty, additional efforts are needed to enhance asset ownership of persons with disabilities and their involvement in decision-making and enterprise development. Special attention should be given to engaging individuals with profound and intellectual disabilities in income-generating activities (IGAs).
4. **Health Support:** Health support should focus on smoothening the rehabilitation process (by tackling challenges experienced by participants and field staff) and strengthening psychosocial support. Challenges such as accessibility to assistive devices, treatment, high transportation costs, lack of manpower (household and operational) to take the person with disability to medical institutions, and resistance from households continue to hinder improvement among individuals with disabilities.
5. **Sequencing:** Finding an effective sequencing between livelihood and health support is a complex task. Although majority of the participants prefer livelihood support first, a significant portion also express the need for health support first. On the other hand, program staff's suggest that sequencing can be addressed by customizing interventions based on participants' specific needs or providing simultaneous support throughout the program, but there are pros and cons of both methods.
6. **Caregiver:** Caregivers play a crucial role and should receive additional support through subsidies or tailored interventions to alleviate their workload and provide stability based on their individual needs.
7. **Graduation Indicators:** The current status of the participants seems positive, but the graduation indicators should be developed with a disability-inclusive approach, considering the accessibility needs of persons with disabilities.

1. Introduction

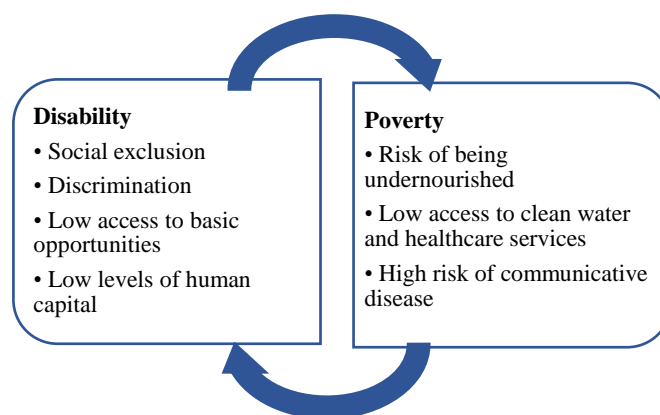
Poverty and disability are significant global concerns, however, tackling them remains a challenge. Poverty and disability interact cyclically, creating a complex poverty trap. Globally, 44 million individuals remain trapped in poverty, while approximately 1.3 billion people face challenges related to disabilities (Baah et al., 2023; Disability, 2023). The “Leaving No One Behind” of the Sustainable Development Goals (SDG) agenda has highlighted the importance of inclusive development for individuals with disabilities within the sustainable development framework. However, it is quite challenging to work in this arena due to the complex nature of both poverty and disability. Understanding the local contexts relevant to the issue is essential for effectively developing customized solutions—inclusive programs and policies that address the specific needs of people with disabilities—for advancing the agenda.

There is solid evidence of the close connection between poverty and disability in developing countries (Braithwaite & Mont, 2009; Elwan, 1999; Fujii, 2008; Hoogeveen, 2005; Mete, 2008; Yeo & Moore, 2003). They perpetuate and reinforce each other (Banks et al., 2017; Braithwaite & Mont, 2009; Elwan, 1999; Yeo & Moore, 2003), forming a “vicious cycle” (Elwan, 1999), as seen in Figure 1, and negatively affecting the goals of building an inclusive society and overall development (Ambati, 2009).

Poor nutrition and working and living standards, limited access to health and maternity care, and inadequate water and sanitation systems heighten the likelihood of disability (Elwan, 1999; Palmer, 2011; Yeo, 2001). On the other hand, individuals with disabilities encounter additional expenses and obstacles when trying to access healthcare services, rehabilitation services, and assistive devices (Elwan, 1999; Groce, Kumbhavi, et al., 2011; Groce, Kett, et al., 2011), increasing their vulnerability to poverty. They also experience exclusion in education and employment, resulting in financial and consumption setbacks (Gudlavalleti et al., 2014). All these factors perpetuate the cycle of poverty and marginalization for persons with disabilities, making it difficult for them to transition out of poverty.

Thus, acknowledging the intersecting relationship between poverty and disability is essential for successfully driving the Leaving No One Behind agenda forward, particularly through designing comprehensive programs and policies to address the specific needs of people with disabilities.

Figure 1: Vicious Cycle of Poverty and Disability



Source: Pinilla-Roncancio (2015)

Impoverished households, particularly in developing countries, struggle to access adequate healthcare services (Gwatkin et al., 2007) face a higher risk of malnutrition (Food and Agriculture Organization [FAO], 2011), encounter limited disability support programs (Mitra, 2006), and often lack accessible and inclusive educational opportunities (World Health Organization [WHO] & World Bank, 2011). Thus, individuals with disabilities in these households are confronted with heightened vulnerabilities. Breaking free from the poverty-disability cycle is a formidable challenge due to the pervasive exclusion of individuals with disabilities, which leads to their poor access to education and employable skills. For instance, individuals with disabilities commonly experience frequent exclusion from the labor market (Yeo, 2001), which may stem from a variety of reasons. Concerns regarding additional expenses of adaptation, a hesitancy to provide necessary accommodations and deeply ingrained biases contribute to a scarcity of employment opportunities for this population. Even when individuals with disabilities secure employment, they often face limitations with working hours and are confined to low-wage, low-skilled positions. Consequently, this perpetuates a dearth of confidence in pursuing opportunities, reinforcing the poverty-disability cycle (Cramm & Finkenflugel, 2008).

In such circumstances, social protection can play a pivotal role in mitigating and preventing their impoverishment and vulnerabilities, ensuring equitable and accessible services, and promoting social inclusion and active participation for individuals with disabilities (Aguilar, 2017). Several developing countries have implemented social assistance programs aimed at providing minimal income support to individuals with disabilities (Gooding & Marriot, 2009; Palmer, 2013). However, these national benefits tend to be insufficient, resulting in the inability of poor individuals with disabilities to escape the cycle of poverty (Ambati, 2009). Moreover, many national social protection systems fail to appropriately address the needs of individuals with disabilities (Aguilar, 2017) as these systems recognize neither the heterogeneity of disability conditions nor their individualized needs. The absence of disability-inclusive strategies may result in a disproportionately high number of individuals with disabilities experiencing chronic poverty (Yeo, 2001).

Similar to other developing nations, Bangladesh grapples with a significant prevalence of disability, which afflicts approximately 6.9% of its population (Bangladesh Bureau of Statistics [BBS], 2019). According to the 2021 National Survey on Persons with Disabilities (NSPD) report, the unemployment rate among working-age individuals with disabilities is 66.22% (BBS, 2022), compared to 3.6% national unemployment rate (BBS, 2023). Similarly, they face a higher incidence of poverty of 28% compared to 24% among individuals without disabilities (Leonard Cheshire, 2018). The disparity imposes a high economic cost on the country. The limited educational and employment prospects for people with disabilities and their caregivers result in an estimated annual income loss of approximately USD 1.2 billion for Bangladesh (WHO, 2011).

Although the national disability policy in Bangladesh allocates a 10% quota for orphans and persons with disabilities in public sector jobs, compliance is low (Ali, 2014). Bangladesh has an extensive safety net system consisting of 143 schemes, but only 1.75% of its budget is allocated to persons with disabilities (The Disability Alliance on SDGs, 2019). In one of the schemes, BDT 750 per month is transferred to individuals with disabilities residing in households with an annual income below BDT 24,000 (Banks et al., 2022). The value of the annual transfer is equivalent to 6.3% of gross domestic product (GDP) per capita; however, the government expenditure on the scheme is 0.005% of the annual GDP of Bangladesh (Institute of Development Studies [IDS], 2020). Moreover, only a fraction of the eligible persons receive

the cash transfer; in 2016, 750,000 people received it among the approximately 24 million people who qualified for the support (ibid). To receive the payment, individuals are required to register for the services, but the difficulties in the registration process, particularly for those with limited education or prior knowledge, lead to a low number of registered beneficiaries (Polu et al., 2015). These safety net programs encounter numerous other challenges, including administrative complexities, high costs, inadequate selection processes, weak governance, corruption, limited transparency, and accountability issues (Masud & Saha, 2014).

The exclusion faced by people with disabilities extends beyond government programs. Mainstream development initiatives are not disability inclusive. For instance, in Bangladesh essential health services such as physiotherapy and assistive devices are primarily available in urban areas, neglecting the needs of individuals at the district level (Polu et al., 2015). Furthermore, individuals with disabilities encounter stigma and discrimination from society (Karki et al., 2023; WHO, 2011). They also face difficulties accessing microfinance institutions as they are unable to meet the requirements due to low income and a lack of regular savings (Sarker, 2013, 2015). These challenges further increase the vulnerability of individuals with disabilities to poverty.

Thus, it is critical to design and implement programs that create employment opportunities and target poverty alleviation for persons with disabilities. To address this issue, the BRAC Ultra-Poor Graduation (UPG) program designed a new program.

BRAC's UPG program, formerly known as Challenging the Frontiers of Poverty Reduction: Targeting the Ultra Poor (CFPR-TUP) program, is widely regarded for introducing the graduation approach to poverty. The graduation approach is a comprehensive, time-bound, integrated, and sequenced series of interventions that aim to empower ultra-poor households, providing them with a pathway out of extreme poverty. The regular UPG program selects ultra-poor households through a rigorous selection process based on a holistic assessment of vulnerable households from economic and social perspectives. Over the years, the program has provided various combinations of interventions, including grants and interest-free loans, to the ultra-poor. Typically, the program spans about two years, and at the end, participating households are assessed to determine if they fulfil the program requirements to graduate out of poverty, indicating improved living conditions.

Numerous studies have been conducted on UPG interventions, clearly indicating their positive impact on poverty alleviation.⁴ Between 2002 and 2020, the program supported more than 2.1 million people. BRAC's UPG model has been replicated and adapted by organizations and governments worldwide. The model's effectiveness lies in its integrated and participatory approach, addressing the multidimensional aspects of poverty while empowering individuals to take charge of their lives and build sustainable livelihoods.

Previously, the UPG interventions mainly targeted the ultra-poor and other vulnerable groups based on economic vulnerability. Many households with persons with disabilities also fell within the target group and received the general UPG interventions. However, recognizing the heightened vulnerability of households with persons with disabilities, the program

⁴ Such as the evaluation by Bandiera et al. (2017) on the grants-only intervention (2007 cohort) and the evaluation by Rahman et al. (2021) on the hybrid intervention (2016 cohort) show that the program had a large, positive effect on income, expenditure, and asset accumulation.

acknowledges the need to provide more customized support to initiate change in their livelihood and socioeconomic conditions.

The fifth and most recent phase of the UPG program is tailored to align with BRAC's five-year strategy (2021–2025) and the present and future contextual factors. In this phase, BRAC prioritizes the inclusion of highly vulnerable and impoverished individuals, with a particular focus on persons with disabilities and from minority communities. Thus, BRAC designed the Disability Inclusive Ultra-Poor Graduation (DIUPG) program to promote the long-term improvement of the quality of life for extremely poor individuals with disabilities and their families, facilitate their transition out of poverty and enhance their ability to participate in society. The program mainly aims to increase work engagement, promote asset growth, and bring about significant changes in the mental and economic status to socially empower and engage the ultra-poor persons with disabilities through various program activities.

Before launching the program on a full scale, UPG initiated a pilot version of DIUPG, providing interventions to 1,000 households in 24 branches across 4 districts (Kishoreganj, Rangpur, Mymensingh, and Kurigram), with technical assistance from Humanity & Inclusion (HI), formerly Handicap International.

Alongside UPG's usual participatory rural appraisal (PRA) method, DIUPG incorporates the use of the Washington Group questionnaires, intensive rehabilitation assessment (IRA), and psychosocial assessment (PSA) to assess household vulnerability and select participants, considering both economic and disability perspectives. The person with disabilities in each household is considered the main program participant, and a household member is assigned as the caregiver of the person with disabilities.

The program provides several services to participating households, including enterprise development training, asset transfer, hands-on training through home and group visits, matched savings, health support, and community mobilization. The selected households are divided into Group A and Group B. Group A receives a full grant package, while Group B receives a grant and credit package, with 50% of the asset value to be repaid. Health support includes rehabilitation assistance and psychosocial counselling. Additionally, throughout the program, participants receive support for accessing healthcare services, social safety net programs, and linkages with OPDs. While many of these program components align with the regular UPG model, they have been modified to have a specific focus on disabilities. Further details on the DIUPG program design and components are provided in Section 2 (pg. 6).

As this is the pilot version of UPG's first disability-inclusive program, studying the program can provide important programmatic insights and learnings on disability-inclusive program designs. Thus, the BRAC Institute of Governance and Development (BIGD) collaborated with BRAC UPG to conduct a rapid assessment of the pilot version of the DIUPG 2021 cohort using a mixed-method approach. The purpose of this study was to gather learnings from the pilot phase, understand the current status of the 2021 cohort, and use the findings to improve the program design and finalize the exit plan for the cohort.

To accomplish this, BIGD designed an exploratory mixed-method study. The study explores the following research objectives: understanding the composition and criteria of the target group, exploring the process of enterprise selection and matching, identifying the appropriate sequencing between health support and livelihood support, examining the dynamics of caregivers, exploring disability-inclusive graduation criteria, and identifying the enabling factors and mechanisms.

Both quantitative and qualitative methods were employed to investigate the research objectives. In-depth case studies were conducted, with a specific focus on persons with disabilities, to capture their diverse characteristics and develop a nuanced understanding of their ecosystem. These case studies aimed to provide refined insights into the rationale behind program activities and an understanding of the participant and program interactions. A quantitative survey was conducted and data from program documents were collected from a subsample of 287 households among the pilot group participants. This quantitative approach offered a broader perspective on the research topics. The findings from both methods were carefully integrated to obtain a holistic understanding of the reality experienced by ultra-poor households with individuals with disabilities and to gain insights into the program's operational details.

Overall, the study findings highlight the need for a dual-focused approach in the program that considers both economic and disability vulnerability equally. The DIUPG program has sufficient expertise in working with the ultra-poor and tackling poverty due to its UPG experience, which was evident throughout its implementation. However, more insights and expertise are required to effectively incorporate the disability-focused approach into the interventions and ensure upward progress in livelihood development.

The remaining portion of the report is structured as follows: Section 2 provides a detailed overview of the program design and the intervention components. Section 3 delves into the rationale behind the use of the mixed-method and provides specific details on the qualitative and quantitative data collection methods. Section 4 presents essential demographic information of the study sample. Section 5, which is divided into seven subsections, presents the findings. The first subsection analyses the effectiveness of targeting and segmentation, and the second one investigates the process of selecting enterprises and matching them to households. The third and fourth subsections examine the dynamics, factors, and mechanisms of livelihood support and health support, respectively. The fifth subsection discusses intervention sequencing options between livelihood and health supports. The sixth subsection explores the role of caregivers, the caregiving mechanism, and the need for further stabilization. The last subsection provides an update on the current status of the households based on UPG graduation indicators. Section 6 summarizes and presents the key findings from each section, and the report ends with a conclusion in Section 7.

2. Program Design

During the implementation of regular UPG program, some ultra-poor households had individuals with disabilities. However, these households face heightened vulnerabilities compared to other ultra-poor households. And, the regular program package does not provide specialized support to address the specific needs of persons with disabilities, making it challenging to facilitate the transition of these households out of poverty.

In line with BRAC's five-year strategy (2021–2025) and considering the present and future contextual factors, the fifth phase of the UPG program prioritizes the inclusion of highly vulnerable and impoverished individuals, with a particular emphasis on persons with disabilities and minority communities. To this end, BRAC UPG has designed the Disability Inclusive Ultra-Poor Graduation (DIUPG) program. The objective of the DIUPG program is to improve the long-term quality of life for extremely poor individuals with disabilities and their families, support their transition out of poverty, and enhance their participation in society. While the primary focus of the regular UPG program is eradication of extreme poverty through positive changes in the status of the ultra-poor population in terms of socio-economic empowerment, increased confidence level, positive behavioral change and higher social inclusion, the DIUPG program also aims to foster the overall development of persons with disabilities. It seeks to increase their work engagement, promote asset growth, and bring about significant improvements in their mental and economic well-being, ultimately empowering them to actively participate in various program activities and mainstream society.

Figure 2: Operational Areas of DIUPG 2021 Cohort



Before nationally scaling up, BRAC implemented a pilot phase of DIUPG in 2021 to test and refine the program design based on the learnings acquired. The pilot program collaborated with Humanity & Inclusion (HI) to use its technical expertise to design a disability-inclusive program. The DIUPG program was launched in 24 branches across four (4) districts in northern Bangladesh, namely Kishoreganj, Mymensingh, Rangpur, and Kurigram, which have a high incidence of poverty.⁵ The pilot program targeted 1,000 households as part of the 2021 cohort, offering tailored support to address their specific needs and challenges.

⁵ Kishoreganj and Mymensingh are selected from the Mymensingh division which has 32.7% of people living below the upper poverty line, and Rangpur and Kurigram are selected from the Rangpur division which has 47.2% of people living below the upper poverty line (BBS, 2020).

2.1. Selection Process and Criteria

The DIUPG selection process is derived from that of UPG and has been modified to prioritize individuals with disabilities. First, the program focuses on identifying the ultra-poor population within the target areas. This is accomplished by leveraging the expertise and local knowledge of BRAC staff to identify poor communities/villages in these areas. Then the program conducts PRAs in each of the enlisted villages. UPG’s PRA method⁶ categorizes the village population into 5–6 economic groups, of which the lowest three groups are considered eligible for primary selection.

The program organizer (PO) and Branch Manager (BM) conducts the primary selection activities, which include visiting households and administering a household questionnaire to assess their economic vulnerability. The questionnaire collects information on household demographics, earnings, savings, loans, asset ownership, and land ownership. Simultaneously, the PO administers the Washington Group questionnaire⁷ to identify persons with disabilities. Both sets of questionnaires are utilized to ensure that households meet the selection criteria established by the program.

The households are first assessed based on the following pre-conditions:

1. The per capita monthly income must be less than BDT 2,000.
2. There must be at least one household member between 18 and 50 years of age.
3. The household should not have any ongoing loans or be affiliated with other non-governmental organizations (NGOs).
4. At least one household member must possess the physical capability to engage in IGAs.

Households that fulfil these pre-conditions are then categorized into UPG Groups 1, 2, or 3 based on the selection criteria outlined in Table 1. If a household meets any two of the three selection criteria, it is primarily selected for participation in the program.

Table 1: Selection Criteria of Regular UPG Groups 1, 2, and 3

Group 1	Group 2	Group 3
1. Household mainly depends on irregular earnings	1. Female household member(s) is involved in IGA due to poverty (mandatory criteria)	1. Household mainly depends on irregular earnings
2. Value of productive assets owned can be a maximum of BDT 5,000	2. Value of productive assets owned can be a maximum of BDT 5,000	2. Value of productive assets owned can be a maximum of BDT 10,000
3. Amount of land owned (including homestead) can be a maximum of 30 decimals	3. Amount of land owned (including homestead) can be a maximum of 10 decimals	3. Amount of land owned (including homestead) can be a maximum of 30 decimals

⁶ The UPG staff ask the villagers to rank the households in six wealth categories in an open meeting. The six wealth categories include destitute, very poor, poor, lower-middle class, middle class, and rich. UPG considers the lowest three categories as eligible for primary selection.

⁷ The Washington Group questionnaire is successfully built on the WHO’s conceptual framing of disability as “a bio-psychosocial model of human functioning.” It includes a set of six questions designed to identify people with functional limitations in moving, seeing, hearing, self-care, remembering or concentrating, and communicating. If the answers to any of the questions are “a lot of difficulty” or “cannot do at all” then the person in question is suspected to have a disability.

One individual with disabilities is verified and registered as the main program participant of a selected household. In cases where a household has multiple individuals with disabilities, one person is registered as a participant, while all persons with disabilities within the household receive program activities.

Following the primary selection stage, the UPG regional manager (RM) conducts the final selection by verifying the households through in-person visits and questionnaire analysis. In the regular UPG program, this marks the end of the selection process, and program activities commence.

However, in the case of DIUPG, an additional round of final identification is conducted. The initial screening for the presence of individuals with disabilities is conducted by the PO, who is not a health expert. Therefore, the final identification and detailed assessment of the physical, psychological, and social status of persons with disabilities are carried out through the intensive rehabilitation assessment (IRA) and psychosocial assessment (PSA) conducted by the rehabilitation officer and psychosocial officer, respectively. Subsequently, the households are divided into Group A and Group B based on their economic vulnerability, with Group A representing the more vulnerable group. Group A receives a full grant package, while Group B receives a grant and credit combination package where they are required to repay 50% of the asset value (provided by the program) through 36 bi-weekly payments.⁸ During the pilot phase, UPG Groups 1 and 2 were assigned to DIUPG Group A, while UPG Group 3 was assigned to DIUPG Group B. The selection criteria for Group A and Group B are presented in Table 2.

Table 2: Grouping Criteria of Group A and B

Group A	Group B
1. Household mainly depends on irregular earnings or female household member(s) is involved in IGA due to poverty	1. Household mainly depends on irregular earnings
2. Value of productive assets owned can be a maximum of BDT 5,000	2. Value of productive assets owned can be a maximum of BDT 10,000
3. Amount of land owned (including homestead) can be 10 - 30 decimals	3. Amount of land owned (including homestead) can be a maximum of 30 decimals

For the DIUPG 2021 cohort, the program conducted 900 PRAs, covering 67,246 households. Among these, approximately 33% (22,183 households) were eligible for primary selection. From this pool, only 7% (1,621 households) successfully passed the primary selection, and 1,085 households passed the final selection. Ultimately, the intervention was provided to 1,000 households. The reasons for non-participation of the remaining 85 households is blurry as there was lack of clear documentation on take-up. However, according the program staff, the participants were mainly excluded due to reasons such as migration, death, and existing loan, and the incidence of self-exclusion was low. The entire DIUPG selection process is summarized in Figure A1 in the annex of the report.

⁸ Group B members were provided four vouchers, where each voucher allowed a delay of one instalment payment.

2.2 Program Components

Though persons with disabilities are the main participants in DIUPG. However, the entire household benefits from the program. Each household designates a caregiver⁹ who provides care for the person with disabilities and assists in implementing the program's interventions. In some cases, other family members who are not part of the household may also serve as caregivers. The program involves three types of field staff responsible for executing various program activities: the program organizer (PO), rehabilitation officer, and psychosocial officer. The specific roles of these staff members are described below. The program provides a range of components to participating households, including enterprise development training, asset transfer, hands-on training through home and group visits, matched savings, health support, and community mobilization. The health support component encompasses rehabilitation and psychosocial support. Additionally, the program facilitates access to healthcare services and social safety net programs and establishes linkages with OPDs. While most of the DIUPG program components align with the regular UPG model, they have been modified to be disability-focused. The detailed descriptions of each program component are given below.

- 1. Enterprise development training:** Following the selection process, program staff conduct enterprise selection activities. At this stage, the program staff (including the PO, rehabilitation officer, and psychosocial officer) meet with the participating household, including the person with disabilities, caregiver, household-head, and any other household members involved in the enterprise. Together, they select an appropriate enterprise combination from three categories: livestock rearing, agricultural activities, or non-farm activities (such as small business, fishing boat/net, or rickshaw/van). The household chooses one enterprise option from any two of the three categories. During this process, the program staff assess the involvement capacity of the person with disabilities in the enterprise development activities, as well as the household's capacity to nurture and develop the enterprise. Subsequently, a comprehensive training session is conducted for the main participant, the person with disabilities, and if applicable, other household members or caregivers involved in the enterprise. The training venue is selected to ensure accessibility and mobility for the participants. In cases where households share a similar enterprise, a maximum of four participants are brought together at a common location for joint training sessions. The training sessions focus on equipping participants with the necessary skills to manage the asset and provide guidance on post-asset transfer activities.
- 2. Asset transfer:** The program ensures that enterprises are matched in a way that allows households to create two types of income-generating sources within a budget of BDT 22,000. One source aims to generate small daily amounts, while the other aims to generate a larger amount within a relatively short timeframe. The larger asset is referred to as the main enterprise, while the smaller asset serves as the secondary enterprise. Asset transfers take place one month within the initial training. The program transfers the assets to the households, declaring the person with disabilities as the owner. Furthermore, households are strongly encouraged to construct necessary components for the enterprise, such as cowsheds for cows or roosts for hens. The program also provides input materials, including tin, vaccination, medicine, and raw materials for building animal shelters, as needed.

⁹ Some households did not have caregivers due to the following reasons: (1) the persons with disabilities had mild problems and did not need much support, (2) the household had very few members, and (3) the household did not have any person without disability.

- 3. Hands-on training through home and group visits:** Participants received home and group visits throughout the program period.
- i. Home visit:** Program staff visited each household every two weeks and this visit is crucial for monitoring the status of the asset or enterprise, ensuring its effective use for income generation, and providing necessary advice and training. The staff also assesses the well-being of persons with disabilities, ensuring that caregivers and individuals with disabilities are following the recommendations provided by the rehabilitation and psychosocial officers.
 - ii. Group visit:** Participants came to the group for the group visit in every two weeks and if the participants have severe disability in that case their caregiver came to the group visit. In the group visit the savings and installment (from Group B) were collected and provided awareness on different health, social and disability-related issues.
- 4. Matched savings:** Each participant is provided with a savings account, and the program offers a matching savings incentive. The savings amount is collected from the participants during home visits. When participants deposit money into their savings account, the program matches the amount up to a maximum of BDT 100 per month. For example, if a participant deposits BDT 60, the program will add another BDT 60, but if a participant deposits BDT 150, the program will match up to BDT 100. This incentive is available for 18 months, with a maximum total of BDT 1,800.
- 5. Health support:** The primary objective of health support is to enhance the overall well-being and stability of persons with disabilities, enabling them to engage in daily activities, IGAs, and active participation in society. However, it is important to note that the DIUPG program follows a social model¹⁰ rather than a medical model, which means that the focus is not on providing comprehensive health support to “heal” the individual with disabilities, but rather on offering basic support to facilitate their empowerment. The health support component is divided into two main parts: rehabilitation and psychosocial support. Both components provide treatment and referrals based on the specific needs of the participants.
- i. Rehabilitation support:** Rehabilitation support aims to empower individuals with disabilities by addressing physical barriers that impede their daily activities, enhancing accessibility, and reducing disability-related challenges. The program assigns a dedicated rehabilitation officer who provides the following rehabilitation activities:
 - **Intensive rehabilitation assessment (IRA):** During the selection stage, the rehabilitation officer conducts a comprehensive assessment of the physical condition of the persons with disabilities using the IRA form. This assessment takes into account their medical history, the severity and type of disability, as well as their functional difficulties and challenges. Based on these assessments, the rehabilitation officer develops a personalized care plan for each individual with a disability.
 - **Caregiver training:** The rehabilitation officer provides training and guidance to caregivers on how to effectively care for the person with disabilities and carry out the

¹⁰ The social model challenges the traditional medical model of disability, which views disability as a personal deficiency or abnormality that needs to be treated or cured. Instead, it argues for removing societal barriers and promoting inclusive policies, practices, and attitudes to enable individuals with disabilities to fully participate in society on an equal basis with others.

activities outlined in the care plan. This includes instruction on personal care assistance, medication management, therapeutic exercises, and any necessary specialized care. Additionally, caregivers are taught strategies to create a safe and supportive environment that enhances the emotional and physical well-being of the person with disabilities. Through this training, the rehabilitation officer ensures that caregivers acquire the knowledge and skills necessary to provide optimal care and support.

- **Home-based therapy:** Based on the IRA assessment, the rehabilitation officer designs a tailored home-based therapy program. This program may include exercises, stretching routines, mobility training, balance enhancement exercises, and other therapeutic activities that can be easily performed at home. The goal is to maximize the person's functional capabilities, expedite the recovery process, and instill a sense of freedom and hope.
 - **Assistive device:** The rehabilitation officer recommends assistive devices to individuals based on their specific needs. These external devices help reduce functional difficulties and enable individuals to perform their daily activities and actively participate in society. Assistive devices can range from mobility aids such as wheelchairs, walkers, or canes, to specialized equipment like hearing aids. The officer explores various mechanisms, including funding from BRAC, community mobilization, and linkage creation with non-governmental and governmental organizations, to provide the necessary assistive devices.
 - **Task adaptation and reasonable accommodation:** The rehabilitation officer also focuses on improving accessibility for individuals with disabilities in various tasks. This may involve suggesting modifications to housing infrastructure to ensure accessibility, such as installing grab bars, ramps, or handrails. The officer guides task adaptation, emphasizing its importance, and collaborates with household members to implement these adaptations.
- ii. **Psychosocial support:** Psychosocial support aims to enable and empower individuals with disabilities by addressing their psychological difficulties and social barriers, thereby improving their mental health, overall well-being, and participation in society. While the support primarily focuses on the person with disabilities, it is also extended to caregivers and other household members, if necessary, as they may encounter challenges that can impact their psychosocial well-being, such as social isolation, trauma, or high levels of stress. The program has a dedicated psychosocial officer to provide the following activities:
- **Psychosocial assessment (PSA):** During the selection stage, the psychosocial officer conducts a comprehensive assessment of the mental health condition and social well-being of the persons with disabilities using the PSA form. This assessment takes into account their psychiatric history, mental health condition, psychological burden, behavioral and cognitive issues, as well as their social interactions. Based on these assessments, the psychosocial officer develops a personalized care plan for the household.
 - **Counselling:** The psychosocial officer provides individual counselling to the person with disabilities, as needed, to positively influence their behavior and attitude, motivate them to engage in productive work, and encourage their cooperation with the program activities. Additionally, individual counselling is offered to caregivers to help

reduce their stress, motivate them to follow advice, and enhance their caregiving practices. These counseling sessions create a safe space for individuals to freely express their emotions, discuss their concerns, and receive guidance from a trained professional. The aim is to empower individuals to navigate their difficulties, develop effective coping strategies, and cultivate resilience in the face of adversity.

- **Community sensitization:** Recognizing that households with persons with disabilities often face negative experiences within their communities, the psychosocial officer actively engages in community awareness sessions to reduce discrimination and promote inclusivity. These sessions involve conducting awareness programs with the community members, including neighbors, friends, and relatives of the participating households to educate them about the rights of persons with disabilities and how to treat them with respect and equality. By fostering empathy and understanding, the program aims to create more supportive and inclusive communities.

iii. Referral and treatment support: Referral and treatment support is an integral part of both rehabilitation and psychosocial support. Referrals may be initiated by either the rehabilitation officer or the psychosocial officer based on the specific needs of the person with disabilities. These referrals can be for purposes such as diagnosis, specialized consultations, or treatment. In cases where medical expertise related to physical conditions is required, the rehabilitation officer facilitates and refers households to appropriate healthcare professionals. Similarly, the psychosocial officer refers individuals to psychologists or psychiatrists when necessary. During the referral process, program staff may accompany participants if needed. The program covers the expenses for the first visit, including check-up fees and medicine but excludes transportation costs. To ensure efficient referral activities, the program establishes partnerships with local healthcare providers and medical institutions, including hospitals, clinics, and medical professionals. Furthermore, the program provides guidance and support to households throughout the process, including educating them about the importance of seeking medical care, explaining treatment options, and offering advice as necessary.

6. Community mobilization: The program promotes the social integration of participants within their local communities by establishing the Village Social Solidarity Committee (VSSC). Comprising 9–11 members from the community, including village elites, non-elites, and members of participant households, the VSSC holds monthly meetings to facilitate the development of social networks and community ties. The committee's main objectives are to ensure the social security of participants, safeguard the assets provided by the program, and create an enabling environment for participants in the village.

7. Other program activities: The program staff also provide advice on available healthcare services and refers other household members as needed. They work to improve access to local hospitals and healthcare centers. Additionally, the staff inform households about available social services and assists with accessing those services, such as registration for allowances and Suborno Cards¹¹. Efforts are made to connect participants with relevant services and organizations catering to the needs of persons with disabilities.

¹¹ Suborno Card is an identification card for persons with disability provided by the government. This allows persons with disability to officially register and to be eligible for social safety net benefits.

3. Study Design

The study aimed to update the program design for the next cohort (national-level scale-up version) based on the learnings from the pilot phase and to gain a comprehensive understanding of the current status of the 2021 cohort to finalize their exit plan. To achieve these goals, BIGD implemented an innovative and exploratory mixed-method study. The study focused on the following objectives:

1. understanding the composition and criteria of the target group,
2. exploring the process of enterprise selection and matching,
3. identifying the appropriate sequencing between health support and livelihood support,
4. examining the dynamics of caregivers,
5. investigating disability-inclusive graduation criteria, and
6. identifying the enabling factors and mechanisms.

The findings of this report are structured in alignment with these objectives.

3.1. Mixed-Method Strategy

The study employed a combination of quantitative and qualitative research tools to address the research questions. The qualitative research involved conducting in-depth case studies that focused on individuals with disabilities, which provided a comprehensive understanding of the program and its participants and captured the diverse range of disabilities and associated challenges. On the other hand, quantitative data were collected from a subset of pilot group participants to gain a broader perspective on the program using descriptive statistics. By integrating both methods, this study aimed to obtain a holistic understanding of the experiences of ultra-poor individuals with disabilities and their households and a nuanced interpretation of the program's impact on their lives.

The research team consisted of experts with backgrounds in both quantitative and qualitative research. Given the urgent nature of this study for the program, the team conducted both methods simultaneously. At the same time, all team members collaborated closely and were actively involved in field research activities across both methods, including study design, data collection, analysis, and interpretation. Further details regarding the quantitative and qualitative data collection methods are outlined in the following subsections.

3.1.1. Qualitative Method

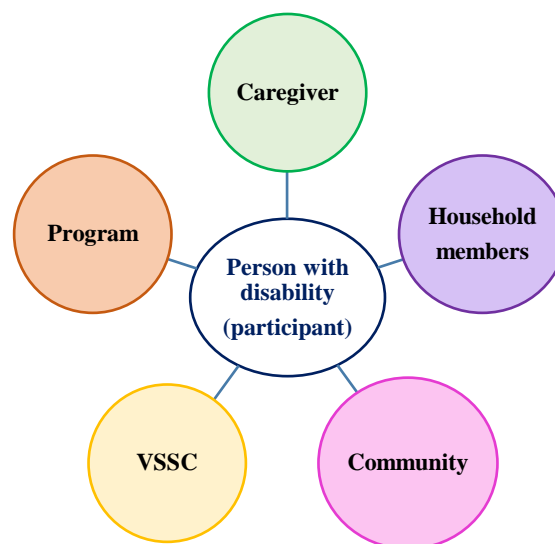
This study heavily relied on the qualitative method due to its flexibility and comprehensive exploration of the research objectives.

Study site: The DIUPG program was implemented in four districts: Mymensingh, Kishoreganj, Rangpur, and Kurigram. Rangpur and Kurigram fall within the Rangpur Division, where approximately 47.2% of the population lives below the upper poverty line (BBS, 2020). Mymensingh is part of the Mymensingh division, where around 32.7% of the population lives below the upper poverty line (ibid). Although Kishoreganj falls within the Dhaka division, it is geographically close to Mymensingh. These regions have the highest poverty rates in Bangladesh. When clustered by region, they can be clustered as the Rangpur-Kurigram poverty belt and Mymensingh-Kishoreganj poverty belt. To capture the local context of the two poverty belts, the study purposively selected two study sites, one from each poverty belt, for qualitative

research. Additionally, the study aimed to capture the influence of urban and rural locations. Therefore, Mahiganj was selected from Rangpur to represent a peri-urban area as it is the closest to Rangpur City Corporation. Conversely, Kuliarchar was chosen from the Kishoreganj sub-district to represent a remote rural area.

Method: To gain a comprehensive understanding of the participants and their experiences, a person-with-disability-focused case study model was employed. This model was specifically chosen to address two challenges. First, studying a topic related to disability within the context of the program presented inherent complexities. Given the wide range of disabilities and their unique characteristics and challenges, it was crucial to adopt an approach that could accommodate this diversity. Second, the experience of each individual with a disability is influenced by various factors such as gender, age, health, and socioeconomic status, resulting in distinct challenges and needs. The case study method allowed for a multi-faceted examination of each individual, capturing their unique circumstances. Within each case study, interviews were conducted with individuals from six categories, as depicted in Figure 3: the main participant (person with disabilities), their caregiver, household members, program staff, community members, and the Village Social Solidarity Committee (VSSC).

Figure 3: Person-With-Disability-Focused Case Study Model



Tools and respondents: For each case study, people from the six categories in Figure 3 were interviewed using various qualitative tools to gather insights about the experiences, perspectives, and narratives of individuals with disabilities and those closely connected to their lives. In-depth interviews (IDIs) were conducted with both the person with disabilities and their caregivers—the primary recipients of the program activities. The person with disabilities was interviewed only if they were adults and could communicate; otherwise, only the caregiver was interviewed.

Key informant interviews (KIIs) were conducted with three different program staff members, including the PO, rehabilitation officer, and psychosocial officer. These interviews provided insights into how the participants were assessed, care plans were developed, action plans were executed, changes in participants were observed by the program, and challenges were encountered. As the same program staff worked with all the participants in one study site,

individual interviews were conducted with the same program staff for each case study; each program staff had to give multiple interviews.

Informal discussions were held with other household members including spouses, household-heads, siblings, and in-laws, if available, to gain an understanding of their perceptions of the person with disabilities, the caregiver, and their interactions with the program. Informal discussions were also conducted with VSSC members and members of the close community, including neighbors, friends, and relatives, to explore their perspectives on the participants, the program activities, and the changes experienced by the participants.

Furthermore, one focus group discussion (FGD) was conducted with all program staff at each study site to capture their collective field-level experiences, challenges, and operational perspectives regarding the overall program operations. Table 3 provides a detailed breakdown of the number of qualitative interviews conducted.

Table 2: Details on the Number of Qualitative Tools and Respondents

Tools	Respondent	Perspective	Number of respondents		
			Rangpur	Kishoreganj	Total
IDI	Person with disabilities	User-end	5	7	12
IDI	Caregiver	User-end	16	16	32
KII	Rehabilitation officer*	Operational	11	11	22
KII	Psychosocial officer*	Operational	11	11	22
KII	Program organizer*	Operational	11	0	11
KII	Branch manager*	Operational	0	11	11
FGD	BRAC DIUPG field staff	Operational	3	4	7
Informal discussion	Community member	Community	10	10	20
Informal discussion	VSSC member	Community	2	2	4
Informal discussion	Other household members	User-end	11	11	22
Total			80	83	163

**During the KIIs with the program staff, each staff is interviewed multiple times (one time for each participant).*

Sampling technique: Purposive sampling was employed to ensure maximum variation in the case studies, primarily based on disability types, as well as gender, age, and role in the household. To identify the disability types experienced by the participants, the study relied on the IRA assessment conducted by the rehabilitation officer that used six categories of disability type (details on disability type are provided on pg. 19). The researchers aimed to select two participants from each disability type, one for Group A and another for Group B. The same process was followed in both study sites to select cases for the qualitative study. The initial target was to conduct 24 case studies; however, due to the unavailability of certain disability-type cases, a total of 22 case studies were successfully conducted. The number of targeted and completed qualitative samples is provided in Table 4. This entire data collection procedure was completed between 12 March and 23 March 2023.

Table 3: Qualitative Sample Distribution

Types of disability from IRA (program document)	Rangpur				Kishoreganj				Total	
	Group A		Group B		Group A		Group B			
	Target	Completed	Target	Completed	Target	Completed	Target	Completed	Target	Completed
Physical	1	1	1	1	1	1	1	1	4	4
Visual	1	1	1	1	1	1	1	1	4	4
Hearing	1	0	1	1	1	1	1	0	4	2
Speech	1	1	1	1	1	1	1	1	4	4
Intellectual	1	1	1	1	1	1	1	1	4	4
Psychological	1	1	1	1	1	1	1	1	4	4
Total	6	5	6	6	6	6	6	5	24	22

Analysis: The collected data was transcribed from audio files to Word documents in Bengali for thematic analysis. The thematic analysis involved carefully reading the transcripts, interpreting the data, and compiling small findings for each theme into an Excel sheet. These findings were then synthesized to develop broader conclusions, which were subsequently integrated with the quantitative data when necessary to obtain a comprehensive understanding of the findings.

3.1.2. Quantitative Method

The quantitative method was employed to investigate all the research objectives, except the enabling factors and mechanisms.

Method: Since this study was conducted during the post-intervention phase, there was no baseline data available for the participants, nor was there a comparison group for analysis. Therefore, BIGD relied on various sources to gather quantitative data, both secondary and primary.

Sampling technique: BIGD utilized the sample that the UPG’s Monitoring Evaluation Accountability and Learning (MEAL) team used in an earlier learning study in September 2022, approximately 15–17 months after the intervention. The MEAL team employed a stratified sampling technique to select 303 households from 10 different branch offices in four districts, ensuring a 95% confidence level. In March 2023, BIGD collected the MEAL data and conducted a resurvey of the same households. The BIGD survey reached 294 households and successfully surveyed¹² 287 households. Detailed information on the number of households surveyed for the quantitative analysis is presented in Table 5.

¹² Successfully surveyed implies that these households gave consent and participated in the survey.

Table 4: Quantitative Sample Distribution

District	Sub-district (Branch)	MEAL sample (Target)	BIGD sample (Complete)
Mymensingh	Dhubaura	30	28
	Muktagacha	31	28
Kishoreganj	Baniagram	30	29
	Kuliarchar	30	30
	Tarail	30	28
Kurigram	Bhurungamari	28	27
	Kashipur	31	27
	Pateshwari	31	30
Rangpur	Mahiganj	30	30
	Nekmamud	32	30
Total		303	287

Data collection: As mentioned earlier, no baseline data were available for this study. However, during the selection process, the program staff utilized hard-copy questionnaires to assess the economic (land, assets, and income) and social condition of the households and disability identification of the persons with disabilities. This data was collected before the participants were enrolled in the program, providing a good estimate of the household’s pre-intervention status. In this study, an innovative method was employed to digitize this data and utilize it as the pre-intervention (baseline) data.

BIGD recruited data collectors who were responsible for digitizing the data from program documents and conducting surveys with the households using the BIGD survey. The data collectors were assigned to specific branch offices, which collected the program documents of the households on the pre-assigned sample list. Researchers designed Survey CTO forms (digital version) of the hard-copy questionnaires. The data collectors simply copied the information from the hard copies onto their tablets using those Survey CTO forms.

After the pre-intervention data was digitized, the data collectors visited the participants’ homes according to the sample list and conducted in-person surveys using the questionnaire developed by BIGD. The survey aimed to collect post-intervention data on the person with disabilities, their caregiver, and the household. It included data on household IGAs, assets, expenditure, food security, perception of program activities, social and subjective well-being, and other primary socioeconomic characteristics. This data collection procedure took place from 11 March to 20 March 2023.

Respondents: Given the study objectives, it was important to gather data from multiple sources, including the person with disabilities, their caregiver, and the overall household. The person with disabilities, the main participant in the program, was expected to be the primary respondent. However, due to the varying functional difficulties experienced by individuals with disabilities, communication challenges arose. Additionally, the program did not impose an age limit for participants, including children with disabilities. This posed a challenge in selecting a fixed respondent type for all households. The study design allowed for three types of respondents: the person with disabilities, the caregiver, and both the person with disabilities and the caregiver together. Table 6 explains the conditions for selecting the respondent type and their incidence in the sample. However, it was required for the person with disabilities to be present during the surveys.

Table 5: Description of Respondents Surveyed Quantitatively

Type of respondent	Condition	Percentage of sample
Person with disabilities	The person with disabilities is above 18 years old (adult), and their condition of disability does create any barriers to participating in the survey. They do not face any problem directly communicating with the data collectors.	44%
Caregiver	The person with disabilities is below 18 years old (underage) or they cannot directly communicate with the data collector due to their condition of disability.	47%
The person with disabilities and caregiver together	The person with disabilities is above 18 years old (adult) and their condition of disability makes it difficult to directly communicate with the data collector but can communicate with help from the caregiver.	9%

Analysis: Once all the data was collected, it was formatted in STATA for analysis. This included various types of data, such as the Management Information System (MIS) data, the MEAL team’s data, pre-intervention data, and the BIGD post-intervention survey data. Descriptive statistics were generated from the data and interpreted in the findings section to provide meaningful insights.

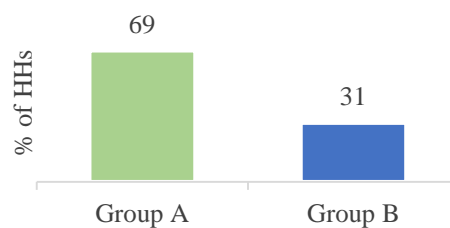
3.2. Limitations

The study has some limitations. First, there was no structured baseline data on the DIUPG 2021 cohort. Instead, the study relies on the data collected through hard-copy questionnaires by the program during their rigorous selection process as close estimate for baseline data. However, it should be noted that this data was originally collected for a different purpose, resulting in limited information available on the pre-intervention status of the households. Second, this study did not include a control group, those who were eligible for the intervention but did not receive it. Therefore, the study only assesses the changes in the participating households before and after the intervention, without a direct comparison to a non-intervention group.

4. Demographics

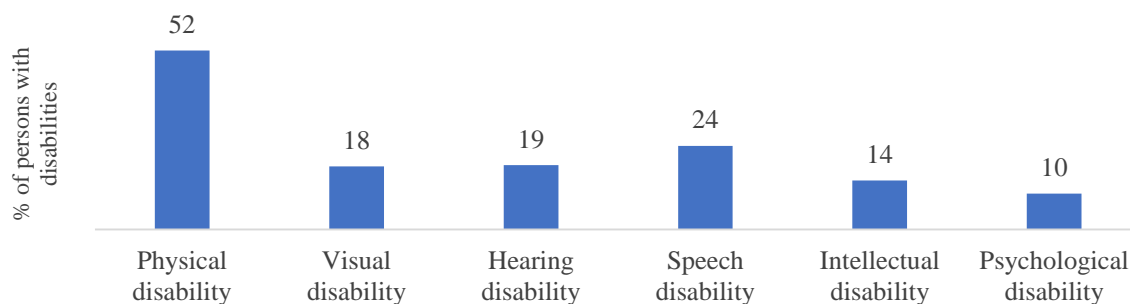
This section provides preliminary descriptive statistics on the demographics of the 287 households surveyed quantitatively, which includes the 22 households selected for the qualitative case studies.¹³ The average household size is 4.13, and 33.45% of the households are female-headed. The average household size aligns with the national average, while the higher incidence of female-headed households (15% higher than the national average) indicates a greater vulnerability among the households. Figure 4 illustrates the distribution of the sample across Group A and Group B, with the majority of households allocated to Group A. Further details on the segmentation are discussed in Section 5.1.2 (pg. 29).

Figure 4: Sample Distribution by Group



Given the focus on disability in this program, the findings sections analyze the program activities, participants' perceptions, and engagement in activities through a disability lens. The study mainly uses the disability type and severity to serve this purpose. The research team relied on the IRA (disability condition assessment conducted by the rehabilitation officer) to gather information on the disability type and severity of the participants. The IRA assesses the disability type using the International Classification of Functioning, Disability and Health (ICF) framework used by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the World Health Organization (WHO). These disability types include physical disability, visual disability, hearing disability, speech disability, intellectual disability, and psychological disability. A person may have one or multiple disabilities. Figure 5 presents the incidence of disability types among the selected participants in the program. This categorization is consistently utilized throughout the report to examine variations by disability type. The percentages in the disability type figures add up to more than 100% as persons with multiple disabilities were distributed into the six categories.

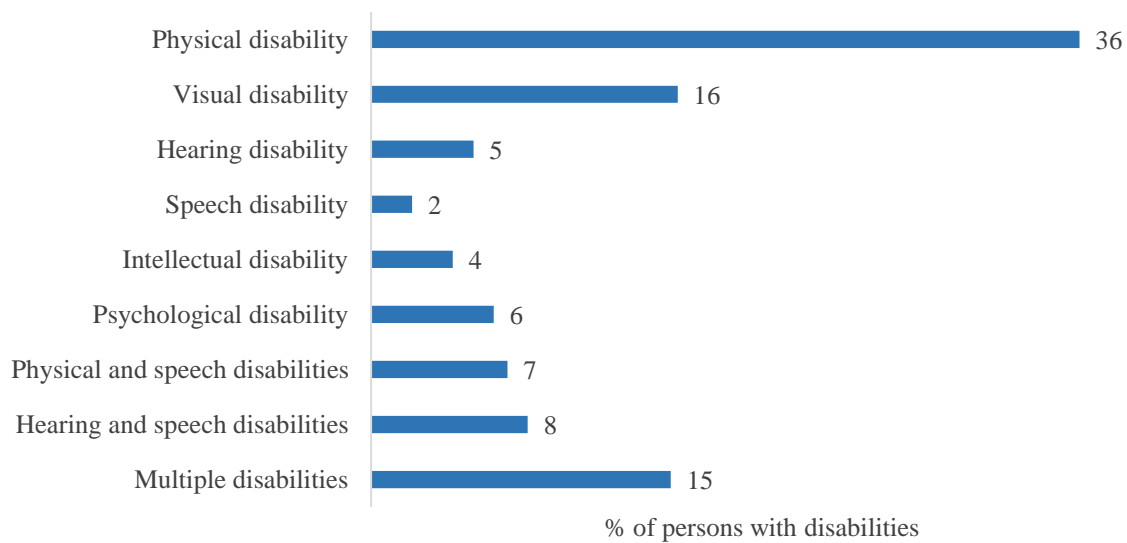
Figure 5: Types of Disability among Persons with Disabilities



¹³ The demographics of the qualitative sample are not discussed separately as they were purposively handpicked to ensure maximum variation.

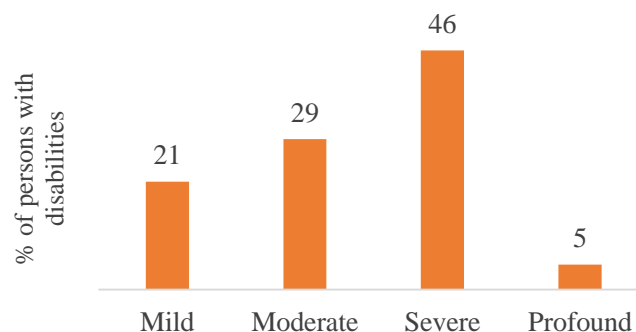
Figure 5 reveals that 52% of the persons with disabilities have physical disability, while 24% experience speech disability. Thirty per cent of the persons with disabilities have multiple disabilities. Figure 6 provides a detailed breakdown of the exact incidence of disability types observed. The major single disabilities (without any other disabilities) are physical disability (36%) and visual disability (16%). The lowest incidence of disability is speech impairment, which stands at 2%. However, speech is found to be associated with other disabilities, such as physical and speech disabilities (7%) and hearing and speech disabilities (8%). Finally, 15% of the participants have multiple (three or more) disabilities.

Figure 6: Clustered Categories of Types of Disability among Persons with Disabilities



The IRA categorizes disability severity into four categories: mild, moderate, severe, and profound.¹⁴ The severity is determined based on the level of assistance required by the person due to their functional difficulties. If a person has a single disability, their severity is assessed based on that specific disability. However, if they have multiple disabilities, all disabilities are taken into consideration when assessing their severity.

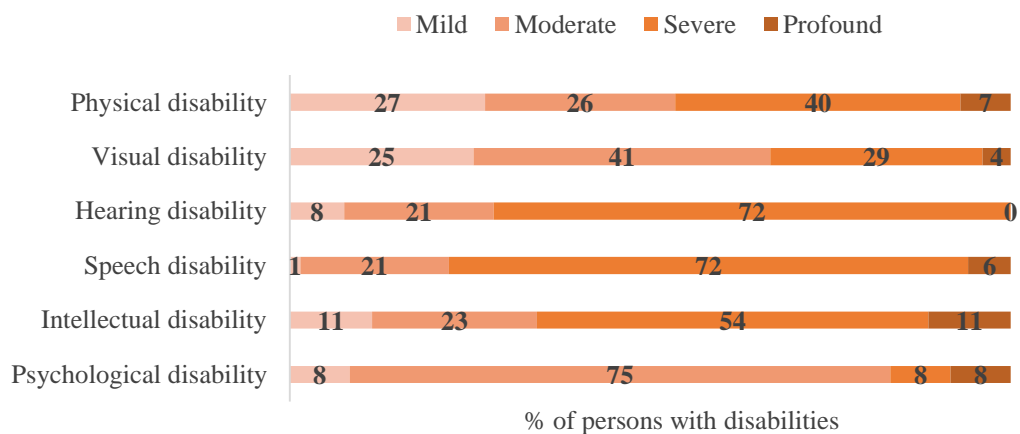
Figure 7: Severity of Disability among Persons with Disabilities



¹⁴ Mild refers to minimum assistance, moderate refers to moderate assistance, severe refers to maximum assistance, and profound refers to completely dependent.

According to Figure 7, the majority of the persons with disabilities selected for the program fall under the severe category (46%). The incidence of profound cases is relatively low, as the program aims to enable persons with disabilities, raising the question of whether the program intends to include profound cases. Figure 8 provides a comprehensive overview of the severity incidence for each disability type. It reveals that the highest incidence of severe cases is observed among those with hearing disability (72%) and speaking (72%). Additionally, intellectual disability has a high incidence of severe cases (54%) and a notable proportion of profound cases (11%).

Figure 8: Severity by Disability Type for Persons with Disabilities



The demographic information of the persons with disabilities selected in the study includes sex, age, education, and marital status. Approximately 54% of the program participants are females, indicating a higher proportion of female representation. Second, the program did not impose any age limits for participant selection. While the majority of participants fall within the working-age range (79%), around 16% are below 15 years old and 5% are above 65 years old, as shown in Figure 9.

Figure 9: Age Distribution of Persons with Disabilities

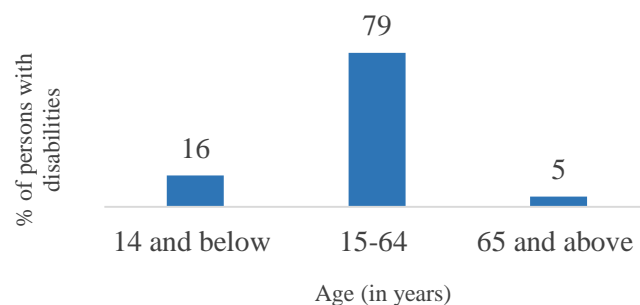
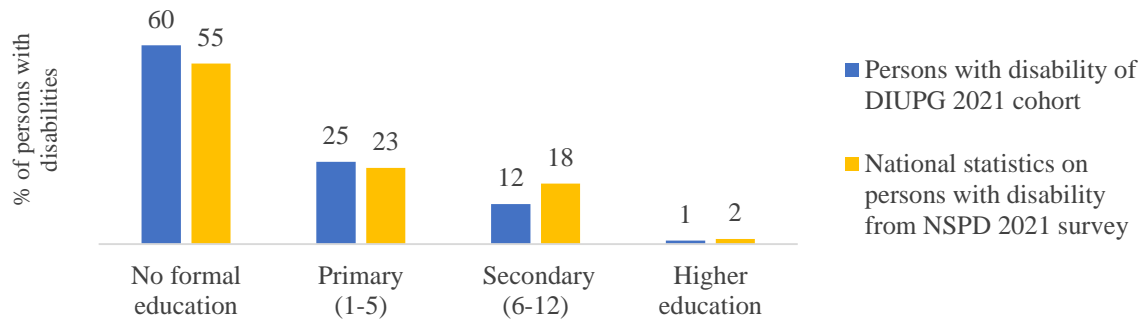


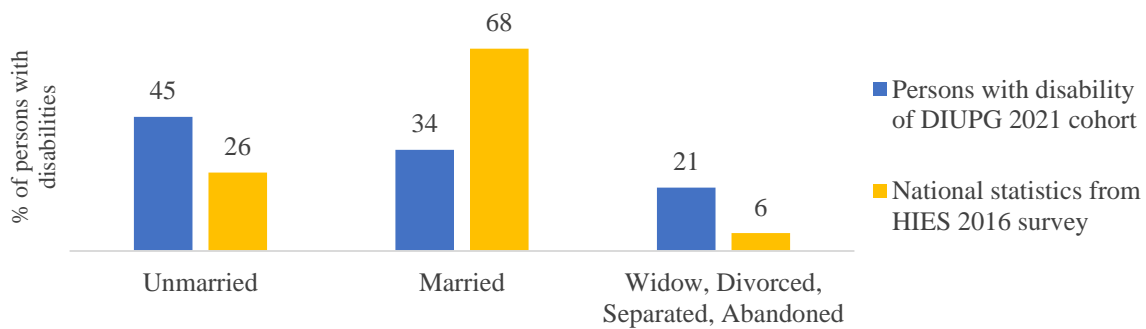
Figure 10 compares the educational attainment of persons with disabilities (above 3 years old) in the program to national-level statistics on persons with disabilities from the National Survey on Persons with Disabilities (NSPD) 2021 report. The majority of persons with disabilities in the program have not received any formal education, with a higher incidence compared to the national average (60% vs 55%). Only a quarter of the population has completed primary education.

Figure 10: Educational Attainment of Persons with Disabilities (DIUPG 2021 vs NSPD 2021)



Next, Figure 11 compares the marital status of persons with disabilities (above 10 years old) in the program to national-level statistics from the Household Income and Expenditure Survey (HIES) 2021 report since the data are not available in the NSPD. This comparison highlights the differences between persons with disabilities and the general population and shows that the majority of persons with disabilities in the DIUPG 2021 cohort are unmarried (45%), and have a lower incidence of marriage compared to the general population (34% compared to 68%). Additionally, the incidence of widowhood, divorce, separation, or abandonment is nearly three times higher among persons with disabilities (21% compared to 6%), indicating an additional layer of vulnerability from a social standpoint.

Figure 11: Marital Status of Persons with Disabilities (DIUPG 2021 vs HIES 2016)



Additionally, the study examines the characteristics of participants who are household-heads. Table 7 reveals that a significant portion of ultra-poor households (approximately 26%) have household-heads with disabilities, with about one-third of them being females. These percentages are higher than the national averages, indicating the heightened vulnerability of both the households and the participants and their purposive selection by the program.

Table 6: Disaggregation of Household-Heads by Sex and Disability (in %)

	Without disability	With disability
Male HH-head	48.53	18.02

Female HH-head

24.97

8.48

Figures 12 and 13 provide a closer analysis of household-heads with disabilities. The majority of these individuals have physical disability (52%) or visual disability (31%). This observation is justified, as effective decision-making is a key role of household-heads, requiring the ability to communicate. Individuals with physical and visual disabilities can still listen and respond consciously, unlike those with other types of disabilities. Figure 13 examines the severity levels among the two major disability types, indicating that the majority of household-heads with disabilities have mild or moderate conditions, however, a substantial percentage have severe conditions as well.

Figure 12: Types of Disability among Household-Heads with Disability

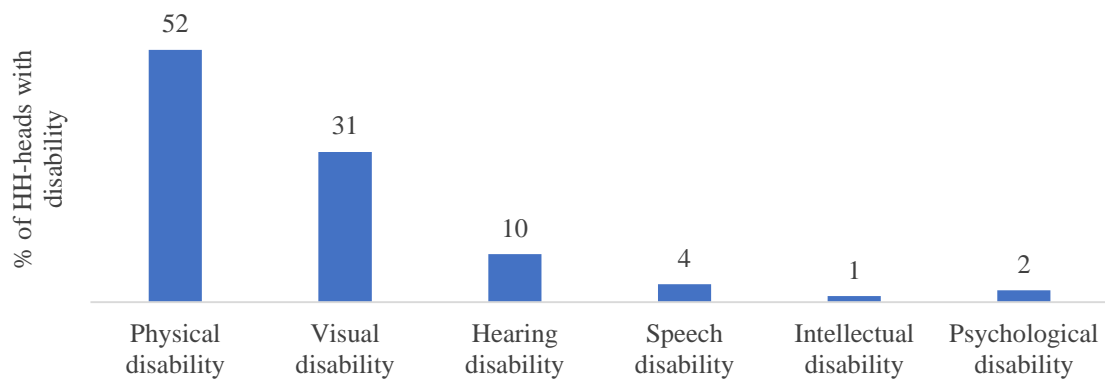
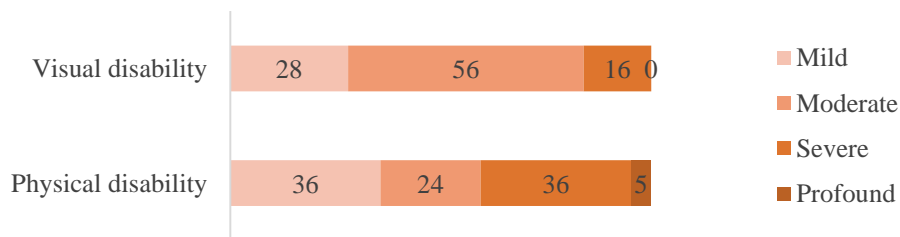


Figure 13: Severity of Disability among Household-heads with Disability



5. Findings

Both quantitative and qualitative data have been analyzed and integrated to generate key insights for the program. The first subsection addresses the first study objective, which focuses on the targeting effectiveness and segmentation mechanism. The second subsection explores the second study objective, the enterprise selection process and how the program matched enterprises to each household. The third and fourth subsections delve into livelihood support and health support, providing detailed insights into the processes and challenges involved. The fifth subsection evaluates the sequencing of interventions between livelihood and health support to address the third study objective. The sixth subsection explores the fourth study objective by examining the condition of caregivers, the caregiving mechanism, and the need for further stabilization. The final subsection presents the recent status of the households according to the existing UPG graduation indicators, addressing the fifth study objective. The sixth objective—identifying enabling factors and mechanisms—was not explored separately; rather it is incorporated within every section, as necessary. However, case study A2 in the annex describes the entire journey of a participant, which may help understand the enabling factors and mechanisms.

5.1. Targeting

This section aims to assess the effectiveness of the targeting process in meeting the criteria for program participation, to understand the composition of the target group, and to analyze the segmentation.

5.1.1. Targeting Effectiveness

In this subsection, the targeting effectiveness is assessed by examining the pre-intervention vulnerabilities experienced by the participating households across four dimensions: economic condition, health, knowledge and awareness, and exclusion. In addition to identifying whether and to what extent the program targeted its intended target group, the analysis also provides insights for potential program modifications based on the participants' needs.

5.1.1.1. Pre-Intervention Vulnerability: Economic Condition

Economic vulnerability of the households is assessed because the program specifically targeted the ultra-poor. Descriptive statistics on the pre-intervention economic status of the households are presented in Table 8. Prior to the intervention in 2021, the households had a very low income base and owned minimal assets. On average, the households had a per capita monthly income of BDT 1,192 and possessed productive assets valued at BDT 2,740. These figures align with the criteria set by the program, as explained in Section 2.1 (pg. 7).

Table 7: Descriptive Statistics on Economic Status during Pre-Intervention

Indicators	Estimates (in BDT)
Monthly household income	4,740.32
Per capita monthly income	1,192.23
Total value of productive assets owned by household	2,740.44

The qualitative findings further illustrate the extreme vulnerability of these households prior to the intervention. During IDIs, household members shared their experiences of limited employment opportunities, which hindered their ability to sustainably support their families. Their limited possession of productive assets also restricted their opportunities for self-employment and engagement in IGAs. Consequently, their income streams were irregular. One participant's mother expressed her situation during an IDI:

“I used to work at people's homes before. They did not pay me much as the people in this village are poor themselves. I went to work whenever they called me, otherwise I had to sit at home. What could I have done?”

Due to their economic vulnerability, these households faced persistent challenges and had limited prospects for improvement, which led to a sense of hopelessness. They had little faith in their ability to improve their living conditions and relied on charity and external assistance to meet their basic needs, further reinforcing a cycle of dependency, eroding their self-esteem, and diminishing their motivation to strive for better circumstances.

5.1.1.2. Pre-Intervention Vulnerability: Health Condition

The targeted households were characterized by the presence of at least one member with a disability who experienced health-related complications. Factors that influenced the prior health condition of individuals with disabilities and the health-seeking behavior of the households are discussed here.

- a) **Factors affecting the overall health condition of persons with disabilities:** Several factors influenced the overall health condition of individuals' with disabilities, including the type and severity of their disabilities, age, and the presence of comorbidities.
- **Type and severity of the disability:** Different disabilities have unique implications for physical and psychological well-being. For instance, individuals facing difficulties with mobility encounter challenges in performing daily activities due to restricted movement. On the other hand, those with intellectual and psychological disabilities experience communication barriers. The severity of the disability also plays a role in determining the impact on an individual's health, ranging from mild to profound. The combination of disability types, functional difficulties, and severity results in variations in health complications and vulnerability.
 - **Age:** For older individuals, age-related health issues complicate their underlying disability, leading to more severe health conditions (Molton et al., 2014). Consequently, older persons with disabilities require increased support and care. However, young children with disabilities also require significant support and care due to their ongoing development.
 - **Presence of comorbidities:** It is well-known that the presence of comorbidities, where individuals with disabilities have multiple chronic conditions, can further impact overall health (Espinoza et al., 2018). The interaction and exacerbation of comorbidities among persons with disabilities result in increased health risks and complexities in managing their health conditions.

b) Factors affecting health-seeking behavior: The health-seeking behavior of households also influences the health condition of persons with disabilities, and this behavior is influenced by factors such as their age and gender and the economic condition of the household.

- **Age:** The age of the person with disabilities plays a role in the health-seeking behavior of households. For children and young individuals (those under 18 years age), household members tend to be more hopeful about the potential for improvement in their health. Consequently, they actively seek treatment and medical interventions. Conversely, health conditions of older individuals with disabilities are often perceived irreversible by themselves and family members, and therefore active treatment may not be sought for them. Besides, due to limited resources and extreme poverty, households may prioritize investing in the healthcare of children, hoping that the child will grow up to be healthy enough to contribute to the household's economic well-being. This is reflected in the statement of the mother (caregiver) of 38-year-old Raziya (pseudonym), an individual with intellectual disability, during an IDI:

“I tried to get her treatment for a long time. Then I gave up because she will not get better. And to tell you the truth, there was a shortage of money back then. My husband had nothing. So, I gave up.”

- **Gender:** Societal expectations and norms based on gender also impact health-seeking behavior. In rural Bangladesh, there are specific expectations for girls, who are often expected to grow up, get married, and take care of their in-laws and children. Thus, for female individuals with disabilities, the anticipation of marriage plays a significant role in the decision to seek treatment. The mother (caregiver) of Hafsa (pseudonym), an individual with intellectual disability, expressed this sentiment during an IDI:

“I would have had so much peace if she had been healthy. I am worried that if I die and she is not married off by then, she will be very helpless.”

On the other hand, societal expectations for males center on their ability to work and provide for the family. As a result, some families may prioritize seeking treatment for the health of male household members, as their ability to engage in IGAs is seen as crucial for supporting the family.

- **Economic condition:** The ultra-poor status of these households and their limited financial resources create barriers to accessing healthcare services. The costs associated with healthcare, including consultation fees, medications, diagnostic tests, specialized treatments, and assistive devices are beyond their means. These households struggle to meet their daily basic needs, and the financial burden of healthcare expenses often leads them to give up on seeking treatment. One caregiver expressed their experience, stating:

“We went to a popular doctor, and the doctor said that his [person with disability] seizures will not get better. The doctor gave me the medicine. I did x-rays of his whole body. I ran around a lot, and it cost me a lot of money, but nothing worked.”

- **Common patterns in health-seeking behavior:** Households often veer from seeking formal healthcare services and turn to informal health systems, such as traditional

healers or home remedies. Several reasons contribute to the preference for informal healthcare, including cultural or religious beliefs, lack of awareness, social influence, and limited access to formal healthcare and the high cost associated with it. However, when the informal healthcare methods fail to yield visible improvements or positive outcomes, households may become demotivated and feel hopeless. This, in turn, diminishes their motivation to continue seeking healthcare services. The mother (caregiver) of Sohel (pseudonym), an individual with speech disability, mentioned in her interview:

“They [villagers] said that there are people in the village who treat patients like my son by playing drums. I went to them as well. I brought 14 people from far away and spent a lot on them, like feeding them 4 meals a day for fourteen days; my son’s condition did not change.”

Failures with informal methods raises doubt about the effectiveness of any treatments, and the households lose confidence in the healthcare system generally. The loss of hope significantly impacts their health-seeking behavior, resulting in discontinuation or reduction in their efforts to this end. In many cases, households had already given up on seeking further healthcare for persons with disabilities before the program’s intervention.

5.1.1.3. Pre-Intervention Vulnerability: Lack of Knowledge and Awareness

Third, the lack of knowledge and awareness among ultra-poor households regarding the health of persons with disabilities poses a major challenge and leads to certain practices and behaviors.

- a. **Reliance on superstitious beliefs:** Superstitious beliefs are still deeply rooted in rural areas, perpetuating misconceptions, fear, and discrimination against individuals with disabilities. Hafsa’s mother (caregiver) mentioned,

“Other villagers told me that she might be possessed by ghosts and advised me to go to a Kabiraj [traditional healer].”

These harmful notions contribute to exclusion and neglect. Some persons with disabilities also accept their disability as an unavoidable fate and cease trying to improve their condition.

- b. **Lack of recognition of additional caregiving needs:** Caregivers and families often fail to fully recognize or understand the additional caregiving needs of persons with disabilities. This lack of awareness can result in inadequate support for individuals with disabilities, including assistance with daily activities, access to proper nutrition, psychological support, and the prevention of harmful practices such as confinement and restraints.
- c. **Lack of awareness of basic hygiene and prevention practices:** In general, ultra-poor households have limited knowledge about basic hygiene and prevention practices, and this lack of awareness is even more pronounced when it comes to disabilities. Before the intervention, these households were unaware of accessible sanitation facilities, inclusive hygiene practices, and basic preventive measures tailored to the unique needs of individuals

with disabilities. Consequently, this may have resulted in higher rates of infections, injuries, and other health complications, further exacerbating their already critical health conditions.

- d. Lack of awareness of available facilities:** These ultra-poor households were largely unaware of social protection programs and benefits specifically designed for persons with disabilities. As a result, they faced challenges in accessing the necessary support and resources that could improve the well-being of individuals with disabilities. Additionally, they lacked information about organizations dedicated to supporting individuals in similar situations. This knowledge gap prevented them from accessing valuable resources, services, and networks.
- e. Pre-conceived notions:** Pre-conceived notions that individuals with disabilities are inherently incapable or less competent further limited their opportunities for education, employment, and social participation. The lack of understanding regarding the potential of persons with disabilities may have hindered their families from fully recognizing the contributions they could make if given the opportunity to be actively engaged in society.

5.1.1.4. Pre-Intervention Vulnerability: Risk of Exclusion

Lastly, the individuals encountered significant barriers stemming from the lack of inclusivity, as discussed below.

- a. Infrastructural and institutional barriers:** Individuals with disabilities faced significant infrastructural barriers, both within their own households and in public spaces, which severely limited their mobility and accessibility. Inadequate features such as inaccessible tube-wells and toilets in their households hindered their ability to access sanitary facilities and safe drinking water, making daily activities even more challenging. For example, Nazim (pseudonym), a person with difficulty walking, expressed the difficulties he faced,

“It was very tough for me to move around....I could not sit on the toilet. I fell on the floor while trying to sit on the toilet 2–3 times.”

The lack of accessibility extended to public spaces, including buildings, roads, and transportation system. Additionally, institutional barriers hindered their inclusion and neglected their needs and rights. Access to formal institutions such as Union Parishads, hospitals, offices, and schools was severely limited. Furthermore, their access to social safety net programs and support from both non-government and government organizations was limited. Prior to the intervention by DIUPG, only 51% of the surveyed households reported receiving some form of social protection or allowance. And only 45% reported receiving disability allowances before the intervention. These infrastructural and institutional barriers significantly impacted the individuals’ ability to fully participate in society and access necessary support and services.

- b. Othering behavior from the community:** Individuals with disabilities often experienced exclusion and marginalization within their communities due to othering behavior from community members. They were excluded from social events such as festivals, invitations, weddings, and gatherings. They were subjected to name-calling, disrespect, and bullying. For instance, Selina’s (pseudonym) mother expressed her grief during an IDI, stating,

“Her peers did not want to be friends with her. They excluded her because she is shorter than others. Their parents also forbade them to befriend my daughter.”

This exclusionary behavior not only affected the individuals with disabilities but also had an impact on their family members. The family members themselves experienced discriminatory treatment from the community, causing some to gradually confine themselves within their homes.

- c. Lack of access to enabling support:** Another challenge faced by individuals with disabilities was the lack of access to enabling support, particularly assistive devices. Thus it was difficult for them to participate in social activities, engage with their communities, and navigate their surroundings with ease. The unavailability and high cost of assistive devices created barriers to access. According to the data, a significant 86% of persons with disabilities did not have any assistive device prior to the intervention. This further hindered their ability to fully participate in social life and limited their independence.

5.1.2. Segmentation

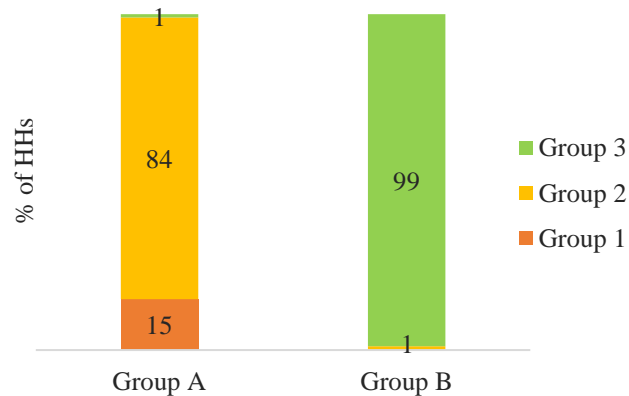
This section takes a closer look into how effectively the program met the selection criteria for each group and to what extent their economic and disability vulnerabilities were considered during the segmentation process. As discussed in Section 2.2, Group A was intended to consist of more vulnerable households than Group B. Table 9 provides an analysis of how well Group A and Group B households fulfil the selection criteria. The data confirms that the program successfully targeted households according to the selection criteria: the values of income, productive assets, and land in Group A indicate that the program effectively allocated the more economically vulnerable households to Group A.

Table 8: Targeting Effectiveness by Group A and B

Group A	Group B
Per capita monthly income <ul style="list-style-type: none"> • Less than BDT 2,000: 98.95% of HHs • Mean: BDT 1,128.06 	Per capita monthly income <ul style="list-style-type: none"> • Less than BDT 2,000: 100% of HHs • Mean: BDT 1,332.82
Value of productive assets <ul style="list-style-type: none"> • Less than BDT 5,000: 95.96% of HHs • Mean: BDT 1,331.21 	Value of productive assets <ul style="list-style-type: none"> • Less than BDT 10,000: 97.75% of HHs • Mean: BDT 2,292.61
Amount of land owned <ul style="list-style-type: none"> • Less than 30 decimals: 98.30% of HHs • Mean: 3.71 decimals 	Amount of land owned <ul style="list-style-type: none"> • Less than 30 decimals: 99.65% of HHs • Mean: 6.46 decimals

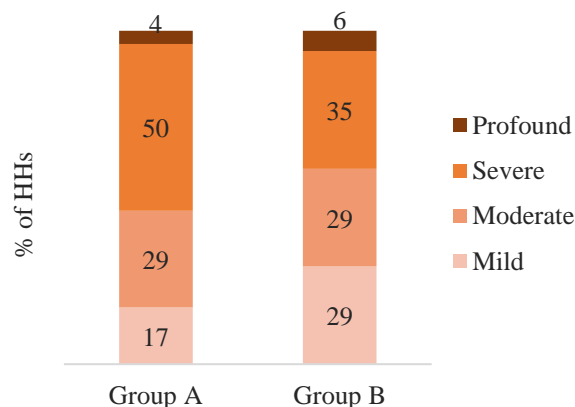
As mentioned earlier, the program first assessed households based on their economic vulnerability and categorized them into UPG Groups 1, 2, or 3. Figure 14 demonstrates that the program effectively allocated households that met the UPG Groups 1 and 2 criteria to DIUPG Group A, and those in UPG Group 3 to DIUPG Group B. Considering that individuals in UPG Groups 1 and 2 were generally more economically vulnerable, this allocation aligns with the program’s rationale for placing them in DIUPG Group A.

Figure 14: Composition of Group A and B by Economic Vulnerability (UPG Groups)



DIUPG also considered vulnerability related to disability. Figure 15 provides a breakdown of the groups by disability severity. As it can be observed, the segmentation is not based on the severity of disability; however, some differences can be observed. More individuals with mild disabilities were allocated to Group B (12 percentage points higher), while more individuals with severe disabilities were allocated to Group A (15 percentage points higher). The distribution of individuals with moderate disabilities was equal between the two groups.

Figure 15: Composition of Group A and B by Disability Severity



A further disaggregation of disability types within the severe category for both Group A and Group B is provided in Figure A2 in the annex. Figure A2 does not indicate a clear pattern. Overall, the segmentation does not have a clear association with the participants’ disability condition.

5.1.3. Challenges of Targeting

This section sheds light on the key challenges faced by the field staff during the targeting process. First, families with persons with disabilities often exhibited a tendency to conceal their situation due to the social stigma attached to disability. They feared being judged, discriminated against, or ostracized by their communities by revealing the information. For instance, some families were concerned about their daughter's marriage prospects if their association with disability was revealed. This reluctance posed difficulties for the program staff in identifying households and convincing them to participate.

Second, challenges stemmed from conservative mindsets and resistance to change exhibited by certain individuals. These families held firmly to traditional beliefs and attitudes, refusing to allow strangers into their homes, and were resistant to altering their established ways of living. Their mindset resulted in skepticism, mistrust, and a reluctance to cooperate with the program.

Third, households were sometimes influenced by external individuals, including community members, relatives, or extended family members, who held conflicting perceptions. Close relatives, for example, discouraged households from participating in the program, questioning its credibility or effectiveness. They harbored doubts that the condition of the person with disabilities would ever improve. During an FGD, a PO expressed the following:

“Her [person with disabilities] uncle living next door was also not positive. He kept saying that this household will not participate in the program. She cannot even take care of her children. How will she take care of the cow? As a result, decision-making within that family was very tough.”

5.2. Enterprise Selection and Matching

This section analyzes the participation of persons with disabilities and their households in the enterprise selection process and the dynamics of enterprise matching.

5.2.1. Participation in Enterprise Selection

The program aimed to ensure the active participation of households, particularly persons with disabilities, in the enterprise selection process. Table 10 displays the primary agent responsible for selecting the enterprise. It is evident that household members (including persons with disabilities, caregivers, household-heads, and other household members) were primarily involved in enterprise selection. Individuals with disabilities primarily made the decision about the main enterprise most often (41%). However, when it came to the secondary enterprise, caregivers were the primary decision makers most often (44%). In a small percentage of households (5–8%), the household-head or other household members made the decision.

Table 9: Primary Decision-Makers during Enterprise Selection

Who primarily selected the enterprise? (in % of HHs)	Main enterprise	Secondary enterprise
Program	11.5	16.38
Persons with disabilities	41.11	33.8
Caregiver	39.02	43.9
Household-head	5.57	3.48
Other household members	2.79	2.44

However, qualitative data suggest that decisions were often made collectively by the household. During an FGD in Rangpur, a program staff member shared:

“The decision is really household-centric. We found cases where persons with disabilities can express their views. We gave them the asset they selected. And in cases where the person with disabilities did not have the capacity to express, caregivers or parents along with other household members took the decision. We considered these two types of decisions.”

Table 10 also shows that some households claimed that the program chose the enterprise for them, accounting for about 11% for the main enterprise and 16% for the secondary enterprise. Similar insights were found in the qualitative findings. One of the program participants shared:

“The PO told me that a cow will be given to me. Then he asked which cow I prefer—heifer or bull? I chose bull.”

The program can further investigate this issue to understand why it occurs and determine if there is a need to address this problem.

The program’s primary focus was to involve persons with disabilities in the enterprise selection process to ensure their voices are heard. Although Table 10 indicates significant participation of persons with disabilities in decision-making, not all individuals are able to participate, influenced by various factors, such as age, gender, and type and severity of disability.

Age: The program did not impose any age barriers for participants. Table 11 clearly shows that age does have an influence in decision making. If the person with disabilities was below 18 years, predominantly the caregiver primarily made the decision for the main enterprise (67%).

Table 10: Primary Decision-Makers during Enterprise Selection by Participant’s Age

Who primarily selected the main enterprise? (in % of HHs)	Below 18 Years	Above 18 Years
Program	10.45	11.82
Person with disabilities	10.45	50.45
Caregiver	67.16	30.45
Household-head	8.96	4.55
Other HH members	2.98	2.72

Qualitative field observations also support this finding, indicating that children with disabilities under 18 years were unable to fully participate in the selection decision. The caregiver of Rumi (pseudonym, a person with visual disability) described Rumi’s role in the enterprise selection process as follows:

“She remains busy in school and study. She does not understand this matter so much. So, I and her father jointly took the decision in selecting enterprises after discussion. However, these enterprises are owned by her.”

Although the person with disabilities above 18 primarily selected the main enterprise most frequently, the rate was just 50%, which means half of the participants in age group were not the main decision makers.

Gender: Gender dynamics can also influence decision-making. Table 12 provides a disaggregation of adult individuals with disabilities who were involved in the enterprise selection, based on their gender and severity. The data reveal that female persons with disabilities had a higher level of participation in the enterprise selection regardless of severity of disability. In case of male participants, decision was made by the caregivers, who were predominantly female. These results indicate a significant female bias in the decision-making process. However, it was most likely due to the program’s focus on empowering females and amplifying their voices and potential, and not reflective of the general rural context, where patriarchal norms tend to exert greater influence.

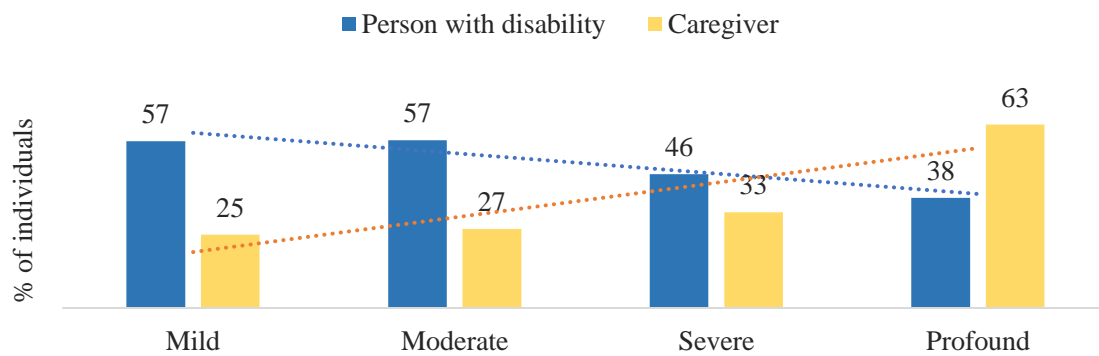
Table 11: Primary Decision-Makers during Enterprise Selection by Participant’s Sex (in % of HHs)

Categories of disability severity	Female			Male		
	Person with disability	Caregiver	Others*	Person with disability	Caregiver	Others*
Mild	69.57	17.39	13.04	42.86	33.33	23.81
Moderate	56.25	25.00	18.75	58.06	29.03	12.91
Severe	50.00	25.93	24.07	39.47	42.11	18.42
Profound	66.67	33.33	0	20.00	80.00	0

**Others include program, household-head, and other household members.*

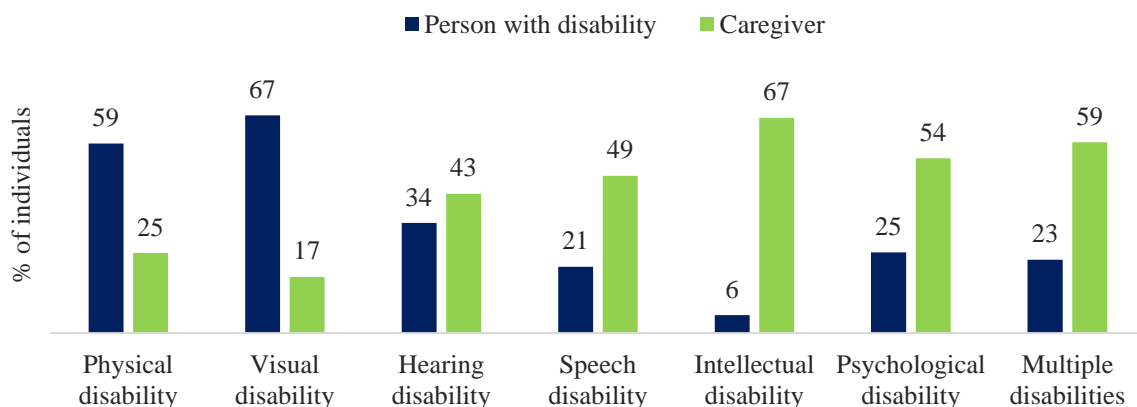
Disability condition: The severity and type of disability can also influence the level of participation of participants with disabilities in the enterprise selection process, and figure 16 breaks it down by the severity of their disability. The data clearly shows that their participation decreases with increasing severity, and the participation of the caregivers increases, indicating that caregivers often assume decision-making responsibilities in cases of severe disabilities.

Figure 16: Primary Decision-Makers during Enterprise Selection by Participant’s Disability Severity



Moreover, the participation of persons with disabilities may vary depending on the type of disability. Figure 17 presents the breakdown of adult individuals with disabilities involved in enterprise selection, based on their disability types. Individuals with visual disability (67%) and physical disability (59%) have the highest rates of decision-making participation. On the other hand, individuals with intellectual disability (6%) and psychological disability (25%) have the lowest rates of participation. This pattern is observed for both the main and secondary enterprises. And once again, when the participation of persons with disabilities decreases, the participation of caregivers increases.

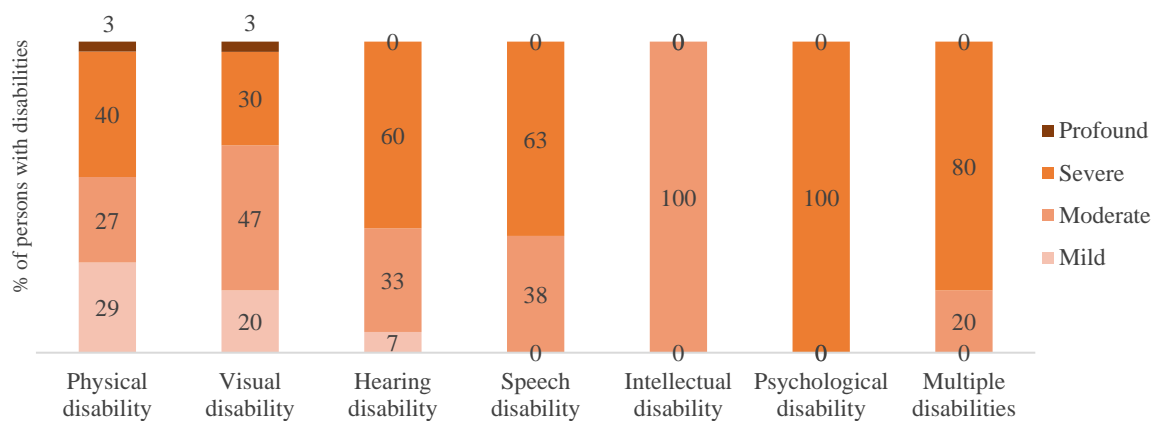
Figure 17: Primary Decision-Makers during Enterprise Selection by Participant’s Disability Type



These findings indicate that it is more challenging for the program to ensure the participation of individuals with intellectual and psychological disabilities, as they may struggle with communication and processing their thoughts. The participation among adults with multiple disabilities is also low (23%). This is likely because individuals with multiple disabilities often have more severe disability conditions. Conversely, the program appears to have an easier time involving persons with physical disabilities, as they do not face similar sensory or intellectual barriers. The highest share of persons with visual disability decide on enterprises (67%).

Figure 18 provides a deeper look into why the participation in decision-making is higher among certain disability types in this study sample; hence, it breaks down the sample of persons with disabilities who made decisions by their type and severity of disability. The majority of individuals with visual disability were able to participate because fewer share of them had severe and profound cases (33% in total) compared to other types. The same pattern can be observed for individuals with physical disabilities (43%). Conversely, disability types with lower participation rates tend to have a higher incidence of severe cases. Nevertheless, it is important to approach the percentages presented in Figures 16, 17, and 18 with caution due to the limited sample size resulting from data fragmentation by disability type and severity.

Figure 18: Disaggregation of Persons with Disabilities Involved in Enterprise Selection by Disability Type and Severity



However, qualitative insights suggest that regardless of the severity, persons with disabilities can participate directly in the decision-making process for enterprise selection if they have the means to communicate. For example, one participant with severe hearing and speech disabilities selected the enterprise herself using sign language to communicate with the PO. Shaila’s (pseudonym) caregiver recounted the incident as follows:

“She [person with disability] understands everything. She selected the enterprise herself. She even expressed her interests to BRAC [the PO], by pointing at a heifer cow and showing that she wants to drink its milk.”

This was made possible because Shaila was able to use sign language, and the PO was able to interpret her communication.

Previous work experience: Previous work experience is an important factor in the decision-making process for enterprise selection. For example, the caregiver of Debi (pseudonym) explained how her previous experience played a role in selecting the enterprise:

“I selected cow as I have previous experience. My father-in-law had several cows and I used to take care of them when needed. I didn’t prefer goats because I don’t like them. Once I had a goat but a fox took it away.”

The program also prioritized participant’s experience in the decision-making process. However, if participants did not have experience, the program prioritized the experience of other household members who were to be involved in enterprise development.

5.2.2. Enterprise Matching

It is crucial for program success to ensure that the selected enterprise matches the characteristics of the household and the capacity of the person with disabilities to engage. Figures 19 and 20 illustrate the enterprises chosen by households in Group A and B. The figures indicate that the majority of households selected bull and heifer cows as the main enterprise, and poultry as the secondary enterprise. A detailed discussion on the possible reasons for this selection bias towards cow is provided in Case Study A1 in the annex.

Figure 19: Main Enterprise Selected by Households in Group A and B

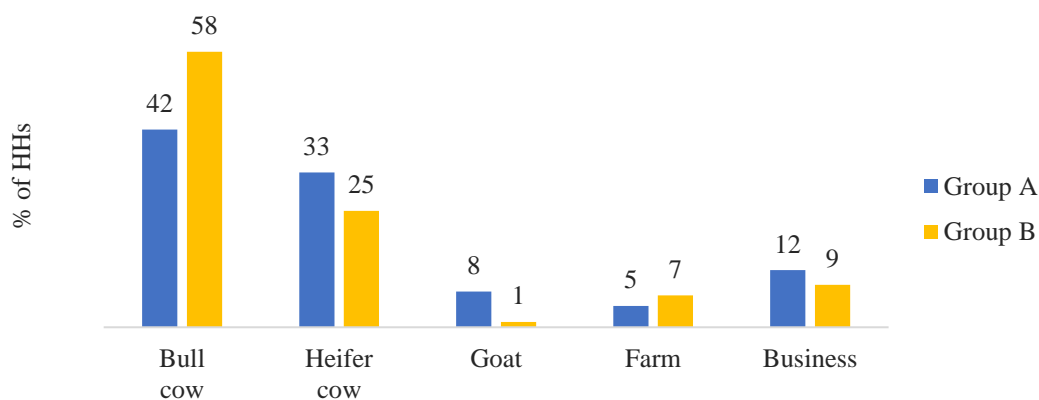
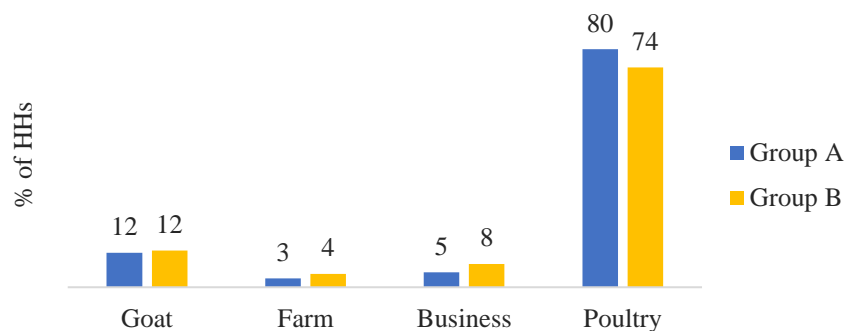


Figure 20: Secondary Enterprise Selected by Households in Group A and B



Some differences can be observed between Group A and B. A 16 percentage point higher share of Group B participants selected bulls, while Group A members tended to select heifer with an 8 percentage point difference. As secondary enterprises, more Group B members (3 percentage point higher) selected a business, while more Group A members (6 percentage point higher) favored poultry. This phenomenon may be attributed to the variation in intervention package. Such as, bulls are known to be more profitable in the short-run; they can be fed and sold within few months. Whereas for heifers, they are profitable in the long-run, as it takes longer for her to bear a calf and provide milk. Similarly, business is requires more effort but can be more profitable as well, but raising poultry requires less effort and brings in less profit. It seems that Group B has a tendency to select enterprises that are more profitable in the short run, as they have to make monthly instalments.

Although cow and poultry seem to be the dominant enterprise combination, the figure 21 and 22 analyze if the enterprise matching vary based on participant’s disability type and severity. Disaggregation by disability severity reveals that households with milder cases of disability tended to choose bull. According to the participants, raising a bull requires more physical effort, which individuals with milder cases of disability are able to handle. However, no other noticeable patterns can be observed.

Figure 21: Enterprise Matching by Disability Severity of Persons with Disabilities

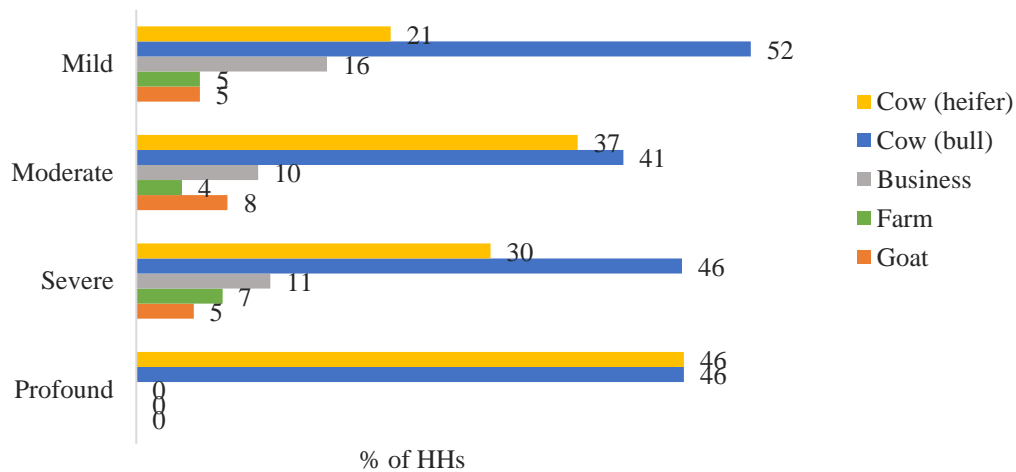
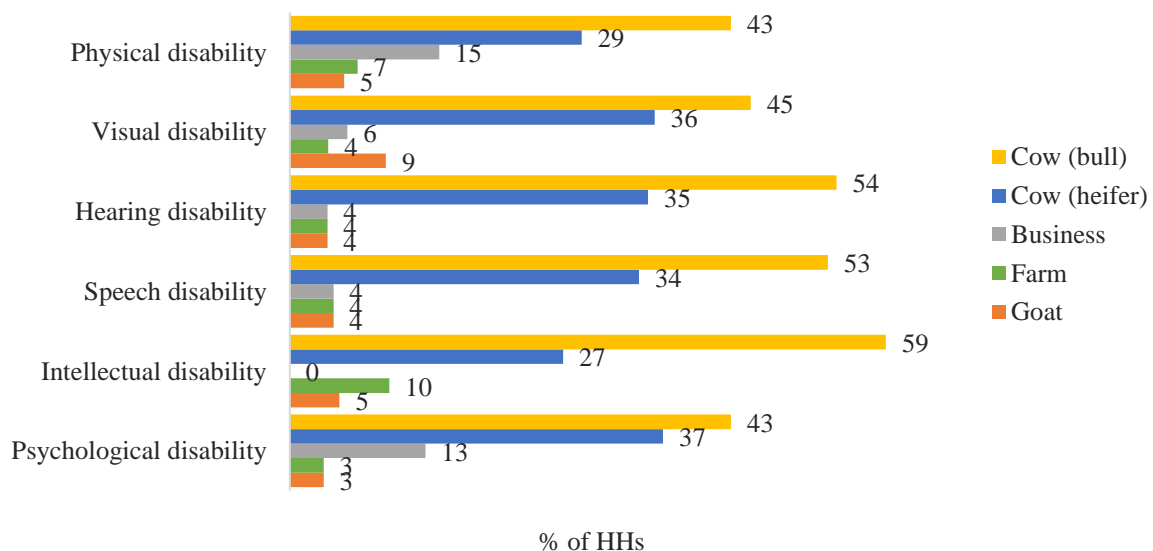


Figure 22 examines the enterprise matched for each household based on the disability type and finds no significant patterns. Both figures indicate a predominant preference for cows, with no discernible differences across disability types and severity, indicating a lack of customization based on the severity of disability when matching enterprises with households.

Figure 22: Enterprise Matching by Disability Type of Persons with Disabilities



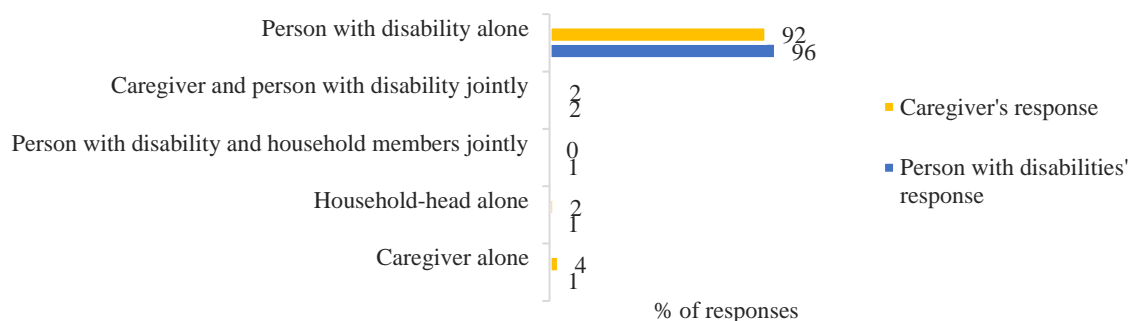
5.3. Livelihood Support

Livelihood support includes asset transfer for enterprise development, enterprise development training and hands-on training through home and group visits, and matched savings (the details are provided in Section 2.2 pg. 9). The program’s primary objective in providing livelihood support is to assist households in establishing resilient, diverse, and sustainable IGAs, enabling them to improve their living standards and progress towards self-sufficiency, thereby breaking the cycle of poverty. DIUPG’s key focus is economic and social empowerment of persons with disabilities through their involvement in IGAs. This section examines the dynamics of asset ownership, decision-making, and the engagement of persons with disabilities in IGAs.

5.3.1. Dynamics of Asset Ownership and Decision-Making

The program aimed to ensure that assets were registered in the name of the person with disabilities. However, given the household-centric nature of the intervention, there was a potential for confusion regarding asset ownership, which could lead to inter-household conflicts. To address this issue and clearly communicate the program’s message regarding asset ownership, emphasis was placed on issue in initial meetings and trainings with the household. Additionally, a written document stating the ownership was provided to further reinforce clarity. The quantitative survey results indicate the success of this strategy, as the majority of caregivers (92%) and persons with disabilities (96%) stated that the assets were owned by the person with disabilities (see Figure 23).

Figure 23: Asset Ownership According to Person with disabilities and Caregiver



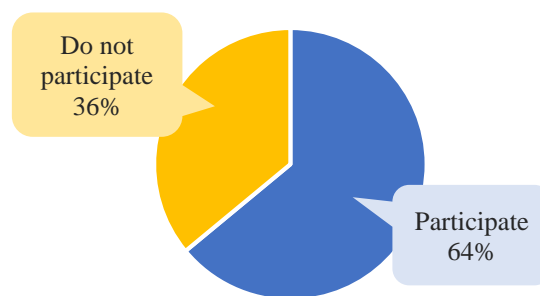
However, qualitative findings reveal a sense of collective ownership within the household. For example, as explained by Amena’s (pseudonym) caregiver,

“As a person with disabilities, she [Amena] owns the assets. Now, we are four members in the household with one child. We all have the right to these assets. My mother-in-law [Amena] will always claim that the assets are owned by the household, not her own only.”

Collective ownership towards the assets may grow as all household members become involved in their care and management. Caregivers, in particular, take on the responsibility of looking after the assets on behalf of the individuals with disabilities, who may be unable to do so due to their health conditions. Additionally, other household members contribute to the care of the assets, such as feeding the animals, which further strengthens their sense of ownership. Since all household members benefit from the assets, there is a collective motivation to take care of them.

However, the decision-making regarding asset dealings, such as buying, selling, and management, may or may not be in the hands of the individuals with disabilities. Various factors influence decision-making, including age, gender, and intellectual and physical capabilities, and status within the household. Field observations indicate that children have minimal engagement in IGAs, and their input is rarely considered in decision-making. Gender also influences decision-making. However, even though a female bias was observed in enterprise selection, in practice, the subsequent decision-making was dominated by male household members. Even in case of female caregivers—who seemed to have better power dynamics as intermediaries between the program and the household, responsible for both the care of the person with disabilities and the assets—major decisions were made jointly with male members. Figure 24 reveals that 36% of persons with disabilities did not participate in decision-making regarding the assets.

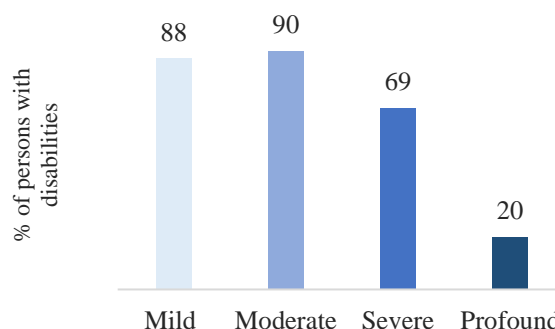
Figure 24: Participation of Persons with Disabilities in Asset-Related Decision-Making



5.3.2. Persons with Disabilities’ Involvement in IGA

The program aims to involve individuals with disabilities who have a minimum level of ability to engage in IGAs in enterprise development. This section examines the extent to which the program succeeded in engaging individuals with disabilities in IGAs and the factors that influenced their participation. Based on the post-intervention data, approximately 75% of the working-age population with disabilities (15–64 years) were involved in IGAs, with the majority being self-employed. This means that a quarter of the participants did not engage with IGAs. Figure 25 provides further insights into the level of engagement based on the severity of disability. Engagement decreases with severity: 13% of individuals with mild cases, 10% of those with moderate cases, 31% of those with severe cases, and 80% of those with profound cases were not engaged in any IGA.

Figure 25: IGA Engagement among Working Age Persons with Disabilities by Disability Severity



The qualitative case studies provide a closer perspective on the level of involvement of individuals with disabilities based on the type and severity of their disability, as shown in Table 13.

Table 12: Persons with Disabilities’ Engagement in IGA by Disability Type and Severity from Qualitative Case Studies

Disability Types	Disability Severity			
	Mild	Moderate	Severe	Profound
Physical disability	Partial/significant involvement	Partial involvement	--	--
Visual disability	--	Partial involvement	Partial involvement	--
Hearing disability	Significant involvement	--	Significant involvement	
Speech disability	--	--	Significant involvement	--
Intellectual disability	Partial/no engagement	--	No involvement	--
Psychological disability	--	--	No involvement	No involvement

Note: The involvement level is the researchers’ own assessment based on the field observations. Significant involvement means that the person can do the majority of the tasks. Partial involvement means that the person can do some of the tasks, not all. No involvement means that the person cannot do any tasks. The dots indicate no observations; as these are based on qualitative case studies, there were limited number of sample.

The table reveals that individuals with mild and moderate difficulties in movement can participate in IGAs to some extent. For instance, one participant in this category shared their experience of engaging in IGA:

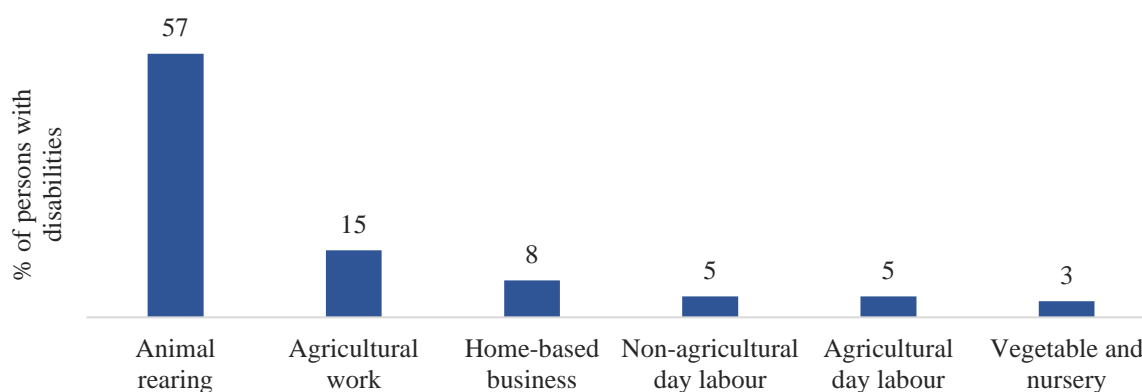
“I can only do the work that can be performed while sitting. I can cut the grass for the cow, I can collect the leaves, I can bring the trash for the furnace, and I can help her [the caregiver] to put the leaves in the sack. Previously I could do nothing. Now I can do some work. BRAC is helping me. Now I have courage. I give food to the cow. I can take care of the hens too.”

Similarly, individuals with moderate to severe visual disability could partially participate in IGA. However, individuals with visual and physical disabilities face more challenges in engaging in physically demanding IGAs, which rely on their vision and movement. On the other hand, individuals with hearing and speaking difficulties have significant involvement in IGA. Although they face challenges in communication, their other senses and abilities allow them to engage in self-employed physical tasks. In contrast, individuals with intellectual and psychological disabilities have no involvement in IGA. This group faces intellectual or mental disabilities, making it challenging to engage and motivate them to participate in IGAs.

5.3.3. Livelihood Development

The overall livelihood support provided by the program has had a positive impact on the standard of living of the households. After approximately 18 months of intervention, the average per capita income of the households has increased to BDT 2,865, and the average value of productive assets has risen to BDT 58,763.¹⁵ These values represent significant improvements compared to the pre-intervention status mentioned in Section 5.1.1 (pg. 24). Furthermore, the program has brought about positive changes in the lives of many individuals with disabilities. The average monthly earnings of employed, working-age individuals with disabilities amounted to BDT 2,027 after the intervention. Figure 26 illustrates that a majority of them were engaged in animal rearing (57%), and smaller shares were involved in other types of work such as agriculture (15%), home-based business (8%), non-agricultural day labor (5%), agricultural day labor (5%), and nursery work (3%). More details on the pre- and post-intervention comparison of the economic condition will be discussed in Section 5.7 (pg. 64), which focuses on the graduation criteria.

Figure 26: Types of IGA Persons with Disabilities Were Involved in



In the DIUPG program, the regular UPG mechanisms for livelihood development, such as IGA diversification and asset growth, were utilized to enhance the socioeconomic status of the households. According to qualitative interviews with participants, households were successful in generating new income sources, including land leasing and purchasing additional productive assets through the acquisition of assets. Their savings also enabled them to save their own money and acquire more assets. The following account was shared by Srayashi's (pseudonym) caregiver, describing how they utilized the program's support to develop their livelihood:

“BRAC provided us with seeds and a bull. We sold the cow for 60,000 taka. This time, we purchased a heifer with a portion of the profit. We took a land on lease with the rest of the money. We cultivated rice paddies in the land and harvested seven mounds of it. We did not have to buy rice for the household. BRAC provided vegetable seeds two times. We consumed the vegetables but also sold some of them to our neighbors. By selling vegetables, I saved around 2,000 taka. I used it to immediately pay the instalments.”

¹⁵ All monetary values of 2023 have been adjusted to the consumer price index (CPI) values of June 2021.

Furthermore, the additional earnings helped improve food consumption and meet their daily immediate needs more smoothly. This had a ripple effect on their social acceptance, as expressed by a participant:

“Now people lend me money if I need it. Before the intervention, they did not lend. Now they do because I have cows and hens. With these support, we can improve the household condition. Before the intervention, the donation and her [the caregiver’s] day labor was the only livelihood option. Now I have more strength than before.”

Prior to the intervention, neighbors were hesitant to lend money to persons with disabilities and their households. However, as the household’s financial capacity improved, the neighbors gained more confidence in lending them money. All these positive changes have provided hope and aspiration to the households.

5.3.4. Challenges in Livelihood Support

Although households and persons with disabilities realized many benefits from the livelihood support, they also encountered some challenges in the process. Upon receiving the asset, the household assumed the responsibility of maintaining and caring for it, which incurred costs. While the program provides a small amount initially for maintenance, some poor households struggle in the later stages. For instance, after receiving the initial support of BDT 300 for cow feed, they face difficulties in covering the ongoing expenses of cow feed. This situation applies similarly to other enterprises, such as shops and farming land. A caregiver shared her experience of struggling with these costs:

“We have to buy one kg of chaff per day for the cow regularly. Our limited income of BDT 300 per day makes it difficult to bear the expense of cow feed and goat feed, and our meal. However, we manage it.”

At the same time, caregivers had to invest a significant portion of their time in livelihood development activities, which increased their workload and reduced their leisure time. However, caregivers willingly accepted this load for future betterment. They believed that in the absence of livelihood support, they would spend their time gossiping with neighbors. Now, they were utilizing their time effectively with the assets. They did not express a need for leisure. However, the researchers observed that they rarely visit neighbors and relatives as they had to constantly take care of their assets, which may have a negative impact on their psychosocial well-being and long-term social engagement.

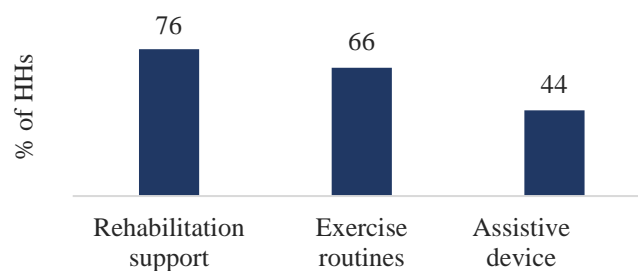
5.4. Health Support

The regular UPG program provides basic health support, including covering medicine costs, implementing prevention methods, and providing treatment for severe illnesses. However, for DIUPG, the health support was restructured to focus on stabilizing the health condition of persons with disabilities in order to enhance their ability to carry out daily activities, engage in IGAs, and participate in society. This section is divided into three subsections: rehabilitation support, psychosocial support, and referral and treatment. Challenges encountered in each subsection are discussed accordingly.

5.4.1. Rehabilitation Support

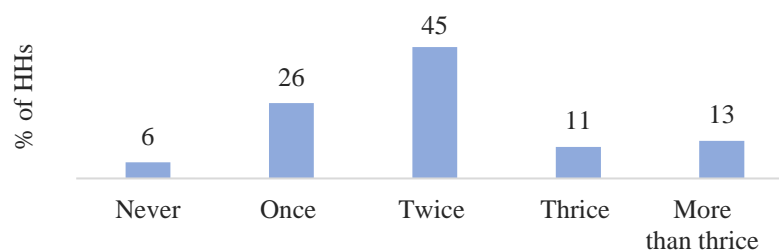
The rehabilitation support was designed to stabilize the health condition of persons with disabilities and enable them to perform daily activities, as discussed in Section 2.2 (pg. 10). According to the quantitative survey, approximately 76% of the households expressed a significant need for rehabilitation support prior to receiving the intervention, as depicted in Figure 27. This need was consistent across all severity groups of disabilities. Additionally, there was a substantial demand for specific services provided through the rehabilitation support. For instance, around 66% of households felt a high need for guidance and support on exercise routines, while only 44% indicated a high need for assistive devices.

Figure 27: Pre-Intervention Need of Rehabilitation Support Components in Participant's Opinion



To ensure the effective implementation of all components of the rehabilitation support, the rehabilitation officer conducted monthly visits to the households based on the individual needs of the persons with disabilities. In most cases, households received monthly visits from the rehabilitation officer, with 26% reporting one visit and 45% reporting two visits per month (see Figure 28). However, 6% of households reported that the rehabilitation officer never visited them. The program should investigate such cases further to address any potential gaps in service delivery.

Figure 28: Frequency of Visits Each Month by Rehabilitation Officer in Participant's Opinion



Although there was a demand for rehabilitation support, its effectiveness varied based on factors such as the individual's disability condition and level of cooperation and compliance of the households. The rehabilitation support was found to be particularly effective for individuals with physical, visual, hearing, and speech disabilities, as they were able to benefit from the available support elements. Conversely, individuals with intellectual and psychological disabilities could not benefit much from the rehabilitation support.

5.4.1.1. Effect of Rehabilitation Support

Individuals with disabilities who received rehabilitation support experienced significant positive changes in various aspects of their lives, such as improved ability to move, communicate, perform daily life activities and self-care, and participate in household chores and IGAs.

Movement and communication: Participants experienced significant enhancements in their physical mobility and communication abilities by utilizing a combination of exercises and assistive devices provided through the rehabilitation support. Tailored exercise regimens allowed individuals with disabilities to strengthen their muscles, improve their balance, and enhance their physical strength. These exercises targeted specific areas of weakness, enabling individuals to regain control over their movements and achieve a higher level of independence. Riton (pseudonym), a person with physical disability, shared his experience:

“He [the rehabilitation officer] told me to keep doing the exercises he prescribed me and also to apply a hot compress on my joint. It has been beneficial for me. My feet ache less these days... I could not walk even a few feet before. The situation has improved a little now.”

In addition, the provision of assistive devices played a crucial role in promoting mobility and communication. Wheelchairs, crutches, and white canes provided individuals with a physical disability the means to move around with greater ease, while hearing aids enhanced the ability of individuals with listening difficulty to communicate effectively. Furthermore, through task adaptation, individuals with disabilities gained confidence and the ability to navigate their households independently. This adaptation fostered a sense of control among them. Sumon (pseudonym), who has moderate visual disability, mentioned:

“They [DIUPG staff] painted parts of my house and trees around my house with yellow color [threshold coloring]; it is convenient for me. I can see the yellow color from afar which helps me walk around.”

Daily life activities and self-care: Rehabilitation activities proved to be instrumental in enhancing the ability of individuals with disabilities to perform daily life activities and engage in self-care. Task adaptation played a vital role in this process by modifying living spaces to improve accessibility, such as installing handrails on stairs, adjusting furniture placement, and improving lighting for individuals with visual disability. As a result, individuals gained the freedom to independently perform daily activities with reduced reliance on assistance. Rajon (pseudonym), a person with visual disability, shared his experience:

“They installed railing on the stairs in front of my house so that my daughter and I can get into the house without trouble. They also installed a railing on my toilet so that I can stand up without falling.”

Furthermore, the collaboration between rehabilitation officers and psychosocial officers provided guidance on overcoming obstacles and accomplishing tasks related to personal hygiene, dressing, eating, and other essential activities of daily living, which proved to be invaluable.

Ability to participate in household chores and IGA: The improved ability to perform daily life activities translated into a tangible difference in individuals’ ability to actively participate in household chores and engage in IGAs. Their increased autonomy and improved capabilities enabled them to actively contribute to household tasks such as cattle feeding, wood gathering, and cleaning. Moreover, the support enabled some individuals to engage more in IGAs. Task adaptation, in particular, involved finding alternative ways to perform specific activities. For example, Riton, an individual with physical disability, received guidance on using assistive devices and adapting his work environment to facilitate his IGA. In his own words:

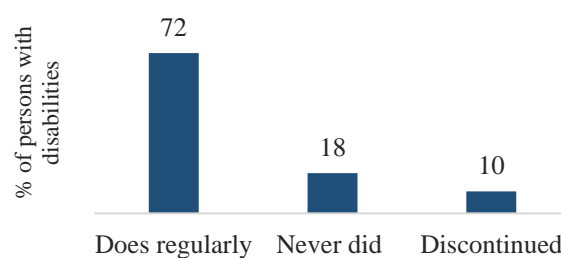
“He [rehabilitation officer] suggested I place my feet on the ring -like circular structure near the bottom of the barber chair to cut people’s hair. I follow his advice; it makes work easier for me... He also asked me to make a small stool to rest my feet on it while working.”

5.4.1.2. Challenges in Rehabilitation Support

Although many individuals with disabilities benefited from the rehabilitation support, some faced challenges that hindered their ability to avail the benefits and experience significant improvement. These challenges were encountered by both the operational staff and the users of the program.

Firstly, one of the primary challenges faced by the program staff was the reluctance of households in persisting with exercises and therapy. According to Figure 29, 18% of households reported never following the prescribed exercise regimen, while 10% mentioned that they initially followed the regimen but later discontinued practicing. These findings highlight the varying levels of compliance with exercise recommendations among persons with disabilities. Various reasons contribute to this phenomenon.

Figure 29: Tendency of Following Exercise Regimen Advised by Program



One reason is the caregivers’ limited time availability to conduct rehabilitation activities for the person with disabilities. Their busy schedules, which involve taking care of the household, the person with disabilities, engaging in livelihood activities, and performing personal tasks, make it difficult to allocate dedicated time for rehabilitation. As expressed by one caregiver,

“I can’t give her time. It’s my fault. I have to do all the work in the world. Although my daughter was told to do the exercises herself, she cannot remember anything most of the time. And her father does not help at all.”

Reluctance may also arise from pre-existing mindsets and beliefs. Some households have accepted the notion that the person with disabilities will not experience significant improvement and consider it as their fate. Consequently, they were not motivated to invest time in conducting rehabilitation activities, resulting in limited progress. The caregiver of a person with multiple disabilities shared,

“The program staff used to come and offer assistance with her exercises, but I prevented them from doing so. I understand that her hands cannot be healed anymore; it is Allah’s will.”

Third, reluctance may stem from a lack of immediate visible results. The exercises and therapy provided during rehabilitation are designed to bring gradual changes over time through consistent practice. However, the slow and subtle visible changes may not provide sufficient motivation for some participants, causing them to underestimate the potential of the exercises and therapies.

Fourth, societal norms, stigma, and expectations can negatively impact compliance among households. In an effort to conform to social appearances or prioritize societal acceptance, some households choose to conceal the presence of disability within their homes. This undermines the effectiveness of rehabilitation efforts and hinders the support needed for the betterment of individuals with disabilities. During an FGD, a program officer shared an example, stating,

“There is this one case. They had a sister who recently got married. But they did not want to install the handrails until she got married. Because no one would want to marry a girl from a family with persons with disabilities. So, we kept installing the handrails, but they kept removing it away.”

Fifth, there is limited support available from the program for individuals with profound and congenital disabilities, such as cerebral palsy or severe hearing, visual, and speech disabilities. These conditions often require expensive adaptive devices, intensive treatment, and long-term support, or may not be treatable at all. The program staff faced challenges in providing comprehensive support for such cases. Nevertheless, they attempted to offer small interventions that could provide some guidance and support to these participants.

Lastly, arranging proper diagnosis and obtaining the appropriate assistive devices proved challenging due to a scarcity of trained professionals and technicians in nearby areas. Individuals often had to travel long distances to access specialized assessments and experts for device customization. However, this posed additional difficulties, as transporting a person with disabilities to another location required manpower and incurred transportation costs. A program staff member highlighted this issue, stating,

“Trips to institutes for diagnosis and acquiring assistive devices were costly, ranging from BDT 200 to 300 or more. It is challenging for them to afford these expenses, especially considering the need for multiple visits.”

Furthermore, the high costs associated with assistive devices often exceeded the budget allocated by the program. Additionally, the local availability of customized assistive devices was limited. A program staff member shared an experience, saying,

“We had a customized chair made for Nasir, who has cerebral palsy and were pleased with the quality. However, the local worker refused to continue making such customized chairs because it was outside their comfort zone. It was more time-consuming and less profitable. They preferred making five regular chairs in the same amount of time.”

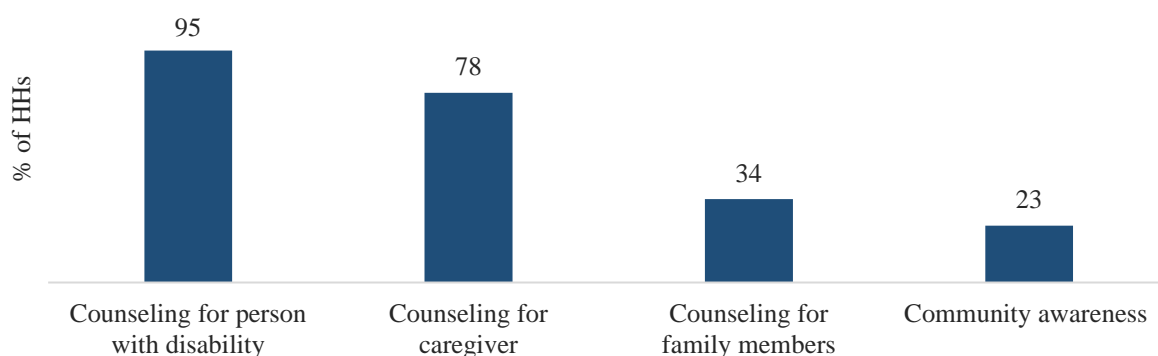
In summary the key challenges with rehabilitation were:

- Reluctant behavior of households in persisting with exercises and therapy
- Lack of immediate visible results
- Societal norms, stigma, and expectations’ negative influence on household’s compliance
- Access to assistive devices posed several challenges for individuals with disabilities

5.4.2. Psychosocial Support

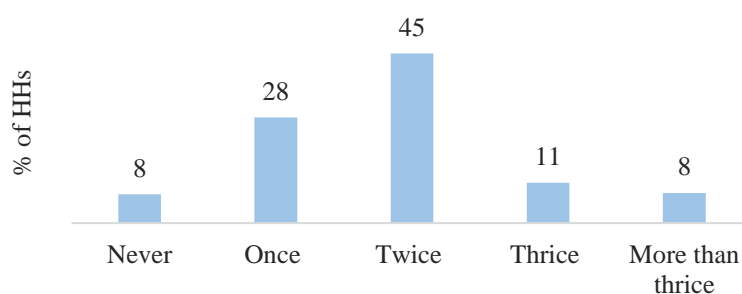
The psychosocial support was designed to stabilize the psychological condition of persons with disabilities and facilitate their integration into society, as described in Section 2.2 (pg. 11). The quantitative data reveals that a significant majority of participants, approximately 78%, had expressed a profound need for psychosocial support prior to the intervention. Through this component, households received various forms of assistance. Figure 30 indicates that approximately 95% of persons with disabilities and 78% of caregivers received individual counselling. Additionally, about 34% of households received counselling for other family members. Furthermore, 23% of households reported that the psychosocial officer conducted community awareness activities within their community.

Figure 30: Psychosocial Support Activities Received in Participant’s Opinion



To effectively implement psychosocial support, the assigned psychosocial officer conducted regular monthly visits to households, customizing the frequency based on the specific needs of individuals with disabilities. Figure 31 indicates that participants reported the psychosocial officer visiting their households once (28%) or twice (45%) a month in most cases. However, 8% of participants mentioned that the psychosocial officer never visited them, warranting further investigation by the program.

Figure 31: Frequency of Visits Each Month by Psychosocial Officer in Participant’s Opinion



The effectiveness of the psychosocial support elements varied depending on the level of engagement of program staff, compliance of households, and the nature of the disability. Qualitative observations reveal that psychosocial support yielded better results for individuals with physical, visual, hearing (mild), and speech disabilities. In cases where counselling could be directly provided to the person with disabilities, the impact was more pronounced. However, for individuals with hearing (severe), intellectual and psychological disabilities, counselling had to be facilitated through the caregiver. It was noted that individuals with intellectual and psychological disabilities required more intensive psychosocial support to bring about meaningful changes in their condition, which was not provided by the program.

5.4.2.1. Effect of Psychosocial Support

Psychosocial support provided by the program had a significant positive effect on the attitude and behavior of persons with disabilities, their families, and community members.

Person with disabilities’ attitude and behavior: Psychosocial counselling played a crucial role in enhancing the confidence and self-esteem of individuals with disabilities. Through the guidance and support provided by the psychosocial officer, they developed a renewed sense of self-worth and belief in their abilities. This newfound confidence motivated them to overcome challenges and actively participate in daily life activities. However, for individuals with more severe intellectual and psychological disabilities, the improvement was minimal; nevertheless, they acquired essential skills for self-care and managing daily tasks, which fostered a greater sense of independence and self-sufficiency. For example, the caregiver of Shokhiron (pseudonym), a person with intellectual disability, mentioned,

“Before, she did not do any household chores. But now, she does some small chores like sometimes she changes her clothes and eats food by herself.”

Families’ attitude and behavior: Caregivers and family members experienced a positive shift in their mindset as they gained a deeper understanding of effective caregiving practices and how to meet the unique needs of individuals with disabilities. The counselling sessions played a key role in instilling courage and hope among caregivers and family members. Tuhin’s (pseudonym) mother shared her experience regarding her son, who has intellectual disability:

“Yes, I feel a lot stronger and courageous now. My son is getting better as he grows up. BRAC Apa [psychosocial officer] told me not to listen to other people. My son even goes to school now.”

Furthermore, the counselling sessions had a positive impact on the caregivers’ attitudes and mental well-being as they received stress management counselling to address their workload.

Community’s attitude and behavior: The impact of psychosocial support extended beyond individual participants and had a positive influence on the attitudes and behaviors of the wider community. Participants reported a reduction in discriminatory and marginalizing behaviors. Through awareness-raising and educational interventions, the program challenged existing misconceptions about disabilities and promoted the recognition of individuals with disabilities as valued members of the community. Community members gained a deeper understanding of the rights of persons with disabilities and the importance of treating them with equal respect. Program staff actively discouraged bullying and harassment among community members. The neighbors of Shahana (pseudonym), a girl with a physical disability, shared their experience:

“Yes, Apa [psychosocial officer] used to come here, gather all of us together to sit and talk. She not only taught us how to maintain hygiene and take care of ourselves but also forbade us to tease Shahana.”

5.4.2.2. Challenges in Psychosocial Support

Although the psychosocial support provided significant benefits to many individuals with disabilities and household members, some faced challenges that hindered their access to and improvement from the support.

One prominent challenge was the difficulty in communication, particularly for individuals with intellectual, psychological, speech, and hearing disabilities. Since the psychosocial officers could not communicate directly with these individuals, interventions intended for them had to be delivered indirectly through the caregiver. This communication barrier made it difficult for the psychosocial officers to fully understand and address the specific needs of each individual, affecting the quality and effectiveness of the support provided.

Another significant issue was the mismatch in timing between the availability of program staff and household members. Due to their busy schedules, particularly those engaged in IGAs, household members had limited time and availability to actively engage in the supporting activities. Some households required counselling for multiple other household members, along with individuals with disabilities. However, the availability of these household members to receive interventions from the psychosocial officer was not always guaranteed. Additionally, if the person with disabilities was a school-going child, finding them at home during the daytime posed a challenge. A psychosocial officer shared their experience, stating:

“Whenever I visited her household, she [person with disabilities] was not there, be it in the morning or evening. I only met her 3–4 times throughout the entire intervention period. So, I talked to her mother instead.”

The Key Challenges faced by the program in providing psychosocial support are:

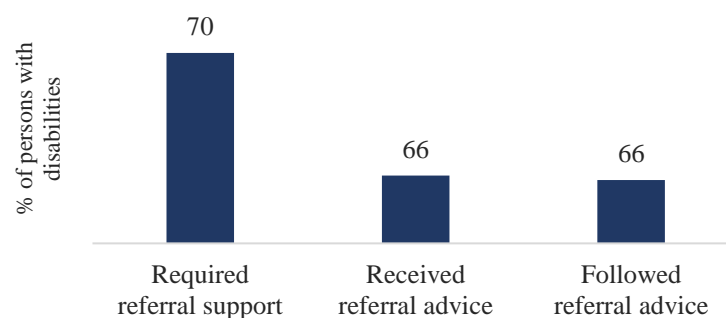
- Challenges in providing direct counselling to individuals with disabilities
- Mismatch in availability timing

5.4.3. Referral and Treatment Support

As mentioned earlier, referral and treatment are intertwined in both rehabilitation and psychosocial support. The details about referral and treatment support are provided in Section 2.2 (pg. 12). The lack of access to appropriate diagnosis and high-quality treatment was a major challenge for persons with disabilities and their households before the intervention.

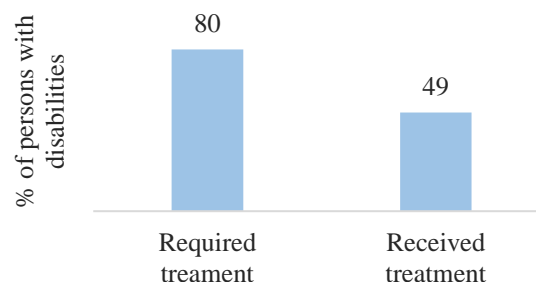
According to the quantitative survey, 70% of the households had a high need for medical cost coverage and referral, as shown in Figure 32. However, about 66% of the participants claimed to have been referred to a medical expert. Among those who were referred, the majority followed the advice and visited the recommended healthcare provider, while 34% did not comply with the referral.

Figure 32: Participant's Opinion on Referral Support



Approximately 80% of the households had expressed a strong need for treatment for the persons with disabilities, as shown in Figure 33. However, only 49% reported receiving treatment support from the program. These findings indicate the necessity for the program to reevaluate the selection criteria for persons with disabilities and the extent of referral and treatment support they provide.

Figure 33: Participant's Opinion on Treatment



Although the majority of the participants received referral and treatment support, its effectiveness varied depending on factors such as the treatability of the disability condition, household compliance, financial capacity, and the availability of necessary medical support. Financial constraints often limited their access to healthcare services and adherence to prescribed treatments. Additionally, the availability of healthcare professionals and resources also affected the treatment process. Furthermore, the health condition and severity of the disability could have influenced an individual's ability to comply with treatment recommendations.

5.4.3.1. Effect of Referral and Treatment Support

Referral and treatment support yielded positive changes among the participating households, including the adoption of formal healthcare systems for treatment and improvements in the health condition of persons with disabilities. As discussed earlier in Section 5.1.1.2 (pg. 25), households tended to rely on informal healthcare systems¹⁶ prior to the intervention. However, after receiving support, some households began seeking healthcare from formal healthcare services for the first time while others resumed utilizing such services after a prolonged hiatus. A caregiver shared their experience:

“Doctor Apa [psychosocial officer] and PO Bhai took him [person with disability] to the big doctor and gave him medicine. PO Bhai told me, ‘Aunty, here are the medicines for a few days and the prescription. Next time if something happens, give her the medicine as per the prescription.’”

Approximately 66% of the households continued seeking healthcare from formal health institutes after their initial visit. This shift in health-seeking behavior can be attributed to increased awareness of available formal healthcare options, a newfound recognition of the need for specialized care for persons with disabilities, and improved access to medical institutes through the guidance of the program staff. The subsidized cost of initial visits also enabled households to try treatment from the formal healthcare system, and upon witnessing positive changes, they continued seeking care independently. This support helped overcome previous barriers that hindered their access to formal healthcare services.

The degree of improvement in the health condition of individuals with disabilities, even after receiving treatment, was influenced by multiple factors, including the type and severity of disability, adherence to treatment, age, and co-existing health conditions. These factors collectively determined the level of observed improvement. The diverse nature of disabilities led to varying outcomes, with some individuals experiencing significant improvements in their health condition. For others, however, inherent limitations resulting from their disabilities or the progressive nature of certain conditions contributed to more modest gains. Nevertheless, even small advancements in health and well-being can have a profound impact on the overall quality of life for individuals with disabilities.

5.4.3.2. Challenges in Referral and Treatment Support

Participants often encountered barriers when accessing referral and treatment facilities, leading to unwillingness and demotivation. One common challenge was the lack of trust in the effectiveness of recommended treatments. This lack of trust stemmed from negative past experiences, skepticism towards the healthcare system, and limited awareness and information. Additionally, the lengthy treatment process, which involved multiple visits to healthcare institutions, created a sense of burden and demotivation for individuals with disabilities and their caregivers. Furthermore, the scarcity of responsible individuals to accompany persons with disabilities to healthcare facilities posed practical difficulties in accessing treatment. Financial constraints, including transportation costs and the expenses associated with treatment and medication, further contributed to the reluctance to pursue referral and treatment. Several

¹⁶ The informal healthcare system refers to healthcare practices that are not regulated or recognized by formal institutions. It often includes traditional healers, community-based providers, or self-medication practices. This reliance on informal healthcare for persons with disabilities highlighted the limited access to formal healthcare services and specialized care that cater to their specific needs.

households mentioned the financial strain they faced in continuing the treatment independently after the support provided by the DIUPG staff ended, leading some to give up. For instance, Shahin's (pseudonym) caregiver expressed,

“Due to the rising costs of everything, it has become exceedingly difficult for us to afford his [person with disability] daily medication. Consequently, there are times when we are forced to forgo this treatment and skip giving him the medicines.”

The program encountered challenges in establishing a systematic referral model, resulting in difficulties in coordinating and minimizing referral costs. This, in turn, prolonged the time required for individuals with disabilities to receive appropriate treatment. Moreover, motivating households to prioritize and take the necessary steps to seek treatment for persons with disabilities proved challenging for the staff. As discussed during an FGD,

“They [participants] gave up on the idea that he might get better if treated; we could not take them to the doctor after trying multiple times. But we know that he had the potential to get better.”

Key Challenges with referral and treatment support are:

- Lack of systematic referral model
- Lack of trust in the effectiveness of recommended treatments
- Difficulty in taking the persons with disabilities to healthcare facilities
- High transportation cost
- Lengthy treatment process which is time-consuming and costly

5.5. Intervention Sequencing Between Livelihood Support and Health Support

Two main intervention components of DIUPG are livelihood support and health support. The livelihood support aims to conduct enterprise development activities to improve livelihoods and lift households from extreme poverty. The health support aims to stabilize the health conditions of persons with disabilities and promote their holistic well-being. The program needs to determine the optimal sequencing of these components to achieve the overall goal of the program. This section discusses the feasible sequencing variations between livelihood and health support and addresses the existing challenges in each variation by integrating quantitative and qualitative data, using both program and participant perspectives.

5.5.1. Operational Sequence during Piloting

According to the KIIs with program staff, the program maintained a structured sequence in the piloting phase. The final selection of participants was followed by a disability assessment using IRA and PSA, which are part of the health support component. Subsequently, the program provided enterprise training and transferred necessary assets, which are part of the livelihood support component. After the asset transfer, the rehabilitation and psychosocial officers began providing interventions to the individuals with disabilities. Meanwhile, the PO continued with enterprise development activities. In this sequence, livelihood support came first, followed by health support. Both supports continued simultaneously throughout the program duration. However, this sequence was implemented during the pilot version of the program as it appeared operationally feasible. Nevertheless, the question of the most effective sequencing remains unanswered.

5.5.2. User-End Preference

Appropriate sequencing requires considering the opinions of the user-end. Therefore, in both quantitative and qualitative interviews, the participants, including persons with disabilities and caregivers, were asked about their preferences. This section discusses the possible biases in the participants' responses, the perceived benefits of each support by the households, the households' preferred sequencing, and factors that may have influenced their preferences.

5.5.2.1. Possible Bias

Before drawing conclusions on the participants' preferences, it is important to consider the factors that could have influenced their answers, as observed during qualitative interviews. Firstly, eliciting authentic answers was challenging due to low levels of realized need, literacy rates, and awareness among the participants. Secondly, formulating the question itself was difficult, so researchers used hypothetical scenarios to prompt responses. Thirdly, preferences may vary depending on the respondent's mindset, the caregiver's relationship with the person with disabilities, and the overall characteristics of the household. Fourthly, the households may have answered under the influence of the program's effect. After receiving all the interventions, they might have become more aware of the need for health support. Lastly, due to the nature of the program activities, households may perceive that the program highly prioritizes the health and well-being of persons with disabilities. Furthermore, since these households have already received the interventions, they might withhold their true preferences and instead share politically correct preferences.

5.5.2.2. Perceived Benefit from Health and Livelihood Support

This section examines how households perceive the benefits of each support. According to Figure 34, the majority of households (54%) perceive health support to be more beneficial for persons with disabilities. Additionally, Figure 35 shows that the majority of households (71%) perceive livelihood support to be more beneficial for the household. It is important to interpret these preferences accordingly.

Figure 34: Most Beneficial Support for Persons with Disabilities in Participant’s Opinion

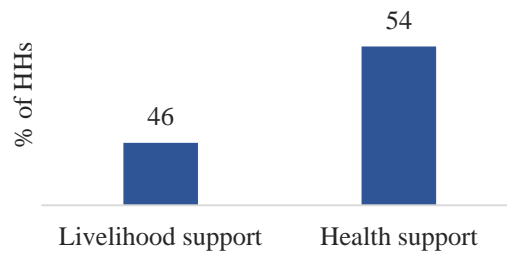
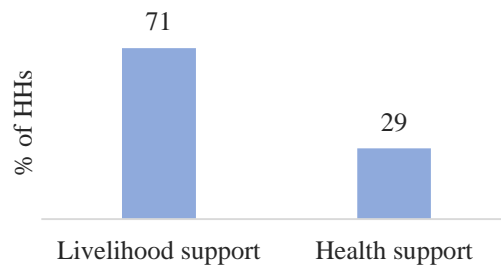


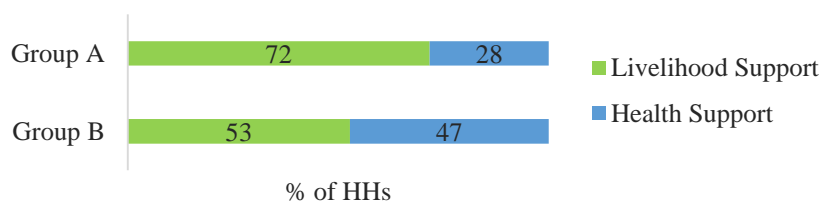
Figure 35: Most Beneficial Support for Household in Participant’s Opinion



5.5.2.3. Preferred Sequence

In the quantitative survey, participants were asked which intervention they thought would be more helpful if it were provided first. Figure 36 displays the results for Group A and B. It shows that the majority of households, regardless of the group, prefer livelihood support to be provided first. However, the preference for livelihood support is higher among Group A (72%) compared to Group B (53%). This could be because Group A, with higher economic vulnerability, prioritizes meeting their daily needs before addressing the health of the person with disabilities. In contrast, Group B, with lower economic vulnerability, has more flexibility to recognize the need for health support; yet, more households in Group B wanted livelihood support first than those who wanted health support first.

Figure 36: Preference towards Intervention Sequencing by Group A and B



During qualitative IDIs, 14 out of 22 participants expressed their preference for health support to be provided first. In one particular IDI, when asked about the reasoning behind their preferences, the caregiver of Asma, a person with hearing difficulty, explained:

“We need the health support first. Would we like it if we had a sick person? I want her [the person with a disability] to be healthy, to walk and eat like us. Treatment of my mother-in-law is necessary first.”

Meanwhile, Shipon’s caregiver explained their reasoning behind their preference towards livelihood support first:

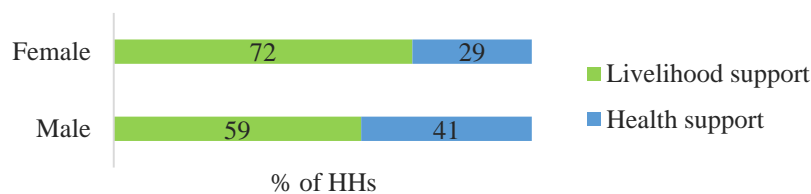
“They [program staff] were talking about treatment but I don’t give priority to it because it’s been a long time with his [person with disability] difficulty in sight. Again, I thought his visual disability would not improve, so I wanted the cow.”

5.5.2.4. Factors That Influence the Preference

In assessing the variations in preference, factors such as gender, age, and disability severity were considered.

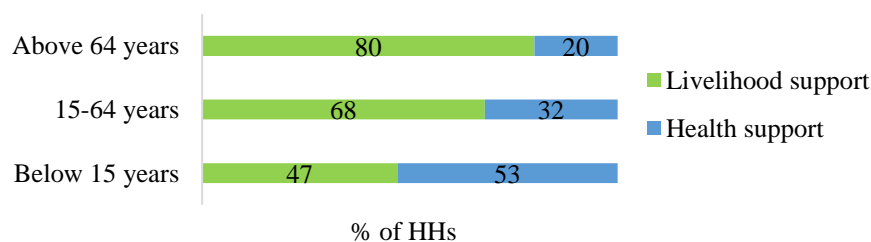
Gender: Figure 37 presents the disaggregation by gender of persons with disabilities. Households with males with disabilities have a higher preference for health support (41%) compared to those with females with disability (29%). The data provides a crucial insight: households prioritize the recovery of males over females, hoping to engage them in IGAs.

Figure 37: Preference towards Intervention Sequencing by Gender



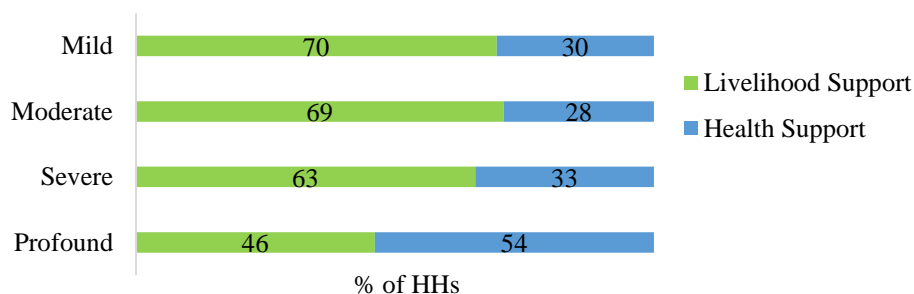
Age: Figure 38 demonstrates that preference is also influenced by age. The household’s preference for livelihood support over health support increases as the age of the person with disabilities increases. This suggests that households are more hopeful to see positive changes in younger individuals but may lose hope for improvement in older individuals. This finding is supported by qualitative IDIs where family members express optimism about the possibility of a cure or the mitigation of difficulties when the disability is addressed at an early age.

Figure 38: Preference towards Intervention Sequencing by Age



Disability severity: Figure 39 indicates that the severity of the disability also influences the household’s preference. The need for health support first is realized more strongly for severe cases. The preference for health support is highest among profound cases (54%) and lowest among mild (30%) and moderate cases (28%).

Figure 39: Preference towards Intervention Sequencing by Disability Severity



5.5.3. Operational-End Preference

This section discusses two suggestions strongly recommended by the field-level program staff: transferring assets after selection and expediting the delivery of health support. They argue for providing both supports simultaneously, starting as soon as possible.

5.5.3.1. Asset Transfer after Selection

The field staff strongly suggest that asset transfer should be carried out immediately after selection. They believe that this is crucial for households and facilitates the smooth implementation of program activities. Assets serve as a tangible incentive for households to actively participate in the program. If the intervention lacks credibility in the eyes of the households, its effectiveness may be compromised. Livelihood support, in particular, creates a positive impression among households, fostering trust and acceptance towards the program, which may not be immediately achieved through health support. The socioeconomic vulnerability of the households drives their desire for economic improvement. Additionally, some households hold a pessimistic view regarding the prospects of improvement for persons with disabilities. Therefore, livelihood support addresses their immediate needs, serving as an entry point for the program. Asset transfer also creates accountability among households, facilitating their engagement with program activities and enabling the smooth implementation of the program. During an FGD in Kishoreganj, one of the program staffs shared their experience, stating,

“From my own experience, I can tell you that if we had not given the asset, the treatments would not have been easy. It becomes risky for us to issue referrals and take persons with a disability to a doctor. It is risky in this sense that even after providing assets, they do not feel motivated to go to a doctor. It’s an obstacle for me to execute the referral or health suggestion.”

Assets also enhance the program’s credibility within the community, resulting in a quicker and more positive response from society. This applies not only to households but also to program

staff, as the provision of assets facilitates community penetration and garnering approval from local residents.

Lastly, a certain duration is necessary to ensure IGA diversification and asset growth for program graduation. If livelihood support is provided later, households will not have sufficient time to diversify their assets and graduate from their pre-intervention economic conditions within the program period.

5.5.3.2. Quick Delivery of Health Support

The field staff also highlight the significance of providing health support at the earliest opportunity. According to their perspective, delivering health support early is crucial as it takes time to observe improvements in the health condition of persons with disabilities. This is particularly important to enable adult persons with disabilities to engage in IGAs. It is essential to ensure that individuals with disabilities are physically and mentally capable before involving them in any activity. Therefore, the field staff emphasize the need to prioritize the prompt delivery of health support to those with severe disabilities. Their arguments are summarized in the following statement:

“I also think that it would be better if health support was started simultaneously with the asset transfer. There are also some persons with disabilities who can immediately participate in IGA once the asset is delivered, such as the ones with mild severity. On the other hand, those who have severe levels of disabilities cannot take part in IGA soon. For them, the health support should be transferred first, followed by the livelihood support.”

5.5.4. Challenges for Various Sequencing Types

The researchers engaged in discussions with the field staff to explore effective sequencing options. Based on their opinions, two viable options have been synthesized and are discussed below, along with the potential challenges associated with each type of sequencing:

- 1. Need-based, customized sequencing (sequential):** Customizing the sequencing based on the specific needs of individuals with disabilities can be beneficial. However, this approach may result in heterogeneity among participating households, as each household receives different support at different times. This could create tension and uncertainty among households regarding the timing and likelihood of receiving assets or treatment. From an operational perspective, implementing customized sequencing can be challenging due to the increased workload and manpower required.
- 2. Simultaneous provision of both supports:** This approach presents its own set of challenges. It may place an additional burden on caregivers, who would be responsible for managing the health needs of the person with disabilities while also overseeing the enterprise on their behalf. Moreover, implementing both supports concurrently may increase initial workload for the program staff.

Despite these challenges, there is always room for innovation to effectively address these issues and find ways to ensure the successful delivery of both supports.

5.6. Caregiver Dynamics

This section delves into the manifestation of the caregiving concept within the context of DIUPG and examines the diverse dynamics of caregivers.

5.6.1. Caregiver's Role in the Program

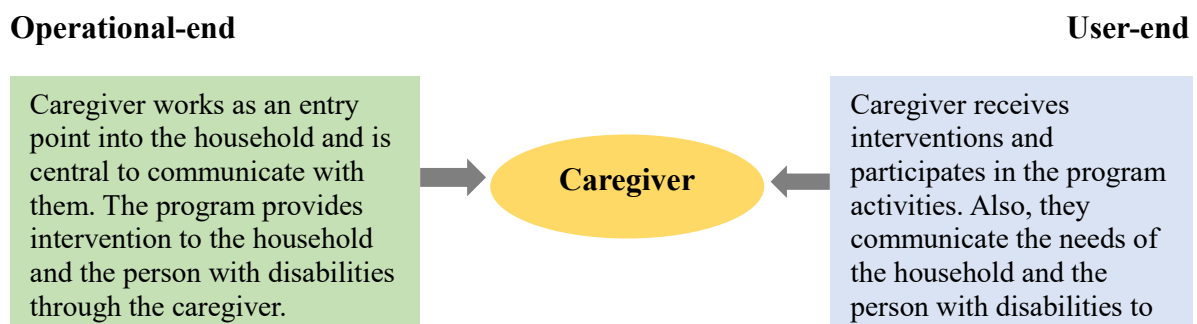
In academia, caregiving is defined as the provision of support and care to individuals with chronic illnesses or disabilities (Chappell, 2002). Caregivers can include professionals in the healthcare field, family members, friends, social workers, or members of religious organizations, and they may offer their services in various settings, such as homes, hospitals, or other healthcare facilities. The objective of caregiving is to assist persons with disabilities in maintaining their independence and dignity (Whitlatch et al., 2007). This assistance can take different forms, including practical or physical aid, emotional support, and financial assistance. Caregiving has traditionally been a family phenomenon, spanning decades (Zarit et al., 2015).

This study aimed to examine the role of caregivers in the DIUPG program. It has been observed that caregivers in DIUPG have multifaceted roles that revolve around providing care to persons with disabilities and managing assets, as assigned by the program. The roles of caregivers in this program are described by a program staff member as follows:

“We term caregiver to be the one who takes care of the person with a disability. The caregiver can include the persons with disabilities’ parents, grandma, or grandpa who live with the person with a disability. For instance, in cases where a child with a disability cannot perform daily activities, his/her caregiver teaches them about when and what to do. We sometimes orient the caregivers with the chart on the aerial board you see to help them understand when and how to take care of persons with disabilities. It is like revising the routine by the caregivers. Besides, we explain some exercise routines and their practicing rules to the caregivers.”

The caregiver serves as the central person for enterprise management and routine caregiving. The nature of care provided varies among persons with disabilities based on their age and health condition. Some individuals require regular exercise routines, while others need intensive mental health support. However, in cases where direct communication with the persons with disabilities is not possible due to functional difficulties or when health support activities require assistance from another person, the caregiver acts as an intermediary. The role of the caregiver as an intermediary link in the program is illustrated in Figure 40.

Figure 40: Caregiver's Role as an Intermediary Link between Program and Participant



5.6.2. Demographics of Caregivers

Figure 41 shows that 11% of the households in the study did not have any caregivers. The remaining households had caregivers, with the majority (84%) being internal caregivers who lived in the same household as the persons with disabilities. Table 14 provides a further breakdown of the caregiver’s relationship with the person with disabilities. In most cases, the caregivers were either parents (50%) or spouses (32%) of the persons with disabilities. This suggests that the program has been successful in selecting caregivers who reside within the same household and have a close relationship with the persons with disabilities.

Figure 41: Type of Caregiver

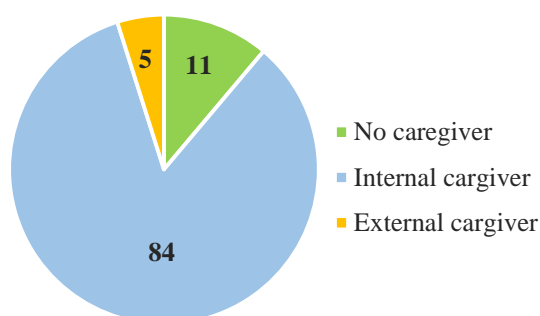


Table 13: Relationship between Caregivers and Persons with Disabilities

Relationship	% of HHs
Parent	50
Spouse	31.78
Son-in-law/daughter-in-law	5.08
Child	3.39
Brother’s wife/sister’s husband	2.97
Grandparent	2.12
Brother/sister	1.69
Stepmother	1.69
Father/mother-in-law	0.42
Other relatives	0.84

The majority of caregivers were found to be females (91%). Qualitative observation revealed that the program deliberately selected female members as caregivers to involve them in program activities. Additionally, there was an existing informal caregiving system where females predominated. The age structure of the caregivers, as shown in Figure 42, indicates that the highest number of caregivers (86%) are adults between the ages of 18 and 64, while 14% are over 65 years old. Furthermore, Figure 43 reveals that nearly all caregivers (97%) were engaged in some form of IGAs. In the rural context, female caregivers often have limited opportunities for engaging in IGA due to poverty, landlessness, and pre-existing constraints. However, after receiving livelihood support through the program, caregivers now have the opportunity to participate in IGA.

Figure 42: Caregiver's Age

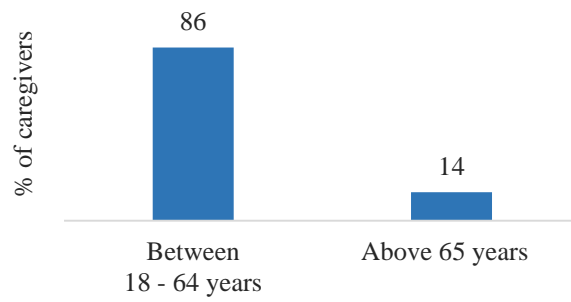
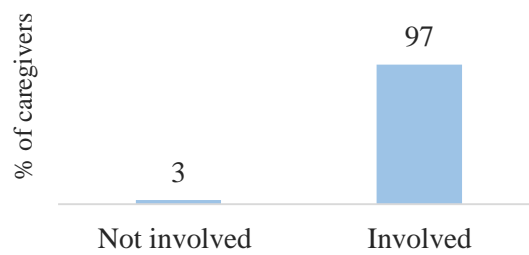


Figure 43: IGA Status of Caregivers



Assessing the health of caregivers is also important as they carry out multiple responsibilities. The increased caregiving tasks may impact their health and ability to continue providing care. Figures 44 and 45 provide insights into the health status of caregivers, with 6% of caregivers having a disability and approximately 12% of caregivers self-reportedly having a poor health condition.

Figure 44: Disability Status of Caregivers

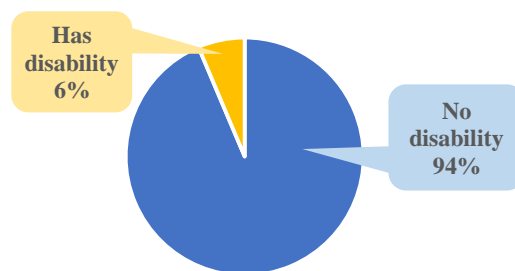
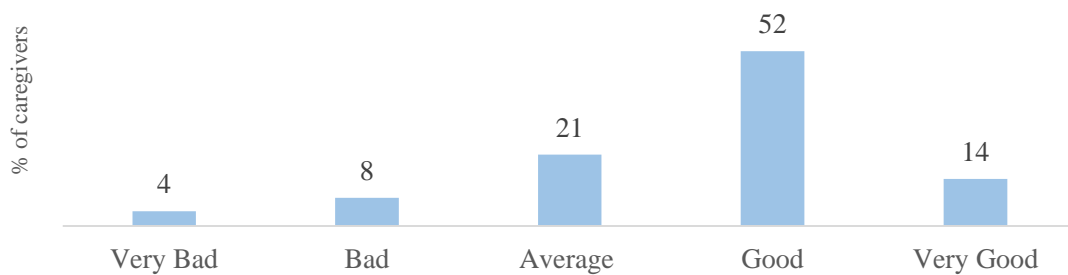


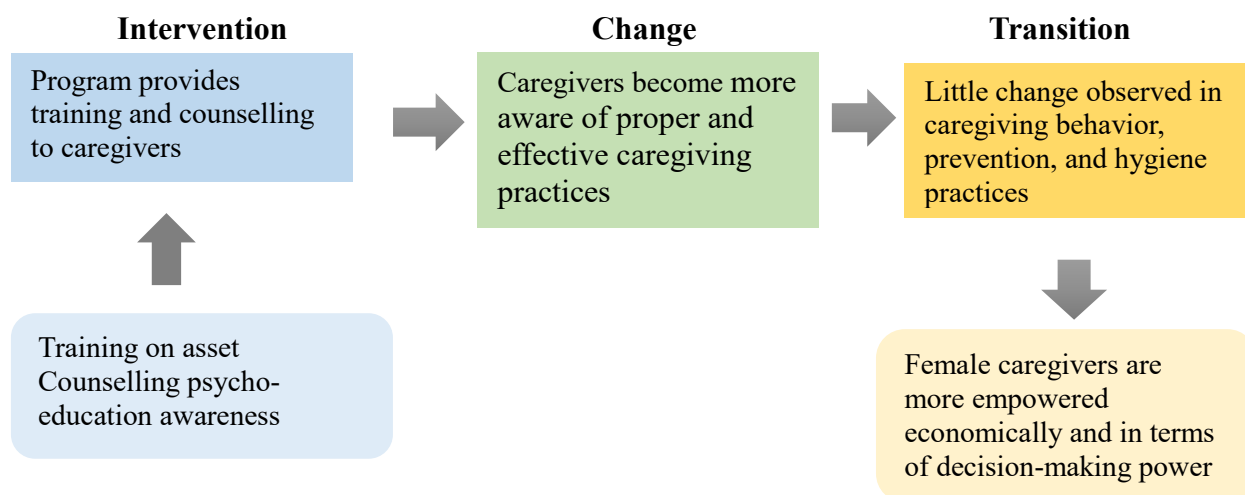
Figure 45: Health Condition of Caregivers (Self-Assessment)



5.6.3. Transition from Informal to a Formal Caregiver

The caregivers underwent training and counselling on how to engage with persons with disabilities. Figure 46 illustrates the interventions received by the caregivers and how these interventions facilitated the transition from traditional caregiving to formal caregiving.

Figure 46: Caregiver’s Intervention and Transition from Informal to Formal Caregiving



The following statement from a qualitative interview with a program staff provides further insights into the shift from informal to formal caregiving:

“We believe some conceptual changes are apparent due to our caregiver training and counselling. For example, we suggest not using words that hurt a person with a disability. Some persons with disabilities are suggested to do certain exercises, but many of them are new to it. So we train the caregivers. If, after referral treatment or giving the suggested care, the persons with disabilities improve, it further motivates the caregiver. Even if persons with disabilities forget to take medicine, the caregivers will arrange it in time. It is unlikely that others except the caregiver will properly take care of the provided livelihood and health support. The support is helping create a good relationship between the caregiver and the persons with disabilities. More specifically, upon giving care, the caregiver is gaining an ownership of the assets.”

These insights highlight that the counselling and training support bring about changes in the caregivers’ approach to caring for persons with disabilities. Although there is no distinct transformation from conventional and prevalent caregiving practices to an established formal caregiving system, there is a noticeable positive change among the caregivers. The program activities have empowered the caregivers, particularly females, in terms of managing finances, generating income from assets, and making decisions regarding asset management. Additionally, the caregivers have assumed a more authoritative role within the household and their opinions are given importance by other household members. One caregiver, Dipannita (pseudonym), emphasized her experience of increased financial independence after the intervention:

“After getting the asset, now I can save some money for meeting the little and immediate expenses such as buying pencils and paper for the kids. Now,

I can sell milk and accumulate money. We have no major source of earnings except the barber shop. After BRAC provided these assets, the family’s earnings increased. Unlike the previous trend, I don’t need to ask for money from my husband for little expenses.”

5.6.4. Work Burden

In the context of existing household work and caregiving activities, caregivers are assigned additional tasks of managing both the assets and the persons with disabilities. According to qualitative data, caregivers acknowledged that their workload has indeed increased due to their involvement in program activities. However, they did not express any feelings of burden or suffocation from the workload. Instead, they mentioned that they enjoyed engaging in enterprise development activities as it allowed them to utilize their spare time in productive work that benefited the household. Field observations also suggest that the caregivers’ workload was influenced by the demographic structure of the household. For instance, if the household had multiple members who assist the caregiver, their workload was minimized. Conversely, a small household size increases the work burden as there are no additional helping hands available. Additionally, some caregivers were observed to have pre-existing health issues, which further complicates their ability to manage all the activities. A caregiver in a household with two persons with disabilities shared their experience:

“I am about to die. It is hard for me to move around. Apart from your uncle [the person with a disability], I have to take care of my daughter [another person with a disability]. I help her bathe and collect water for her from the tube-well. I help her change clothes again. Even I help to tie her hair. I have to wash all of her clothes.”

In the quantitative survey, caregivers were asked about the amount of time they spend assisting persons with disabilities in performing various daily activities, such as moving around and outside the house, eating, bathing, changing clothes, and communicating. On average, caregivers reported spending 2.8 hours per day on caregiving activities. Figure 47 provides a breakdown of caregiving time based on the severity of the disability of the participants. It reveals that caregivers spend the most time, approximately 4.7 hours per day, for individuals with profound disabilities, while the least time, 1.6 hours per day, and is dedicated to those with mild disabilities.

Figure 47: Time Spent by Caregiver on Caregiving Activities per day by Disability Severity

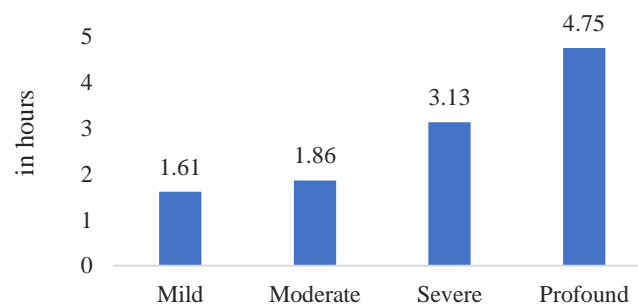
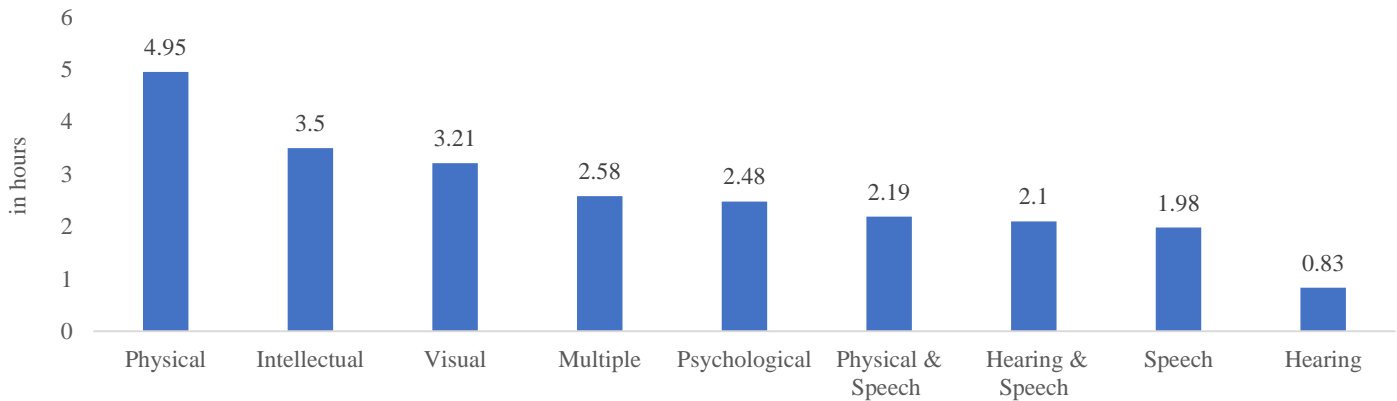


Figure 48 further breaks down caregiving time by disability type. On average, caregivers spend the highest amount of time, around 4.9 hours per day, for individuals with physical disability only, while less than one hour per day is spent on those with hearing disability only.

Figure 48: Time Spent by Caregiver on Caregiving Activities per Day by Disability Type



The program staff also strongly acknowledge the increased workload faced by caregivers. However, they believe that the workload is manageable. One staff member expressed their perspective on the matter:

“Before, maybe they spent their time picking potatoes, sitting at home, playing Ludo or gossiping with others or sewing. Now, we modified their daily work a little; we ask them to invest additional 30 or 40 minutes to their daily activities. If we modify their time for their advantage, it doesn’t seem like much of a problem then.”

5.6.5. Motivating Factors and Need for Stabilization

Despite the increased workload, caregivers demonstrate their motivation to assume their role under various circumstances. One of the primary factors influencing their decision is the emotional bond they share with the person with a disability. It was observed that caregivers had been involved in providing care prior to the intervention, and they continued to provide care even in the absence of the program. As mentioned earlier, the majority of caregivers are female (91%). Female household members already possess a sense of responsibility towards the household and take ownership of family affairs. Caregivers may also have an implicit financial incentive. Additionally, through their engagement in enterprise development activities, caregivers develop a sense of entitlement and ownership over the assets.

The study aimed to investigate the demand for additional support to stabilize caregivers, which means to ensure the caregiver is in appropriate condition from economic, health, and all other aspects necessary to conduct the caregiving and livelihood development activities. Initially, during the piloting stage, no specific intervention was implemented to stabilize or support caregivers. When questioned about their needs, caregivers did not recognize the need for stabilization support or assistance in caregiving activities. Instead, they expressed a preference for support benefiting the household as a whole. The program staff provided an explanation for this phenomenon, stating,

“The caregiver is part of the household. Maybe they are a mother, sister, [or] anyone else. They belong to that household. Since the household is receiving a cow, agriculture, or whatever the enterprise is, the earning from the asset is not only benefited by the persons with disabilities but also consumed by other household members including the caregiver.”

Close family members serving as caregivers and residing within the household already possess strong motivation for their activities. In contrast, external caregivers, such as relatives or those living in separate households, may benefit from incentives to enhance their motivation. Additionally, some internal caregivers may face challenges in adhering to program advice due to various issues including a heavy workload and health issues. Therefore, the program could consider providing incentives such as subsidies, rewards, or free services to motivate and stabilize caregivers.

5.6.6. Challenges of Caregiving

Several challenges can be addressed to streamline the caregiving process. Firstly, prioritizing caregiver stabilization, with a particular emphasis on their health and financial well-being, can be beneficial. Secondly, the significant workload placed on caregivers may have long-term implications for their health. Finding ways to alleviate this burden is crucial. Thirdly, ensuring that caregivers consistently follow program advice can be a challenge for program staff. Therefore, it is essential to consider strategies for promoting sustainability in caregiving practices.

5.7. Insight on the Status of Graduation Indicators

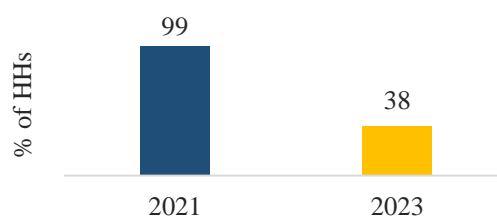
This section provides an overview of the status of households from the 2021 cohort regarding key graduation indicators of the mainstream UPG program as of February 2023.

5.7.1. Livelihood Promotion

5.7.1.1. Income

In 2021, prior to the intervention, a staggering 99% of households were below the poverty line of USD 2.15 per capita per day. However, in 2023, this percentage dropped to 38% as shown in Figure 49, indicating a substantial reduction in poverty rates.

Figure 49: Percentage of Households below the Poverty Line (USD 2.15 per Day)



Furthermore, the statistics in Table 15 show a significant increase in per capita income.¹⁷ The average monthly per capita income before the intervention was BDT 1,192, which was below the poverty line (equivalent to BDT 2,070 per month). After the intervention, it increased to BDT 2,865, surpassing the poverty line. Group B witnessed a greater surge in per capita income, with a notable increase of 153%, compared to the 133% increase observed in Group A. While working age male household members had the highest monthly income post-intervention (BDT 7,771), working age females household members experienced the largest increase, a 444% rise. Table 15 also provides information on the post-intervention monthly income of persons with disabilities, caregivers, and household-heads, but unfortunately, data on their pre-intervention income is not available. The average monthly income of persons with disabilities stands at BDT 2,027, slightly below the poverty line. However, the average monthly income of caregivers and household-heads is above the poverty line, at approximately BDT 2,337 and BDT 6,022, respectively.

Table 14: Income Status Before and After Intervention (in BDT)

Categories	Pre-intervention (2021)	Post-intervention (2023)	Percentage change (%)
Household monthly income	4,740	11,704	146.89
Per capita monthly income	1,192	2,865	140.35
Group A HH's per capita monthly income	1,128	2,629	133.07
Group B HH's per capita monthly income	1,333	3,380	153.56
Monthly income of working-age male population	3,848	7,771	101.95
Monthly income of working-age female population	569	3,099	444.64
Person with disabilities' monthly income	-	2,027	-
Caregiver's monthly income	-	2,337	-
Household-head's monthly income	-	6,022	-

5.7.1.2. Employment

As discussed in Section 5.1.1, the ultra-poor households had fewer opportunities for IGAs before the intervention. The statistics in Table 16 demonstrate a significant positive change in the employment landscape among the participants.

In 2021, prior to the intervention, approximately half of the working-age individuals (52%) were employed. However, after the intervention in 2023, nearly 85% of the working-age individuals are employed. Although there is no difference in the post-intervention employment rate between the two groups, there is a subtle difference in the percentage change, with Group B experiencing a greater change (26 percentage points). The most notable increase is observed among the female working-age population, whose employment rate jumped from 31% in 2021 to 85% in 2023. As mentioned in the previous section, there is a lack of pre-intervention quantitative data on persons with disabilities, caregivers, and household-heads, but their employment rates can be compared to the overall average. The post-intervention employment rates among working-age persons with disabilities, caregivers, and household-heads are approximately 75%, 99%, and 97% respectively. The employment rates among caregivers and

¹⁷ All monetary values of 2023 were deflated according to June 2021's CPI values.

household-heads are very high, whereas the employment rate is 25 percentage points lower among persons with disabilities. This suggests a lower level of IGA engagement among individuals with disabilities, which also brings down the overall household employment rate.

Table 15: Rate of Employment before and After Intervention (in %)

Categories	Pre-intervention (2021)	Post-intervention (2023)	Percentage change (%)
Working-age population	52.27	85.58	63.73
Group A members	55.11	85.63	55.39
Group B members	47.08	85.50	81.59
Working-age male population	76.49	86.17	12.65
Working-age female population	31.46	85.09	170.48
Person with disabilities	-	75.22	-
Caregiver	-	99.54	-
Household-head	-	97.27	-

5.7.1.3. Productive Assets

Key factors that have contributed to the increase in earnings and employment are the asset transfer by the program and asset growth. Table 17 illustrates the significant level of asset growth experienced by the households. On average, the value of productive assets increased from BDT 1,628 in 2021 to BDT 58,763 in 2023. Group B participants saw a larger increment (3,500%) compared to the 2,900% increase observed in Group A. Although there is no pre-intervention data on persons with disabilities and caregivers, on average, own productive assets of the persons with disabilities were valued at about BDT 41,624, whereas caregivers' own productive assets were worth about BDT 8,447. The high value of assets owned by individuals with disabilities can be attributed to the program's asset transfer specifically to them. However, caregivers also seem to own a small percentage of the household assets.

Table 16: Value of Productive Assets Owned by Households before and After Intervention (in BDT)

Categories	Pre-intervention (2021)	Post-intervention (2023)	Percentage change (%)
Participating Household	1,628	58,763	3,963.78
Group A Household	1,331	54,098	2,915.82
Group B Household	2,293	69,141	3,509.35
Person with disabilities	-	41,624	-
Caregiver	-	8,447	-

Figure 50 presents a detailed graph on the types of productive assets owned in 2023, after the intervention, by the households, persons with disabilities, and caregivers. The majority of them owned livestock-based assets, such as poultry, cows, goats, and livestock shelters. Ownership of assets related to other enterprise options, such as vehicles, fishing nets, sewing machines, and agricultural tools, was lower. Within the households, it was evident that persons with disabilities owned a significant share of the livestock assets, but caregivers also possessed a considerable portion of the assets.

Figure 50: Types of Assets Owned in Post-Intervention

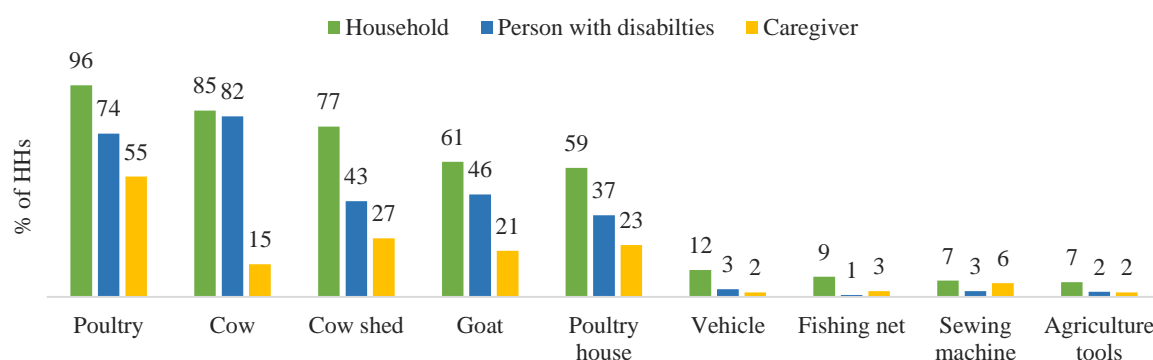


Table 18 displays the average value of the assets owned by the households before and after the intervention. Although the incidence of vehicle ownership is low, those who owned a vehicle experienced the highest value gain (306%), followed by poultry (270%) and goats (122%).

Table 17: Value of Assets Owned by the Households before and After Intervention¹⁸ (in BDT)

Categories	Pre-intervention (2021)	Post-intervention (2023)	Percentage change
Cow	22,500	46,009	104.48
Goat	3,676	8,163	122.07
Poultry	764	2,832	270.46
Vehicle	5,813	23,609	306.18
Sewing machine	2,786	2,718	-2.42

5.7.2. Financial Inclusion, Social Protection, and Empowerment

5.7.2.1. Financial Inclusion

Table 19 provides an overview of the savings and loan status of the households after the intervention. Since there is no pre-intervention data available for comparison, the focus is on the post-intervention figures. According to the table, approximately 97% of the households had savings, with an average amount of BDT 5,176. Savings were also observed among 88% of persons with disabilities with an average of BDT 3,663, and 22% of the caregivers with an average of BDT 5,363. Notably, the majority of the savings were held at BRAC.

Additionally, 50% of the households had outstanding loans, amounting on average BDT 17,448. Among the participants, 18% of persons with disabilities and 50% of caregivers had outstanding loans, averaging around BDT 13,953 and BDT 8,555, respectively. The loans primarily originated from shopkeepers (45%), relatives (24%), and local money lenders (14%).

¹⁸ The statistics in Table 18 are conditional averages of households who owned the certain type of asset, not collective average of the full sample.

Table 18: Savings and Loan Status during Post-Intervention

	% of population who have savings or loans outstanding	Value of savings and loans outstanding among those who have it (in BDT)
Savings		
Household	97.21	5,176.36
Person with disabilities	88.50	3,663.46
Caregiver	22	5,363.69
Outstanding Loan		
Household	50.17	17,448.40
Person with disabilities	16.02	12,511.37
Caregiver	50.43	8,555.80

5.7.2.2. Social Protection

One of the program’s primary objectives was to enable households to acquire Suborno cards. The data reveals that following the intervention, 57% of households successfully obtained the Suborno card, while 19% were still in the process of receiving it (see Figure 51). During the intervention period from September 2022 to February 2023, the households received support from various sources. The government provided support to 76% of the households, NGOs other than BRAC assisted 2% of the households, the community contributed to 13% of the households, and VSSC supported 31% of the households (see Figure 52).

Figure 51: Accessibility to Suborno Card during Post-Intervention

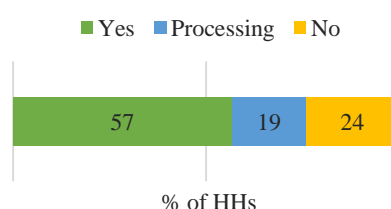
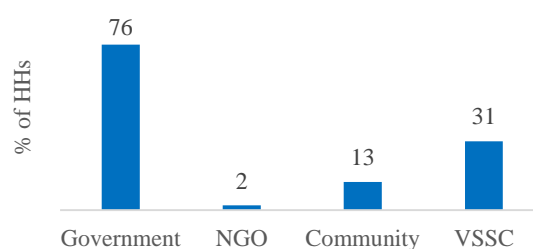


Figure 52: Sources That Provided Support to the Households from Sept. 2021 to Feb. 2023



5.7.2.3. Social Empowerment

The housing condition is a key indicator of social empowerment. After the intervention, about 99% of households had tin roofs, 97% had tin walls, 94% had mud floors, and 6% had durable *paka* (cement) floors. The survey results also show that a commendable 96% of households now had access to sanitary latrines. However, about 12% of individuals with disabilities reported not using the same latrines as the rest of the household, which may be attributed to

accessibility challenges. The majority of households (77%) reported drinking water from tubewells located inside their houses (Figure 53).

These findings indicate an overall improvement in the living conditions of the majority of households. Nonetheless, Table 20 reveals that a small percentage of persons with disabilities still face difficulties in independently performing basic daily life activities.

Figure 53: Source of Drinking Water during Post-Intervention

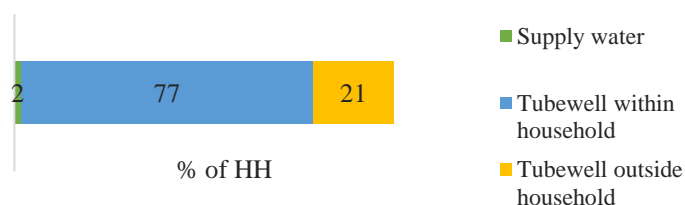
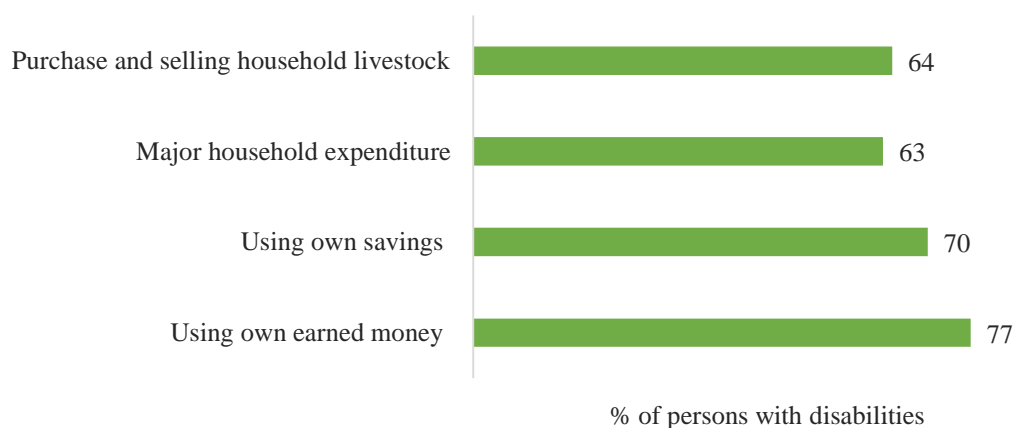


Table 19: Individuals with Disabilities’ Ability to Perform Daily Life Activities without Anyone’s Help during Post-Intervention

List of daily life activities	% of individuals with disabilities
School-going aged children who can go to school	33.33
Eat	82.93
Use latrine	76.66
Drink water from water source	67.25
Move from house to yard	84.32
Move from house to outside of yard	78.4

Figure 54 underscores the significant involvement of persons with disabilities in various household decision-making processes.

Figure 54: Participation of Persons with Disability in Decision-Making during Post-Intervention



6. Key Takeaways

Targeting: The study reveals that vulnerable households face a range of obstacles due to their lack of awareness and accessibility to resources, highlighting the importance of DIUPG's intervention. The data clearly demonstrates the success of DIUPG in targeting highly vulnerable households. However, the primary focus of targeting appears to be on economic vulnerability, similar to UPG. While DIUPG staff possesses extensive experience working with the ultra-poor and a strong economic lens from their years of experience with UPG, it is crucial for DIUPG to readjust its focus and adopt a bi-focal perspective that equally prioritizes both economic and disability lenses.

Currently, there is no standardized segmentation mechanism for grouping individuals based on their disability status. This lack of clarity poses a challenge, as households may be more vulnerable in terms of disability but less so economically, potentially leading to misallocation in a less severe group. Therefore, it is imperative to establish clearer criteria and instructions for selecting and categorizing individuals with disabilities based on both the severity and type of disability and their economic vulnerability.

Additionally, information regarding the non-take-up rate of the DIUPG program is unavailable, which limits the assessment of its success compared to other disability-inclusive programs. Future cohorts should consider examining the non-take-up rate to better evaluate the program's effectiveness and facilitate comparisons with similar initiatives.

Enterprise selection and matching: Overall, the enterprise selection and matching process need to be more disability-focused. Although there is high participation of persons with disabilities in the enterprise selection, a certain percentage of them are still unable to participate. The program should consider factors that affect their participation in enterprise selection and develop ways to increase their overall participation. Results in table 12 indicate that gender dynamics may influence participation, as female persons with disabilities and female caregivers were seen to have a higher participation during enterprise selection. Program can consider such factors and reassess the strategies if necessary.

Secondly, although the enterprise matching is strongly influenced by the household's preference, there is a need to further customize the enterprise packages considering the disability condition of individuals with disabilities.

Livelihood support: The livelihood support has been a successful component due to UPG's long-term experience and expertise. However, there is scope to strengthen asset ownership, participation in decision-making, and engagement in enterprise development for persons with disabilities. Specifically, IGA engagement remains lowest among profound cases and those with intellectual and mental disabilities. The program should find ways to engage participants who are unable to participate in livelihood development activities.

Health support: The program has made a significant impact on the lives of individuals with disabilities by providing basic health support interventions. However, there are numerous field-level challenges that continue to impede potential improvements. There is a need to further enhance the rehabilitation process by ensuring better accessibility to assistive devices. Psychosocial support should be emphasized as it has proven to be beneficial for individuals with disabilities, caregivers, and other family members.

Additionally, participants still face barriers in accessing referral and treatment support due to high transportation costs, the need for manpower to accompany persons with disabilities to medical institutions, and long-term medical expenses. Individuals with intellectual disability, psychological disability, severe cases of multiple disabilities like cerebral palsy, and profound cases are not able to benefit significantly from the health support. The program needs to reassess its approach to providing health support to such cases.

Intervention sequencing between livelihood and health supports: Identifying an effective sequencing method is challenging due to the complex nature of factors affecting individuals with disabilities. From the user-end, the majority of participants believe that livelihood support should be delivered first, but a significant portion also expresses the need for health support to be prioritized. On the other hand, field-level program staff suggest transferring assets and providing health support simultaneously, immediately after selection. The program can consider innovative ways to customize the sequencing according to the specific needs of each person with disabilities for improving efficiency.

Caregiver dynamics: The caregivers have played a pivotal role in the program. The majority of caregivers are female and close family members, making it easier to involve them in program activities. However, as they fulfil their dual role as intermediaries between the program and the household, and enablers in health and livelihood activities, caregivers face significant work burdens. The program should consider strategies to further support and stabilize caregivers through subsidies or other customized interventions, even if the caregivers themselves may not realize or request such support.

Status of graduation indicators: The overall post-intervention status of the persons with disabilities and their households appears promising. However, the program should prioritize the development of disability-inclusive graduation indicators. This means not only focusing on whether indicators such as income, assets, housing, latrine, and social empowerment have increased over time, but also ensuring that they are accessible to persons with disabilities. It is important to consider the accessibility aspect in evaluating the success of the program's impact on individuals with disabilities.

7. Conclusion

The DIUPG program aims to promote inclusivity and improve the living standards of ultra-poor households with individuals with disabilities. It combines tailored interventions from the UPG program with disability-focused interventions to address the specific needs and vulnerabilities of persons with disabilities. The program's pilot was implemented in four districts in northern Bangladesh, with technical assistance provided by Humanity & Inclusion (HI).

As it was the first disability-inclusive program under UPG, the study was undertaken to provide valuable insights and knowledge for improving the program design. To accomplish this, BIGD collaborated with BRAC UPG to conduct a rapid assessment of the 2021 cohort of DIUPG, focusing on various program components, including targeting, enterprise selection and matching, livelihood support, health support, intervention sequencing between livelihood and health support, caregiver dynamics, and the status of graduation criteria.

The findings of the study underscore the importance of adopting a dual-focused approach that considers both economic and disability vulnerability. It is crucial for the program to establish clearer selection criteria and instructions to categorize individuals with disabilities based on their specific disability conditions. Moreover, the enterprise selection and matching process should address barriers to participation for individuals with disabilities and develop customized enterprise development plans that account for their unique strengths and challenges.

While the livelihood support component has been successful, efforts should be intensified to enhance asset ownership, increase decision-making participation, and promote engagement in enterprise development for individuals with disabilities.

In terms of health support, there is a need to improve the rehabilitation process, strengthen psychosocial support, and address challenges in accessing referral and treatment services. Determining an effective intervention sequencing between livelihood and health supports is challenging, but customization based on individual participant needs and simultaneous support delivery could be considered.

Throughout the program, caregivers play a crucial role, and their potential can be further enhanced through additional support, such as subsidies and tailored interventions designed specifically for them. Furthermore, the program should develop graduation indicators with a disability-inclusive approach, considering the accessibility of individuals with disabilities.

Overall, the program should strengthen its disability-focused lens, expand expertise in disability-focused interventions, and continue to make progress in livelihood development. While the program has experience in working with the ultra-poor and addressing poverty through the UPG model, it is important to further develop expertise and insights in incorporating disability-focused interventions while maintaining positive progress in livelihood development within DIUPG.

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Annex

Figure A1: DIUPG Selection Process

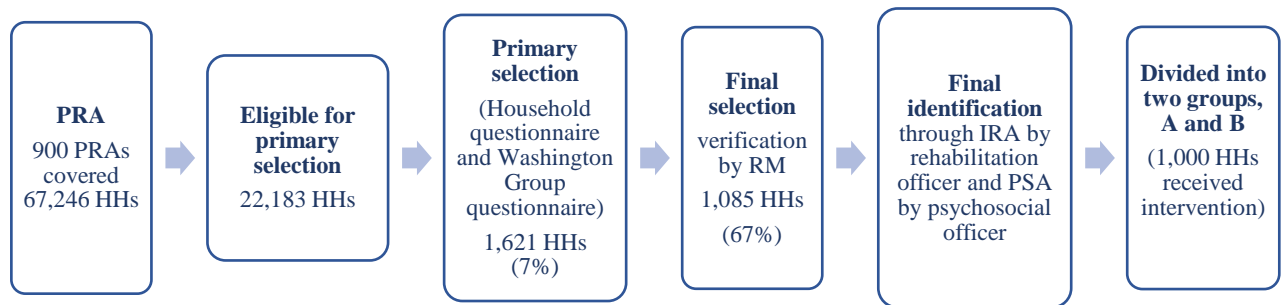
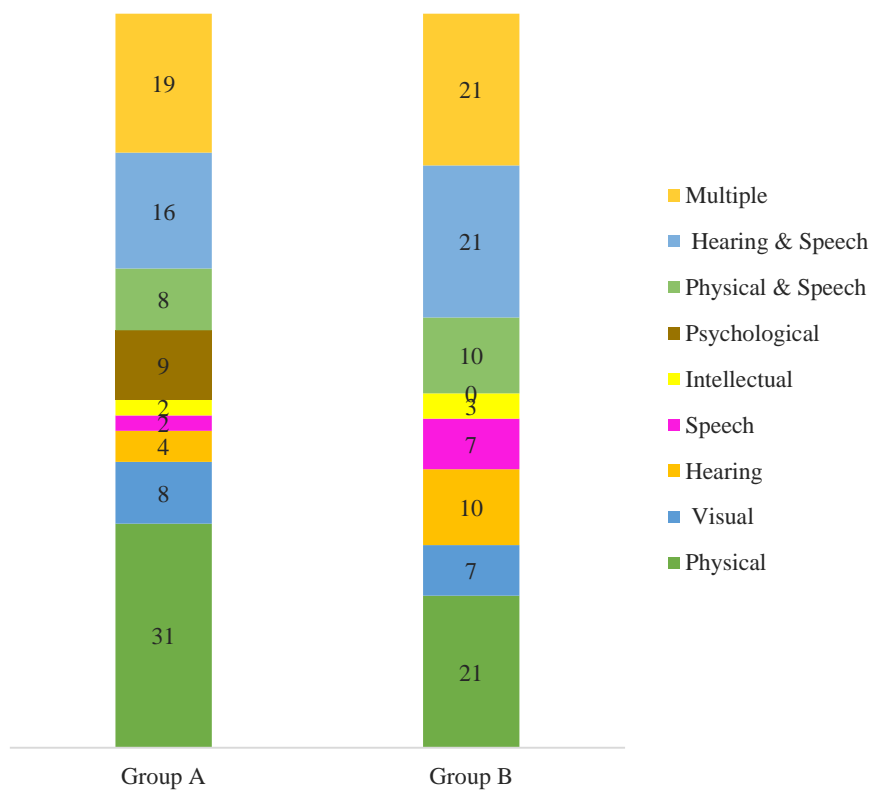


Figure A2: Differences in Composition of the “Severe” Category in Groups A and B



Case Study A1: Understanding the Strong Preference towards Cows

Participant perspective: Female caregivers prefer to engage in IGAs within the boundaries of the household. They believe that the easiest way to participate in IGA is by owning a cow, as it does not require going outside. While alternative enterprises like goats offer the same advantage, participants perceive cows as more lucrative and offering quick returns. Instead of opting for goats through the program, most households desire a visible and substantial enterprise, such as a cow, which can later facilitate the purchase of additional assets like goats. One caregiver, responsible for Ferdous, explained her choice of cow over other assets:

“Cow is a big asset. I chose cow because it will give a huge amount. Besides, I have previous experience of rearing cows. So, I selected cow.”

Since rearing cows can be conducted within the boundaries of the household, it is easier for other household members to participate in the asset's care on a regular basis or in the absence of the main caretaker, typically the caregiver. Many poor households have long aspired to raise livestock, including cows, but have been financially unable to do so. This program enables them to fulfil their wish of owning cows without incurring the purchase cost and initial investment. Eventually, they can sell the cows after a certain period and receive a lump-sum amount of money. This amount can be utilized for further investments in assets, major household expenses, and savings. Therefore, households believe that cows, compared to other assets, provide quick returns and contribute to the gradual accumulation of savings.

However, once the preference for cows is established, participants have the option to choose between bulls and heifers. Qualitative findings indicate that heifers are mainly favored by female household members (caregivers) to fulfil their personal interests. Another significant reason for selecting heifers is the advantage of milk consumption by household members. On the other hand, bulls are preferred for their potential to generate faster profits, allowing for re-investment in asset diversification. One caregiver, responsible for Shammi, expressed her choice:

“The BRAC [program staff] came to me and wanted to know my preference. First, I wanted to choose the asset which will benefit me the most. But then I requested them to give me a bull. When they asked the reason, I responded that bulls will grow faster, and we will be able to use it for our improvement.”

Another participant, the caregiver of Srayashi, shared her perspective:

“The program asked me to choose the type of cows. I chose bull because its value increases quickly, and it can be sold quickly if reared properly. On the other hand, a heifer gives birth to cows after rearing for several months. It takes time.”

However, one participant named Jiniya contradicted the preference for bulls and expressed a preference for heifers, explaining her reasoning as follows:

“I didn't choose bull because the heifer could give birth to another calf. Choosing a bull means purchasing another cow after selling it. Instead, heifer will breed and it will increase the asset without any buying or selling.”

Another caregiver, responsible for Asma, shared her experience:

“My mother-in-law had a wish to rear a heifer. She wanted to consume milk from the heifer. Besides, heifers can give birth to calves.”

Program perspective: During the selection process, the program emphasizes the ability and preferences of the beneficiaries. They also take into consideration the previous experience of the household, including the person with a disability, in dealing with assets. Specifically, the program assesses the caregiver’s capacity to nurture assets and engage in IGAs. The program analyzes which assets are suitable for the household in terms of future benefits and potential success. The selected beneficiaries are provided with options, and according to the data, most households chose cows. The program conducted an FGD in Mahiganj, Rangpur, to understand the factors influencing the preference for cows among households:

“They prefer cows because it’s easier for the households to take care of the households. It also gives faster benefits. More specifically, there is a tendency to prefer bulls among households. This is because it is possible to swiftly make a profit and benefit from bulls which can be sold within five to six months. On the other hand, a heifer can take up to a year to get earnings from it. Therefore, bulls give faster income compared to heifers. Although the asset may vary from household to household and across persons with disability, it is important to see which asset is more profitable for the household. What the households are getting is enough for them. We have been advised by the upper authority that we can supply assets such as a van and sewing machine if required by the person with disabilities. But we are providing what the household is choosing.”

The program also discussed the significance and suitability of cows in poor rural households with individuals with disabilities. The following reflects the discussions held during an FGD with program staff in Kishoreganj:

“Cows can be raised at home and needs less effort if they are rearing other livestock as well. Looking after a cow is comparatively easier as anyone in the household including a person with disabilities can take care of it based on their ability. It does not require activities outside the home. It can be bathed easily like through a pipe, and it can be fed very cheap available food such as grass, scrapes of vegetables, and hay. If someone chooses other enterprises, for instance, the non-farming option, like a shop, it requires time to sit at the shop all day. By being a shopkeeper, they can earn a little money, like about BDT 50–100 per day. On the other hand, a cow is more profitable and easier to rear. For example, bulls can be sold within a few months at a high price as it has high market demand. Also, some people love to raise as their passion or hobby.”

Case Study A2: Saleha's Journey through DIUPG

Saleha, a fifty-year-old housewife, resides in Kishoreganj and has faced significant hardships in her life. Being deprived of the opportunity for education, she was married off at the tender age of 13. Coming from a financially disadvantaged background, she struggled alongside her husband and their three children: two daughters and a son. To cover the expenses of her husband's prolonged illness, they had to sell their land, which sustained them for some time. Tragically, her husband passed away from a stroke four years ago, leaving the homestead as the only asset.

Prior to the intervention, the household's financial condition was extremely vulnerable, placing them in a precarious situation. Saleha's eldest daughter is married off, while her second child (aged 20) works at a sweet shop, earning a daily wage of BDT 200. The youngest child, aged 12, had to discontinue her schooling because her mother was unable to bear the burden of school fees. Instead, she attended a *madrrasah* where education was free of cost. To contribute to the family's income, Saleha used to make hand-bearing fans from palm leaves at home, earning BDT 150 for every hundred fans. On average, the family's monthly income amounted to approximately BDT 6,000, while their expenses ranged from BDT 3,000 to BDT 4,000.

Saleha has been grappling with hearing difficulty since her puberty period. According to her neighbor's description, one day Saleha's husband hit her ear in a fit of anger during the early stage of their marriage. As a consequence, she experienced intense pain in her head and ears. Although the headaches eventually subsided with the aid of medication, her hearing capability gradually deteriorated.

Following her husband's decease, their close relatives provided some support; however, Saleha and her family continued to face persistent poverty and hunger. In 2021, Saleha was fortunate to be selected for the intervention by BRAC's DIUPG program. She underwent a rigorous selection process, which included PRA procedures, a household survey, the Washington Questionnaire, and approval from the regional manager. The regional manager carefully evaluated the household to ensure it met the selection criteria.

After being selected, Saleha underwent IRA to confirm her hearing disability and PSA to identify and address her psychological problems through a care plan. Once her disability and psychological issues were confirmed, the program initiated the enterprise selection process for her. Saleha's daughter was assigned as the caregiver based on her capacity to manage the assets and provide care for Saleha as a person with a disability. This assessment ensured that the caregiver could effectively support and nurture the enterprises.

Based on the IRA and PSA, the PO assisted Saleha in selecting an enterprise that would be suitable for her disability condition. The selection process followed a step-by-step procedure, which involved Saleha providing input on the different enterprise options, including information on groups, instalments, matched savings, and the advantages and disadvantages of each enterprise. Saleha expressed a preference for a bull as the main enterprise. The PO, along with the branch manager, rehabilitation officer, and psychosocial officer, discussed the suitable enterprise based on Saleha's disability and preference. They considered Saleha's previous experience with the specific asset, her capabilities to develop enterprises, the local market conditions, and the opinions of her neighbors and well-wishers. Taking all these factors into account, the decision was made to select a bull as the main enterprise for her household, with hens chosen as the secondary enterprise.

After the enterprise selection, both Saleha and her caregiver received training, and the enterprises were handed over to them accordingly. The PO conducted regular and fortnightly home and group visits to provide continuous support and guidance. Additionally, the rehabilitation officer and the psychosocial officer made regular visits to provide health support based on the care plan.

Providing rehabilitation support to Saleha presented several challenges that the rehabilitation officer had to overcome. One of the main obstacles was the limited time available to efficiently engage with Saleha. Additionally, her financial constraints, concerns for her safety, and lack of trust initially made her hesitant to pursue referral treatment. To overcome these barriers, the rehabilitation officer had to persistently persuade Saleha and work on building trust by highlighting the benefits of using a hearing aid and addressing the social stigma associated with her hearing difficulties. Eventually, Saleha and her caregiver agreed to visit the doctor as referred.

The rehabilitation officer took proactive measures to facilitate referrals and establish linkages for Saleha, ensuring comprehensive and supportive care. They coordinated with the Emergency Nurse Practitioner (ENP) department at Sadar Hospital to arrange a hearing test for Saleha. The test revealed hearing difficulties in both ears, with the left ear being more affected. Based on the results, the doctor recommended a suitable hearing aid for her. The rehabilitation officer assisted Saleha in consulting with the doctor and acquiring the hearing aid, creating a reliable connection between Saleha, the hospital, and the doctor. Presently, Saleha uses the hearing aid as needed to communicate with others, both within and outside her household. In addition to the hearing aid, other rehabilitation measures were implemented to support Saleha. Sufficient lighting was arranged near the tube-well and toilet areas to help her navigate safely during nighttime. Since receiving the intervention, Saleha's confidence has significantly increased as she can actively listen to others and express her opinions. Previously, she relied on others to interpret conversations and actions on her behalf. Saleha also reports that using the hearing aid has improved her mental well-being, enabling her to participate more fully in daily activities. However, a post-intervention challenge she faces is discomfort while wearing the hearing aid during work, primarily due to its weight and overall nature.

Saleha's hearing disability had a profound impact on her social withdrawal, leading to feelings of isolation. Recognizing these challenges, the psychosocial officer developed a comprehensive care plan based on the psychosocial assessment, considering Saleha's limited involvement in societal activities. The plan included regular use of the hearing device, individual counselling sessions, caregiver counselling, and raising awareness among neighbours. Through these personalized care plans, Saleha gained the ability to make informed decisions and developed self-confidence to communicate with her neighbors on various issues. As a result, her neighbors now value and listen to her. This change in perception can be attributed to the continuous visits by program staff and the awareness-building efforts of the psychosocial officer. However, it is important to note that there was a shortage of psychosocial officers in the Kishoreganj branch for a period of eight months, which resulted in certain gaps in the provision of mental health care, including the absence of community mobilization specific to Saleha's case. Despite this challenge, the psychological support that Saleha did receive played a crucial role in improving her performance, enhancing her decision-making abilities, and overall promoting her mental well-being.

In addition to the positive impact on Saleha's mental well-being, the DIUPG program has brought about visible improvements in her household's overall condition through the livelihood intervention. Since joining the program, Saleha and her caregiver have gained

knowledge and skills in raising hens and cows, which were provided by the program as part of the livelihood intervention. They now work together to take care of the cows and hens. Saleha has successfully sold her bull twice and used the funds to lease land for vegetable cultivation. While they primarily consume their own produce, they also earn additional income by selling the surplus to their neighbors. Saleha has also developed a habit of saving her earnings, which has financially empowered her and enabled her to meet immediate needs without relying on loans. She has been able to save money in her BRAC account, and her improved financial situation has gained her the trust of her neighbors, who no longer hesitate to lend her money. Additionally, Saleha now receives a widow allowance and has diversified her assets. Overall, the two years of support from the DIUPG program have significantly improved Saleha's household's financial situation and brought a sense of joy and confidence in their progress. While they may still not receive frequent invitations to social events and may not attend such events regularly, it is worth noting that the community around them appreciates their involvement in the DIUPG program and their recent achievements more than ever before.

During the livelihood intervention, the POs encountered various challenges. Firstly, Saleha's son lived separately due to work commitments, and initially, her daughter was not engaged with the program. This posed difficulties in establishing regular communication and coordination with the entire household. Secondly, at the beginning of the program, Saleha displayed a lack of interest and respect towards the program staff. However, over time, as the household received consistent support, a remarkable transformation took place, and Saleha now greets the program officers with a warm and genuine smile on her face. This positive shift in attitude serves as evidence of the program's impact and the efforts made by the organizers.

In conclusion, Saleha expresses deep gratitude and satisfaction with the assistance and support she has received from the program. She does not have any additional expectations from DIUPG and intends to utilize the profits from her assets to repair her living house and arrange her daughter's marriage in the near future.



BIGD is a social science research and post-graduate teaching institute of Brac University.

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