LEAVE NO ONE BEHIND!
Exploring the healthcare-seeking behavior of floating population/street dwellers in Dhaka city, Bangladesh: a pilot study

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How we defined our study population

Our study population is: People who are living in the streets, entry points to Dhaka city (e.g., rail station, launch terminal and bus station), hat-bazar, Mazar (religious shrine), stair cases of public/government buildings, and other open spaces of Dhaka city for at least a month. Internal migrants coming from other parts of the country first become part of floating population, moving here and there for a place to earn and sleep until they find a shelter, and settle to become street-dwellers. Even after a month, they may change places and become floating again until find a place of choice. Thus, ‘floating population’ and ‘street dwellers’- these two terms are used interchangeably in this report.
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Acronyms
CoE-HS&UHC  Center of Excellence for Health Systems and Universal Health Coverage
DMCH  Dhaka Medical College and Hospital
HSB  Health Seeking Behavior
ICSOs  International Civil Society Organizations
IDI  In-depth Interviews
JPGSPH  James P Grant School of Public Health
KII  Key Informant Interviews
LMIC  Low and middle-income countries
MDG  Millennium Development Goal
NGO  Non-governmental Organization
OTC  Over-the-counter drug
PPP  Public-Private Partnership
PSTC  Population Services and Training Center
SDG  Sustainable Development Goals
SRH  Sexual and Reproductive Health
SSMCH  Sir Salimullah Medical College and Mitford Hospital
STD  Sexually Transmitted Disease
UHC  Universal Health Coverage
UN  United Nations
UPHC  Urban Primary Health Centre
Executive Summary

Background
Due to rapid urbanization, thousands of people come to Dhaka city every day and land on its streets to start with. These floating people/street dwellers are being deprived of basic human rights including rights to healthcare. This study aimed to explore the illness experiences of these floating population/street dwellers and their health-seeking behavior including experiences of interaction with formal health systems, and identify the gaps in policy and practices from the perspective of ‘Leave No One Behind’.

Methodology
This qualitative study, conducted during Jan. - May 2019, followed purposive sampling method followed by snowball sampling technique and comprised of 15 in-depth interviews (IDIs) and six informal group discussions with the floating population/street dwellers, six key informant interviews (KIIIs) with the health service providers and three with policymakers. We included young adult males (18-35 years), women of reproductive age (18-49 years), adult males (36-59 years) and elderly males and females (≥60 years). We collected information from the floating population/street dwellers in three purposively selected areas of Dhaka city having a high concentration of the target population: High Court Mazar, Sadarghat launch terminal and Kamlapur railway station. Besides, we interviewed relevant health care providers and policymakers (Government officials) to elicit their perspectives. Data were collected through face to face interviews using IDI and KII guidelines and data analysis was performed using ATLAS.ti version 8.0.

Results

Socio-demographic characteristics
Our study participants were between 18 and 75 years of age, majority were Muslim (95%), male (55%), and landless (95%). Of the female respondents (n=18), half were (50%) either separated or widowed. Majority of them (65%) did not attend any school and 37.5% were beggar. The respondents came to Dhaka from different districts of Bangladesh. Their average duration of living in the streets varied widely, e.g., two to 35 years, however, one woman (53 years old) was living in the street since her birth.
Live and livelihood: social determinants of health

Our study respondents did not have any fixed place for living as they can be evicted by police at any time. They usually take shower in the open place and use toilets at nearby areas. They used to take food from the Mazar or, sometimes, buy from the cheap roadside makeshift food outlets. Most of them are unable to maintain regular hygiene practices like using soap, brushing teeth, and taking shower regularly etc. Rarely, they cooked by themselves.

Majority (87.5%) of the participants mentioned that they used to spend almost all of their daily income on buying food. They usually earn from different activities such as begging, assisting in the marriage, sewage worker, van driver, day labour etc. But, this can’t be taken as granted daily. So, sometimes they have to spend money saved from earlier income to survive their day to day life. As a result, they ultimately end up with no saving at hand. Some people (12.5%) could save some money over a long time, but, ultimately the saved money gets into the thief’s pocket.

Respondent’s living arrangement, long duration staying on the road, food habit, pattern of taking food, nature of occupation and WASH practice have a great influence over their health. For example, people who were rushing and taking shower irregularly ran the risk of skin diseases and people who used to carry heavy weight or, driving van for prolonged period, used to have the problem of back pain. Fever, cold, flu etc. are the common health condition due to their living arrangement on the road.

Respondents faced challenges while sleeping at night, as police did not allow them to sleep in open spaces and likes, and theft of belongings used to be a very common scenario for these people. Life of floating/street-dwelling women was more vulnerable than the males in terms of safety and security issues. Females were physically abused by local people and sometimes by the police as well.

Health care-seeking behavior and healthcare services

Among male respondents, fever and respiratory illness (59.09%) and injury (54.5%) were more prevalent than other illnesses, and among female respondents, 77.7% suffered from fever and respiratory illness and reproductive-aged women, 80% were suffering from different reproductive age illness.
Most of the respondents (95%) did not visit the health facilities/hospital for common illnesses like fever, cold, cough etc. Most of them (82.5%) favoured going to nearby drug shops for seeking any treatment they want. Interestingly, the majority (72.5%) of the respondents did not seek treatment in Government Medical College Hospitals unless they suffer from serious illness such as injury or severe gastric pains or they perceive the illness as serious. They mentioned a range of causes for not seeking health care e.g., financial inability, absence of identity card, long hospital queues etc.

Most of the respondents mentioned that they need affordable health care including low diagnostic charges in terms of dealing with their illness. At the same time, they suggested starting mobile health care services for people like them so that they can get the services easily when they need it.

**Service Providers’ perspectives (from KIIIs)**

Interviews were conducted with the health service providers of Government, and Non-Government Organizations (NGOs). Practitioners from public health facilities revealed that they do not provide any health services targeting these populations specifically, however, anyone can receive any available services from public health facilities. On the other hand, providers from NGOs pointed out that there are some small-scale projects and programmes targeting the floating people/ street dwellers available in Dhaka city.

**Policymakers’ perspectives (from KIIIs)**

We also conducted the key informant interviews with high government officials for getting policy perspectives. They proposed to develop specific policies, especially health policy including free health care services for these people, and also, nutrition policy for providing adequate nutrition. They opined that in this way, the floating population/ street dwellers can access free treatment from any formal health facilities, and through proper nutrition the illness prevalence will be reduced. For this, programmes need to be implemented to take health care services near to them, based on their needs and priorities. They also suggested to implement relevant health programmes in a coordinated manner by both the government and non-government organizations for this group of destitute population.
Conclusion
The floating population/street dwellers are mostly lacking basic livelihood amenities, including access to health care services. Whatever services are available from the public and NGO sectors (free or subsidized), are not being utilized due to lack of awareness, lack of spare money to expend on health care, and mixed experiences of the health facilities and providers. This is a pilot study and is not representative of the whole floating population/street dwellers of Dhaka city, however, given the inclusion of different population groups to identify their particular problems, we hope that findings will help policy makers and practitioners to develop and design relevant policies and programmes, integrated in the mainstream health systems in the spirit of universal health coverage.

Recommendations
Based on our study findings, we suggest a few recommendations to improve the current conditions. These are grouped under service provision, programme, community and health system and policy.

A) Service provision

Mobile clinic: As the study findings reveal that despite provision of low cost services, especially at the public facilities visit by floating population/street dwellers are rare due to various issues e.g. lack of awareness, opportunity cost, diagnostic cost, accessibility and acceptance. To address these, mobile clinics can be initiated through public-private partnership (PPP) model to make the services available for street-dwellers in time and place convenient for them and providing services as needed e.g. SRHR, family planning, disability, diarrhoeal/skin/respiratory diseases, drug/substance abuse/addiction etc.

Health card for priority access: As the study findings disclose that floating population/street dwellers usually do not have any formal identity, thus face challenges in terms of availing basic constitutional rights including health. Special cards can be introduced (e.g. as done for slum dwellers by UPHC) to ease priority access and minimize the cost, especially of diagnostic and medicines.
B) Programme

**Coordination of interventions to avoid duplication/ segregation of efforts:** To improve the overall health status of the floating population/street dwellers, coordination of interventions involving relevant stakeholders are needed. For this, agencies involved can form coordination committees, preferably based on locality they serve, and supported by higher authority.

**Provision for basic amenities:** As our study revealed that floating population/street dwellers are struggling with problems of safety and security and basic amenities. They do not have safe place to sleep, have no privacy, always at risk of theft of belongings and money, have to take unhygienic food from roadside makeshift food shops, and do not have access to safe water and sanitation. Hence, some interventions such as ‘Night Shelters’; ‘Day Care Centre’; ‘Locker Services’; ‘Low cost hygienic food shops’; ‘Free toilet/Wash Facility’ etc. can be organized, by for example, the NGOs in their living areas in cooperation with relevant ministries of the government.

C) **Inform about available services:** Our study revealed that most of the floating population/street dwellers are not aware of the existing low-cost services provided by public and private sectors including NGOs. This information gap needs to be addressed through coordinated awareness campaigns including motivation for use of these services to the maximum. NGOs can take this initiative as well.

D) **Policy and health system**

**Map/census on floating population/street dwellers for informed policy and programme planning:** To improve the health status and overall living conditions of the floating population/street dwellers, a census is needed to identify the location and number of floating people living in Dhaka city (and other big cities with substantial proportion of these population). This will help to organize needed healthcare and other services (related to social determinants of health) in a coordinated manner by the public and non-state sectors, complementing and supplementing each other.

**Action/implementation research to assess scope of integrated interventions:** Implementation research on the floating populations/street dwellers are needed to find out the
best model for service provision for these populations including barriers and enablers that is accessible and acceptable to them, towards achieving UHC be 2030 as envisaged by the government, leaving no one behind.
Background
Sustainable Development Goals (SDG) aimed to ensure services for the people of all sphere of the society particularly marginalized and people who are left behind, especially in low and middle-income (LMIC) countries (United Nations, 2015). To achieve the SDG successfully, in the next 15 years, it is necessary to know the in depth scenario and taking necessary steps to address the need of the marginalized people or people who are left behind (Amnesty International, 2013).

Bangladesh has made remarkable progress in social and economic development in recent decades. The success of Bangladesh in achieving the health-related MDGs has been acclaimed globally (Government of Peoples Republic of Bangladesh, 2015). An estimated, 30 million marginalized people are still living in Bangladesh, and they are from different categories, cultural identities, religions, and ethnicities, however, they are still historically inclined to exclusion which makes them tremendously vulnerable (Manusher Jonno Foundation, 2016). Benefits of development are not equally distributed among these vulnerable or marginalized group of people, which is clearly visible from the existing limited data. Identifying the needs and priorities of the marginalized or vulnerable population for reforming and restructuring of the health system is a vital responsibility for a health system, failure of this responsibility leads to large coverage gaps, and the unhealthy disparities lead a fall in health system performance (Health Affairs, 2007).

The United Nations (UN) 2016 SDG report pointed that the data needed to identify and address marginalized/vulnerable groups and their needs is often unavailable (SDG goals report, 2016). Twelve of the largest International Civil Society Organizations (ICSOs) sharing a common platform for a unique knowledge base, and having exceptional outreach and experiences in reaching out to the most marginalized communities worldwide, came up with a multi-year project “Leave no one behind’ in 2017. The goal of this collaboration is to identify, support, and empower marginalised and vulnerable groups worldwide in the context of SDG implementation. In the first phase, the Bangladesh platform explored the scenario and data availability on marginalized population in the context of Bangladesh through a rapid review of the available literatures. In the second phase, the project aims to explore the deficits regarding health coverage
for street/floating population of Dhaka city and how to overcome these in the policy and practice for achieving an inclusive and ‘universal’ health coverage (SDG 3.8).

The growth of urban population in Bangladesh mainly arose through the migration of rural poor people (icddr, b, 2016). A total of 16,582 persons came into the urban slum areas of Dhaka and Gazipur city corporation areas in 2016, resulting 132.9 immigration rate (per 1000 population, 129.1 for male and 136.5 for female) (icddr, b 2017). The floating people are coming from the different parts of Bangladesh. Some of them got work to earn their livelihood and have shelter in the slum areas. However, some of them failed to ensure a shelter, even a place to sleep at night. They live on the streets in open space, without a cover over the head. They are deprived from the basic human rights such as education, health, shelter etc. Baseline Population Census revealed that, the majority (62%) of household heads of a slum migrated for having better work and income options (GoB, 2016). Beside urbanization, there are other factors like flooding, drought, river erosion, landslides etc. which displace people from their home and force them to migrate to big cities like Dhaka. They became floating people/street dwellers after coming to Dhaka due to lack of livelihood and shelter. A study on the displaced population revealed that, about 68% of the respondents live on the side of rail line, in the slum or in the government’s khash land after displacement (Shetu et al., 2016). Eighty-six percent of the displaced people were having some kind of diseases (Uddin et al., 2009). Morbidity among floating people is quiet high and diarrhoea, scabies, infective hepatitis are quiet common (Islam et al., 1995; Khanam et al., 2002, Uddin et al., 2009). Diarrhoea (16%), asthma (12%), heart disease (11%) were the dominant diseases (Shetu et al., 2016). Unfortunately, they are unable to avail the health care from health facilities for the disease conditions due to financial constraints. They are rushing to the health facilities near them, only, in emergency situations (Uddin et al., 2016). This scenario needs to be changed to include everyone in the bigger picture. To achieve this aim, it is important to explore their current health seeking behavior, type of health care provider and facilities they contact and gaps in existing health systems policy and practice to deliver needed services to the marginalized population groups. There is lack of in-depth data on their health care-seeking behaviour, the barriers for them to access services, the type of services needed and the responsiveness of service providers. This study, conducted by a research team from BRAC James P Grant School of public
Health (JPGSPH), BRAC University, aims to fill-in this knowledge gap and inform the policy makers and practitioners for designing necessary prioritized interventions.

The research has been commissioned by the Leave No One Behind (LNOB) coalition, and BRAC Advocacy for Social Change, Technology, and Partnership Strengthening Unit as the secretariat of the coalition lead the initiative.

**Objectives of the study**

**General**

This pilot qualitative study aims to explore the current scenario regarding illness profile and relevant health care-seeking behavior of the floating population/street dwellers in Dhaka city including available health care services for them, and identify gaps at the policy and programme levels towards achieving universal health coverage by 2030 as envisaged by the government.

**Specific**

1. To explore their illness profile and the remedial actions they seek.
2. To explore the types of health care providers they contact, facilities they visit to seek care and experiences of the services they receive.
3. To explore the responsiveness of the health system to cater the services for these population.
4. To explore possible ways to improve the current scenario at policy and programme levels.

**Methods**

**Conceptual framework**

The conceptual framework guiding this study is based on the literature review on the topic (Ahmed et al., 2011). It shows that there are different factors or reasons behind becoming floating population/street dwellers or becoming homeless. Being a floating people/street dweller, they face several challenges such as livelihood and security challenges, remaining physically fit to earn an income and social challenges (Figure 1).
Study design
Qualitative approach was used to explore illnesses of floating population/street dwellers of Dhaka City, relevant health seeking behavior, their experiences of interactions with health care service providers. This study also explored the health care provider’s perception/responsiveness
to cater services for this group of population and elicit perspectives of some key informants at policy and practice to improve the scenario.

**Study method**

To meet the study objectives, we conducted in-depth interviews with floating population/street dwellers, and Key Informant Interviews (KII) with relevant health care service providers and policy makers. At first, to explore the first and second objectives of the study, we conducted face to face in-depth interviews (IDIs) and informal group discussions with the floating population/street dwellers. After that, we conducted face to face KII with the relevant health care providers, and explored the responsiveness of the health system to cater the service for these population. Finally, to identify the possible ways to improve the scenario at policy and programme levels, we conducted face to face KII with the relevant policy level persons.

Overview of methods based on our study objectives are shown below (Table 1).

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Study methods employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obj.1: To explore their illness experiences and the actions they take</td>
<td>Informal group discussions and face to face IDIs with the floating population/street dwellers</td>
</tr>
<tr>
<td>Obj. 2: To explore the types of health care providers they contact, facilities they visit to seek care and services they receive</td>
<td>Informal group discussions and face to face IDIs with the floating population/street dwellers</td>
</tr>
<tr>
<td>Obj. 3: To explore the responsiveness of the health system to cater the service for these population</td>
<td>Face to face KII with the relevant health care service providers, who are providing service for the floating population/street dwellers</td>
</tr>
<tr>
<td>Obj. 4: To explore possible ways to improve the scenario at policy and programme level</td>
<td>Face to face KII with relevant policy makers</td>
</tr>
</tbody>
</table>

**Study duration**

The research project started on 10 January and ended on 30 May 2019. Field data collection continued from 17 January to 15 April 2019.
**Study setting**

This qualitative study collected information from the floating population/street dwellers in three purposively selected areas of Dhaka city having a high concentration of the target population. These three areas are identified in the map, Figure 2 (Swapan *et al.*, 2017). These areas were identified from a previous quantitative survey conducted by BRAC RED in 2011, where, they measured the concentration level of floating people in these areas and identified these areas with highest concentration of people in Dhaka city (Ahmed *et al*. 2011).

The study areas are as follows:

- Kamalapur rail station (one of the major entry points into the city)
- Sadarghat launch terminal (another major entry points into the city) and
- High Court Mazar premise (an area with a high concentration of floating population/street dwellers)
Study population

The study included adult (≥18 years old) floating population/street dwellers living in these three selected areas for more than one month, and the people who have no roof over their heads. Based on age categories, we divide the IDI participants in six different groups. We included young adult males (18-35 years), women of reproductive age (18-49 years), adult males (36-59 years), adult females (49-59 years) and elderly males and females (60 years onwards). We conducted 15 IDIs and 6 informal group discussion with the above mentioned categories of floating population/street dwellers. Participants of informal group discussions had the same characteristics as IDI respondents, however, in informal group discussions, we interviewed the
participants in a group and the groups were organized with more than four persons of same age and sex groups. Then, we conducted the KIIs with the government and non-government health care providers who provide services to the floating population/street dwellers in their health facilities. Finally, the KIIs were conducted with the relevant policy level persons in their offices and at their convenient time with prior appointment. Study population and sample size of this study is presented in Table 2.

Table 2: Study population and sample size included in this study

<table>
<thead>
<tr>
<th>Study population</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demand side</strong></td>
<td></td>
</tr>
<tr>
<td>Floating population/street dwellers</td>
<td>21 (15 IDIs, 6 Informal Group Discussions)</td>
</tr>
<tr>
<td><strong>Supply side</strong></td>
<td></td>
</tr>
<tr>
<td>Government Health Care Providers e.g. Medical Officers</td>
<td>3 (KII)</td>
</tr>
<tr>
<td>Non-Government Health Care Providers e.g. Medical Officer, Promoter, Manager</td>
<td>3 (KII)</td>
</tr>
<tr>
<td><strong>Policy level</strong></td>
<td></td>
</tr>
<tr>
<td>Policy makers e.g. Director (Primary Health Care, DGHS), Chief Health Officer &amp; Programme Manager, UPHC Services Delivery Project, Project Director (Additional Secretary), UPHC Services Delivery Project</td>
<td>3 (KII)</td>
</tr>
</tbody>
</table>

**Sampling strategy**

Study samples were selected through purposive sampling technique, followed by a snowball technique to identify and reach the most appropriate IDI respondents. Before starting the actual data collection, we had a quick visit to the selected study sites which provided us with an idea regarding the characteristics of street-dwelling populace and their lifestyles. This also aided the study team to determine the way for approaching subsequent study participants. The study team visited the identified areas from morning to evening to understand the respondent’s availability in their residing places and build rapport with the local people to understand the context. Based on the participant’s availability at her/his convenient time, we interviewed them. Even if they told us to visit them in another day/time, in that case, we visited them another day and conducted interviews accordingly. We selected our key informants purposively, who are working at
different Government facilities and entities and engaged with service design, provision and implementation.

**Tool development, pretesting, and training of data collectors**

As per study objectives, we developed guidelines for IDIs, informal group discussion, and KIIs. We also prepared an observation checklist to observe the health facilities and the study sites. Tools were made based on literature review and the research team’s previous experience of working with street dwellers (Ahmed *et al.*, 2011). The English version of the questionnaire was developed, which was then translated into Bangla version once we had expert review and comments or feedback from the principle investigator. IDI questionnaire included the following domain or themes to explore the information of the study participants:

- Domain 1: Socio-demographic characteristics
- Domain 2. Being a floating people/street dweller and reasons behind becoming floating population/street dwellers
- Domain 3: Living characteristics
- Domain 4: Livelihood characteristics
- Domain 5: Safety and security issues
- Domain 6.: Health-care seeking behavior
- Domain 7: Suggestion and recommendation

For reproductive-aged group women and elderly population, we asked a few additional relevant reproductive health-related questions as well. IDI tool was also followed during the informal group discussion.

In KII guideline, we mainly focused on the health service provision-related questions for the services providers (types of services, cost of services, types of patient visit, and available service hours) and for policymakers, we focused on the questions regarding the existing and upcoming policies pertinent to health issues for the floating people. Moreover, for both categories of KII participants, we included their opinion, suggestion, and recommendation regarding the improvement of the health system in the Bangladeshi context. All the tools are attached in Annex 1.
The Field Data Collectors were recruited based on their experiences in qualitative research and previous experience of working with the marginalized group. Following recruitment, they underwent three-day long training, which included study methodology, ethical issues, general principles of data collection, and specific training on the tools used in this study. The training was held on January 13-15, 2019. The filed pre-test was done on January 16, 2019. Tools were pre-tested in Mohakhali bus terminal and Nakhalpara rail gate areas to test the IDI guideline, whether any modification required before starting the data collection. This training was conducted by the core research team members (public health experts).

**Data collection process**

At the initial stage of data collection, the study team visited each area to understand the context of that area and trying to identify the timing of availability of the respondents and identify the gate keepers from local area, who are living in these areas for long time and help these floating population. For example, in Sadarghat area, we talked to the ‘Chacha/Mama’, who are helping these people in earning their livelihood with income generating activities such as cotton work, collecting garbage etc. In High Court Premise, we talked to the security guard and some street leaders who allowed these people to stay inside the High Court premise. In the Kamalapur railway station area, we talked to the elderly people of that area, who are really considered as the leaders of that area. The research team built rapport with these group from 3 study area and they helped to organize the informal discussion and in depth interview (IDI’s). It took around 2-3 days to build rapport with the gateman of each area and the study team had to stay full day including evening time in the study site to convince these people and the study respondents. Initially, we conducted the informal discussion in each area and then, we conducted IDI’s. During informal discussion, one researcher conducted the discussion and 2 data collectors had taken the discussion notes. Each informal group discussion consists of 4-5 people of same sex and pre-defined age group.

From each area, we conducted 5 IDIs and 2 informal group discussions. List of IDI and informal group discussion are showed in Table 3.
Table 3: List of IDIs and informal group discussions conducted in the three study sites

<table>
<thead>
<tr>
<th>Study Area</th>
<th>Types of Interview</th>
<th>Age Group and Sex</th>
<th>No. of Interview</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sadarghat Launch Terminal</strong></td>
<td>In-depth Interview (5)</td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reproductive Aged Woman (18-49 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elderly Male (≥60 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Informal Group Discussion (2)</td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reproductive Aged Woman (18-49 years)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>High Court Mazar</strong></td>
<td>In-depth Interview (5)</td>
<td>Elderly Female (≥60 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Young Adult Male (18-35 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elderly Male (≥60 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Informal Group Discussion (2)</td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reproductive Aged Woman (18-49 years)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Kamalapur Railway Station</strong></td>
<td>In-depth Interview (5)</td>
<td>Young Adult Male (18-35 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elderly Female (≥60 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Informal Group Discussion (2)</td>
<td>Elderly Female (≥60 years)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Male (36-59 years)</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

| Total                          |                    |                                                        | 21               | 40                  |

So, based on the availability of the respondents, we conducted IDIs with 9 male and 6 female respondents. Among the six informal group discussions, 3 were conducted with the male group and 3 were conducted with the female group, the total no of male and female participants were (5+4+4=13) and (4+4+4=12) respectively. The total number of respondents from IDI and informal group discussions from our selected study sites are presented in (Table 4).
Table 4: Total number of participants from the three study sites at a glance

<table>
<thead>
<tr>
<th>Type of interview</th>
<th>Male</th>
<th>Female</th>
<th>Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDIs (15)</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Informal group discussion (6)</td>
<td>13</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>18</strong></td>
<td><strong>40</strong></td>
</tr>
</tbody>
</table>

After that, we conducted the KIIIs with the relevant health care services providers and finally, with the potential policy level persons. List of service provider and policy makers are displayed in (Table 5).

Table 5: KII respondents included in this study

<table>
<thead>
<tr>
<th>Type of Respondent</th>
<th>Designation and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Providers (Government)</td>
<td>Medical Officer, Dhaka Medical College and Hospital (DMCH), Dhaka 1000</td>
</tr>
<tr>
<td></td>
<td>Medical Officer, Sir Salimullah Medical College and Mitford Hospital (SSMCH), Mitford Rd, Dhaka 1100</td>
</tr>
<tr>
<td></td>
<td>Medical Officer, Urban Primary Health Care Centre, Kamalapur, Dhaka-1217</td>
</tr>
<tr>
<td>Service Providers (Non-Government)</td>
<td>Medical Officer, RHSTEP Center, Hospital Outdoor, Sir Salimullah Medical College and Mitford Hospital (SSMCH), Mitford Rd, Dhaka 1100</td>
</tr>
<tr>
<td></td>
<td>Health Promoter, RHSTEP Center, Hospital Outdoor, Sir Salimullah Medical College and Mitford Hospital (SSMCH), Mitford Rd, Dhaka 1100</td>
</tr>
<tr>
<td></td>
<td>Manager, Amrao Manush Project, Sajeda Foundation, Babubazar Bridge, Old Dhaka 1100</td>
</tr>
<tr>
<td>Policy Makers (Government Officials)</td>
<td>Director (Primary Health Care), Director General of Health Services, Mohakhali, Dhaka -1212</td>
</tr>
<tr>
<td></td>
<td>Chief Health Officer &amp; Programme Manager, Urban Primary Health Care Services Delivery Project, Nagar Bhavan, Dhaka South City Corporation, Dhaka-1000, Bangladesh</td>
</tr>
</tbody>
</table>
All the IDIs were tape-recorded and interview-notes were taken. Researchers conducted the interviews and data collectors assist them by taking notes and recording observation. Some of the Key Informant’s, who were high level Government official did not allow the research team for voice recording.

Data analysis
Organized transcripts were made in Bangla by the field data collectors. Transcripts were randomly checked against audio recording to ensure quality of transcriptions. All transcripts were translated in English by two researchers. Several a priori codes were prepared during preparing the IDI guidelines, and inductive codes were developed during the repeated reading of the transcripts (Annex 2). Data familiarisation was done followed by charting of data in tables to produce a data matrix. The framework analysis used these matrixes to explore emerging patterns, identify themes, examine commonalities and contradictions in the data and also allow a comparison by case and category of participants. Data analysis was performed by using ATLAS.ti version 8.0. Content analysis was done for summarizing the key themes from the case studies assembled.

Data management and quality control
To maintain the quality of this pilot qualitative study, we developed the study protocol and strictly adhered to this in consensus. Data collection was done by the study team (researchers and field data collectors); field data collectors worked under the supervision of three researchers and each of the transcripts were checked thoroughly with the audio record by two researchers from the study team. Data were analyzed by the study team under the guidance of the Principal Investigator (PI). Thus, the entire process ensured the reliability and validity of the data collected for the study.
Ethical considerations

Ethical approval (2019-001-IR) for this study was obtained from the Ethical Review Committee (ERC) of BRAC James P Grant School of Public Health, BRAC University (Annex 3). All ethical principles, such as autonomy, and justice were strictly adhered to. Appropriate consent process was followed before collecting any research data. We took verbal consent from each IDI respondents and both verbal and written consent was obtained from KII respondents before conducting the interview and informed them that it might take around one hour.

Results
Socio-demographic characteristics of the respondents

We conducted IDIs and informal group discussion with 40 floating population/street dwellers, KII with six service providers and three policy makers. Age of the floating population/street dwellers was between 18 and 75 years of age, majority of them were muslim (95%), male (55%), and landless (95%). Among the female floating population/street dwellers (n=18), half were (50%) either separated or widowed. Majority of them (65%) did not attend any school and 37.5% were beggar. Socio-demographic characteristics of the floating people is displayed in (Table 6). The respondents came to Dhaka from different districts of Bangladesh e.g. Pabna, Mymensingh, Comilla, Netrokona, Tangail, Bholo, Barisal Rajshahi, Rangpur, Chapainawabganj, Brahmanbaria, Shariatpur, Patuakhali, Munshiganj, Faridpur, Kushtia, Jhenaidah, Noakhali and Pirojpur., their average duration of living in the streets varied widely, e.g., two to 35 years, however, one woman (53 years old) is living in the street since her birth.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22 (55%)</td>
</tr>
<tr>
<td>Female</td>
<td>18 (45%)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>38 (95%)</td>
</tr>
<tr>
<td>Hindu</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td>Converted (Hindu to Muslim)</td>
<td>1 (2.5%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>15 (37.5%)</td>
</tr>
<tr>
<td>Single</td>
<td>15 (37.5%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>7 (17.5%)</td>
</tr>
<tr>
<td>Separated</td>
<td>3 (7.5%)</td>
</tr>
</tbody>
</table>
**Education**

No Formal Education 26 (65%)
Below Primary 8 (20%)
Primary Education completed 5 (12.5%)
Secondary Education and above 1 (2.5%)

**Occupation**

Begging 15 (37.5%)
Day labour# 11 (27.5%)
Collects and sell broken products 3 (7.5%)
Newspaper hawker 3 (7.5%)
Work at shop## 5 (12.5%)
Domestic helper 2 (5%)
Small business (Oil) 1 (2.5%)

#Day labour= Van driver, rickshaw puller, cobbler, coolie, assist on wedding programme, shifting furniture during home change); ## Work at shop = Tailoring, helper of a tea stall (male); and four females worked as commercial sex workers.

**Becoming floating population/street dwellers**

Most of the respondents from the interview and informal discussion were from the lower socio-economic class of the society and most of them were landless and homeless. They are dwelling at different places of the road ranges from side of the road, footpath, launch terminal platform, mazar premises, mosque premises and railway stations. In reality, most of the respondents we interviewed were not living on the road from their earlier life. They started living on the road due to many reasons including family problems, political harassments, death of parents, tortured by stepmothers or husband, or in quest of better livelihood.

**Conflict with family members**

Most of the respondents mentioned family conflicts arising from behavior of step mother, conflicts with family members over property or marriage related issues.

Some illustrative quotes:

‘‘I came here because I was getting angry with my family members at home, so I left home…. I used to spend time with my area’s brothers, we used to live together, sometimes we did have some quarrels, once there was a big argument with them, and I left home’’. [Adult male, age 30 yrs, Sadarghat launch terminal]

An adult woman 50 years old, living in Kamalapur railway station mentioned-
“My cousin... he got married when he was under-aged, and grabbed everything (property) forcefully.” [Adult female, age 50 yrs, Kamalapur railway station]

**Poor income of parents/guardians**

Some of the respondents mentioned that their parents or guardians did not have enough money to run the family. Eventually, they had to come to Dhaka and started living and earning as well. An adult male residing in Kamalapur railway station said –

‘‘When my father was alive, he used to pull a rickshaw, and he could not give us food, could not maintain the family, so, 35 years ago, he sent me to Dhaka for earning and I have started working as coolie.’’ [Adult male, age 48 yrs, Kamalapur rail station]

**Torture of stepmother /husband**

Some of our respondents expressed that they had to leave their home due to the torture of stepmothers or husband. Sometime they even torture them physically and that was difficult for them to tolerate. They felt they cannot survive the way they were living. As a result, they had to choose this uncertain floating/street life. An elderly male, currently dwelling in the High Court Mazar area explained his loss of properties during river erosion and he had to come to Dhaka for his livelihood-

“Actually, I was doing nothing in Bikrampur, my home district. I had my parental property there, which was lost during the river erosion.... Then, I had to come to Dhaka to look for an earning source.” [Elderly male, 70 yrs, High court mazar area]

**Lost from school**

A reproductive-aged woman from Sadarghat launch terminal described her miserable life story during an informal group discussion, and explained that how she lost from school and could not go back to home. She expressed-
“Actually, my home district is in Barisal. I am living and sleeping in one shop at Sdarghat market. I am doing embroidery work/tailoring here. Sometimes, collect the wastage and sold in the market. Actually, I was studying in school, lost from my home in my childhood, and came here with one of my uncle (trafficking case).” [Reproductive aged woman, 18 yrs, Sadarghat launch terminal]

Political reason
Few of our study participants mentioned that due to some political reasons they had to leave their village and which is the reason behind their stay at the roadside in Dhaka city. One of the male respondents uttered-

“For actually, we used to support a political party and worked for BNP. Many people like us who used to do BNP, they flew from their village, because, the leaders of another party is not allowing them to live in the village.” [Adult male, 36 yrs, High Court Mazar area]

Social determinants of health
When the respondents decided to come to Dhaka and started to live on the road, it imposed a greater level of uncertainty in their life as they are living here without any friend, family and identity. Most of them were not confirm about their source of food, income, treatment facility, emotional support and other basic amenities. These conditions make them vulnerable from the beginning of their life in Dhaka, which ultimately, affect their mental health condition from the beginning of their life in Dhaka as floating population/street dwellers.

Live and livelihood
Respondents mentioned once they came to Dhaka, they started living on the road with uncertainty and living a difficult and challenging life. Most of the respondents perceived this life as unproductive and shameful life as they are living in the open place and have to suffer for seasonality, VIP movement and other issues. This uncertainty of living making them physically and emotionally vulnerable and leave them abandon. One respondent mentioned with regret-
“I would not call this life- this life and a dog’s life is similar, whatever you think. People used to beat dogs and they move here and there. We are doing the same.” [Women of reproductive age, 24yrs, High Court Mazar]

Most of the respondents perceived living on the road is the main issue behind all the health and livelihood problems and they thought their problems will be solved if good accommodation can be arranged for them. One respondents mentioned-

“I am living with my family, sometimes, we (husband and wife) are unable to mix (Intercourse) with each other as we are staying on the road among people.” [Young adult male, 32 yrs old, Sadarghat]

**Living arrangements**

Actually, they did have any definite place to live and sleep. Most of the time, they preferred to live and sleep near their earning sources. For example, most of our study respondents are living either in Kamlapur, sadarghat or, high court mazar for their earning. During day time, they used to move from one place to another place in the same area based on their need.

Their living arrangements made them vulnerable and prone to diseases like cold, cough, fever etc. Most of the study respondents mentioned that they are living in the open space including banyan tree, open field, platform of railway station etc. In extreme weather conditions, they tried to move in a shredded place, but, if they did not found they had to stay at open place with their family. Ultimately, they had to stay outside in extreme weather and they were ended up being ill. One respondent mentioned with a deep breath-

“We used to sleep under the banyan tree here every day since independence of the country. ” [Female, age 60 yrs, High court mazar premises]

However, some respondents expressed that they do not have any place to go even during the rain.
“I sit down here during rain…. If I lie down, water will fall on my body, so I sit down when it raining.” [Adult Male 48 yrs, Kamalapur]

**Water**

Most of the respondents took water from the nearby areas of their living. In our study, respondents from the high court mazar premises took and used water from the mazar and mosque. Respondents from Kamalapur area used to take water from the supply water of the station and respondents from the Sadarghat area were taking water from the launch or, the river. Most of the respondents used to use and drink water directly without any water purification system. This habit of using water made them prone to water borne diseases. Some people were also drinking water during taking rice only. One respondents mentioned-

“I only drink water whenever I eat rice from the nearby hotel.” [Adult male, 48 yrs, Kamalapur]

**Sanitation**

The respondents used to go to the toilets in the mosque or, mazar or, Ramna park or, in the launch based on the distance from their living area. In some of the areas, they had to pay for using the toilet. Most of the respondents tried to identify a toilet, which they can use without paying money. Some people discharged during taking shower in the river to save the cost of toilet. In some areas, there were some NGO centers who gave access only to females to use the toilet without paying. Because, with their little income, using toilet each time paying money is quiet expensive for them. Irregular toilet use might cause different diseases related to urinary tract. One of the female respondents from Sadarghat mentioned-

“I have to pay 5 BDT each day for using the toilet and we have a center here, who allow us (females) for using toilet during day time.” [Women of reproductive age, 20yrs old, Sadarghat]
**Personal hygiene**

Respondents mentioned that they rarely can maintain their personal hygiene. They could not maintain cleanliness of their body and clothing to preserve overall health and well-being. Most of them (87.5%) mentioned that they could not buy soap to keep them clean due to lack of money. Only a few respondents said that sometimes they used soap. A male respondent said-

> “Sometimes I do use soap, it takes BDT 10 to buy a soap...”  [Adult male, 48 yrs, Kamalapur railway station]

**Brushing teeth**

Brushing was quiet irregular due to cost and few of them (17.5%) mentioned that they brush their teeth, however they did it irregularly using charcoal, ash, tree bark and one of them use toothpaste, which was provided by an NGO. Rest of the respondents did clean their teeth only using water. One respondents mentioned -

> “I clean my teeth with charcoal after 4/5 day... I do not have money to but toothpaste.”

[Adult male, 55yrs, Sadarghat launch terminal]

**Taking shower**

Most of the respondents used to take shower in their nearby area of living. In some toilets, they had to pay money for taking shower and without money they were not allowed to take shower. So, taking shower was a quiet irregular practice for them. Their bathing was quiet irregular due to cost and insufficient number of toilets for them. One respondent mentioned with regret-

> “If I want to take shower in the public toilet, it needs 15-20 BDT.”  [Young adult male, 21yrs, High Court Mazar Premise]

Another respondent mentioned with sadness-
“I take shower once in each 10-12 days. I brush my teeth once in each 10-12 days with my finger using ash, came from the mud burner.” [Women of reproductive age, 24yrs, Sadarghat]

**Food, nutrition and nutritional status**

The food habit, pattern of taking food and nutritional status depended on their living area and amount they earned for their livelihood. The study revealed differences in the pattern of taking food and food habit in three different areas. The common finding was, most of the respondents’ food habit and pattern depended on their income. If they earned a good amount, they could spend a good amount in their food and lack of earning was causing starvation and they ended up having no food sometimes. But, spending good amount of money was not ensuring nutritious food for them. As most of them do not have the proper knowledge of nutritive food. Most of the respondents were not cooking for themselves, they were taking rice two times a day either with dal or, without any curry. They used to collect their food from different areas including mazar, mosque, launch etc. They had only 2-3 plates with them, which they used for keeping their collected food. As a result, nutritional status of these group of population remained poor most of the time. One respondent from Sdarghat mentioned-

“I have to beg for feeding my kids every time. Apart from this, I do not have any other income source.” [Reproductive-aged woman, 25 yrs, Sadarghat launch terminal]

Another respondent from High Court Mazar premises mentioned with regret that-

“I need 300-400 BDT for my food every day. If we can manage the amount after struggling, we can eat better, otherwise, we have to spend the day without eating.”

[Pregnant female, age 29 yrs]

In terms of food habit, most of the respondents who lived in the mazar premises, used to take ‘khichuri’ as lunch from the mazar and ‘khichuri’ as dinner from ‘Shamrat’s (a political leader) place, near the mazar area. Most of the respondents from the High Court Mzar area were not habituated with the breakfast. In Kamlapur area, most of the respondents used to beg for
collecting their food and eat rice once a day and eat bread at breakfast and dinner. In Sadarghat area, respondents bought paratha, dal, tea in the morning and rice, curry at night and collect free food from the launch in the afternoon. One respondent mentioned-

“If I eat rice here with BDT 40, for 3 times a day, then need to spend BDT 120 per day on food. So, I eat bread during breakfast and dinner and I eat rice during lunch to save my cost.” [Elderly male, 70 yrs, Kamalapur rail station]

The abovementioned findings indicate that most of the time they used to eat either ‘khichuri’ or, bread or, plain rice. Most of them used to take food two times a day, rather, 3 times and did not take any animal protein like egg, chicken and vegetables, which are source of vitamin. So, it ultimately, affected their nutritional status.

**Clothing**

Most of the study respondents had maximum two sets of clothes, which they used alternatively. Some of the respondents had also one set of cloth to wear and they used to wear that every day. Wearing same cloth every day without washing might causes them skin diseases. Some of the respondents who had one set of extra cloth, they had experience of losing their clothes as they kept it at insecure place. One women of reproductive age mentioned with regret-

“Thief took our belongings and send it to the old cloth market and we have to buy again.” [Women of reproductive age, 24 yrs, High Court Mazar premise]

Respondents also mentioned that they had to suffer for clothes during rainy and winter season and it might cause health issues like fever, cold, flu etc. One respondent mentioned-

“We have to wet in rain and we feel colder during winter season due to lack of clothes.” [Adult male, 48 yrs, Kamalapur rail station]
**Income-earning activities**

Most of the study respondents were engaged in marginal income-earning activities including begging, floating/street vending, remnants and edible picking from the dustbin, prostitution etc. Most common occupations were assisting in the marriage, sewage work, van driving, day laborer etc. But, this could not be taken as granted daily. Some of them had to look for new means of livelihood every day. As a result, they had to spend their little saving in their food and nothing left for meeting the emergency health or, need. They were unable to avail any permanent or, fixed job due to absence of identity card or, birth certificate with them. An adult male described his source of income and working duration, as he illuminated-

“*I do work (a cobbler) here from 6:00 am to 10:00 am, then I take my bath, after that, I take my lunch and again I start working from 1:00 pm and work until 10:00 pm. Almost every day I work here from 10am to 10pm, till the earning is not satisfactory and it is very difficult for me to run my family.*” [Adult male, 48yrs, Kamalapur rail station]

A young adult male dwelling at High court mazar area said-

“*In terms of my work, we have some people called ‘sardar’ (leader) who used to give us work. We have to pay some money from our income later on. They used to take us for certain types of work and send us to that particular place. But, it is not possible to have such types of task every day. Previously, we have these types of work almost every day. But, now, we have scarcity of work.*” [Young adult male, 21 yrs, High Court Mazar premise]

**Income, expenditure and savings**

The daily income of the study respondents was varied as per their occupation and nature of their occupation. Their average income per day ranged from 150 to 400 BDT, depending on their occupation. But, they mentioned with regret that everyday living was uncertain for them as their source of income was not permanent and no one was willing to give them permanent job due to lack of their identity. So, if they did not found any work, they ended up being bagger on the road, which was posing a mental pressure and make them traumatized sometimes. On the other hand,
most of the time they had to spend almost all of their daily income for buying food, when they did not get any work. As a result, they ultimately ended up with no saving at hand and unable to seek health care when needed due to lack of money. Some people could save some money over a long time effort, but, ultimately the saved money became theft and gets into the thief’s pocket. One of them expressed that more vividly-

“We do not have any fixed income. Currently, the work we are doing, we cannot even eat properly, when we do not have the proper earning, how we can save money.” [Adult male, age 45 yrs, High Court Mazar Area]

Another elderly male said-

“I need to borrow money for treatment sometimes…. Suppose, if I visit a doctor during my begging time, then I cannot earn. Once I went to the doctor for four consecutive days and could not earn enough money.” [Elderly male, 70yrs, Kamalapur]

Substance abuse and floating population/street dwellers
The practice of taking drug was very frequent among floating population/street dwellers of three different study areas. But, the concentration is high in high court mazar premises compared to the other areas. Usually, these peoples took drugs to fulfill their various needs including recreation, recovering from illness, to chat with their friends, to awake themselves for work, to complete hazardous work for their livelihood etc. Most of the study respondents had smoking habits and they used to take very cheap quality of cigarette called ‘biri’ in the local language. Some of them took yaba, marijuana (gaza) and heroine as addictive substance. Most of them took drugs to freeze their physical, emotional pain, remove their depression and replace their need for food. Taking these drugs regularly was increasing the chance of developing different health problems (cardio vascular disease, chronic obstructive pulmonary disorder, diabetes, hypertension etc.) and may lead to violence and exploitation. A male respondent aged 20 years mentioned in informal discussion in Sadarghat:
“I spend BDT 100 to buy Gaza, spend BDT 150 for three times food and also drink tea-water; the people I stay with sometimes offer cigarette -tea, then I take that too.” [Male, 20 years, Sadarghat launch terminal]

One young adult male, aged 21 years from High Court mazar premises said-

“Sometimes, for doing sewage works, I have to take marijuana or, yaba. Otherwise, I would not able to continue this work for my survival.” [Male, 21 years, High court mazar Premises]

Security issues (physical, social, economic, emotional)
Most of the study respondents were detached from family and they did not have any relatives with them who could help and protect them from insecurity. At the same time, living in the open space and uncertainty in getting work for survival were another big challenge, which made them economically and emotionally vulnerable and posed emotional threat among the respondents. On the other hand, police and local area people who were influential sometimes tortured them and police did not allow them to stay in terms of any VIP movement. Few of the study respondents were apprehended by police for different reasons, such as for purchasing the additive substances for others, theft, conflict etc. Living on the road was more socially vulnerable for females. They were often physically abused by the local area people and police.

Reported illnesses and links to social determinants of health
Respondents’ living arrangement, long duration staying on the road, food habit, pattern of taking food, nature of occupation and WASH practice had a great influence over their health. For example, people who were rushing and took shower irregularly, they were prone to skin diseases and people who are carrying heave weight or, driving van for prolonged time, had the problem of back pain. Fever, cold, flu etc. are the common health condition due to their living arrangement on the road.
Problems faced while living on the street
In the in depth interview and informal discussion participants mentioned a number of problems which they faced while living on the road. The problems included livelihood related issues, poverty, torture, disease, illness, physical and sexual abuse, insecurity etc. Overall, the social and economic context of the road was not supportive for their living, which ultimately, affect their mental health status.

Poor access to basic amenities
Most of the study respondents had to suffer to arrange their basic amenities for their survival including food, shelter, cloth, education and medical treatment. They were always in uncertainty regarding accessing these basic things and most of the times they had to seek help from others. Even, after seeking help from others, they were unable to arrange a secure living arrangement, three times meal, toilet for brushing, bathing, defecating and a secured place for keeping their belongings. We are moving forward in the race of development, but, these peoples are failed to ensure their basic amenities even after struggling. One of the major focus of SDG is ‘leaving no one behind’, so, we need to include them in the mainstream development process.

Lack of regular income
Many of our respondents expressed their great need of permanent job to lead a decent life. But, they mentioned they were unable to avail any fixed term and recognized job due to absence of identity card and lack of reference instead of having capacity to do the job. They even did not have any training opportunity, from where they could receive training and had a good earning to improve their quality of life. As a result, many of them had to embrace hazardous occupation and search work every day to keep the wolf of hunger away from their stomach.

Disempowerment, injustice, social exclusion and abuse
Most of the respondents mentioned about their powerlessness in terms of their safety, security, having no relatives on the road. They reported that they were being bullied by the unscrupulous people, troubled by police and abused (physical and mental) by the local area leaders. Females who were living on the road particularly face violence and exploitation by the employers during doing the job. Even, in terms of seeking health care after any kind of abuse, they had to either
show their identity card or, showing different cause of injury other than abuse. Lack of relatives and dear ones pose emotional threat on their life and made them emotionally vulnerable.

**Poor physical and mental health vulnerability**
Floating population/street dwellers were experiencing disempowerment, injustice, social exclusion and abuse from the very beginning when they started to live on the road and they were struggling even to arrange their basic amenities and always in anxiety. As a result, they always had a feeling of insecurity and fear, which affect their mental health and sometimes they became depressed and fearful about their existence. Even, sometimes, they did not have option to seek health care due to lack of money and identity card or, corresponding address. In terms of maternal and child health care, they did not receive any antenatal, perinatal and post-natal care unless, they reach in extreme emergency condition. The scenario was same for the reproductive age women who are suffering from different kind of diseases. These group of people even did not have any idea regarding any kind of preventive health care for prevention of diseases.

**Poor social networks**
As they used to live in different locations in different times, they did not have relationship with particular group and people. As a result, they did not have any social support to take if they were in emergency. For example, during their illness usually they did not have anyone with them to offer them a glass of water even.

**Reported illnesses and relevant health seeing behavior**

**Inventory of reported illnesses**
The most common illness reported by floating population/street dwellers were fever and some respiratory illnesses such as common cold, and cough, and few of them suffered from typhoid and pneumonia as well. Among the 22 male and 18 female respondents, 59.09% male and 77.7% female reported suffering from fever, common cold, cough, typhoid, and pneumonia. Frequency of reported illness among the male and female floating population/street dwellers are shown in Table 7 and Table 8 respectively.
Majority (87.5%) of young adult suffered from trauma/injury such as incidental injury (abused by police/local people), the hand/leg fracture/broken, however, trauma/injury was the second most common illness among the overall male respondents (54.5%). Among the female reproductive aged woman, 80% of female reported that they suffered from reproductive age illness/complications, for instance, tumor in the uterus, abdominal pain, urinary tract infections, pregnancy complications, delivery related issues, seek maternal newborn and child health (MNCH) and received family planning services.

Table 7: Frequency of reported illness among the male floating people/street dwellers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and respiratory illness</td>
<td>5(62.5%)</td>
<td>7(63.6%)</td>
<td>1(33.3%)</td>
<td>13(59.09%)</td>
</tr>
<tr>
<td>Trauma/injury</td>
<td>7(87.5%)</td>
<td>5(45.4%)</td>
<td>-</td>
<td>12(54.5%)</td>
</tr>
<tr>
<td>NCDs</td>
<td>-</td>
<td>3(27.2%)</td>
<td>3(100%)</td>
<td>6 (27.2%)</td>
</tr>
<tr>
<td>Gastrointestinal illness</td>
<td>3(37.5%)</td>
<td>-</td>
<td>2(66.6%)</td>
<td>5(22.7%)</td>
</tr>
<tr>
<td>Paralyzed/disabled</td>
<td>1(12.5%)</td>
<td>1(9.09%)</td>
<td>2(66.6%)</td>
<td>4(18.1%)</td>
</tr>
<tr>
<td>Pains/aches</td>
<td>1(12.5%)</td>
<td>2(18.1%)</td>
<td>-</td>
<td>3(13.6%)</td>
</tr>
<tr>
<td>Skin disease</td>
<td>1(12.5%)</td>
<td>-</td>
<td>-</td>
<td>1(4.5%)</td>
</tr>
<tr>
<td>Others</td>
<td>2(25%)</td>
<td>3(27.2%)</td>
<td>1(33.3%)</td>
<td>6 (27.2%)</td>
</tr>
</tbody>
</table>

Among our study respondents, 27.2% male and 22.2% female street dwellers reported that they suffered from different types of non-communicable diseases NCDs such as diabetes, heart disease, chest pain, palpitation, hypertension/high blood pressure, low blood pressure, and stroke. Gastrointestinal illness such as jaundice, gastric, constipation, and diarrhea was reported among 22.7% and 22.2% males and females respectively. Pains/aches including arthritis, severe headache, hands, legs, and body ache were reported among 13.6% male and 16.6% female respondents. Among them, 4.5% male and 5.5% female, reported suffering from skin diseases.

Among the total floating population/street dwellers, 11.1% male and 18.1% female respondents were reported as paralyzed/disabled. Among them, 27.2% male and 33.3% female reported that they suffer from some other illnesses such as dizziness, and weakness.
Table 8: Frequency of reported illness among the female floating people/street dwellers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and respiratory illness</td>
<td>8(80%)</td>
<td>2(100%)</td>
<td>4(66.6%)</td>
<td>14(77.7%)</td>
</tr>
<tr>
<td>Reproductive age illness and MNCH care</td>
<td>8(80%)</td>
<td>-</td>
<td>-</td>
<td>8(80%)</td>
</tr>
<tr>
<td>Trauma/injury</td>
<td>6(60%)</td>
<td>-</td>
<td>-</td>
<td>6(33.3%)</td>
</tr>
<tr>
<td>Gastrointestinal illness</td>
<td>1(10%)</td>
<td>-</td>
<td>3(50%)</td>
<td>4(22.2%)</td>
</tr>
<tr>
<td>NCDs</td>
<td>1(10%)</td>
<td>-</td>
<td>3(50%)</td>
<td>4(22.2%)</td>
</tr>
<tr>
<td>Pains/aches</td>
<td>1(10%)</td>
<td>1(50%)</td>
<td>2(33.3%)</td>
<td>3(16.6%)</td>
</tr>
<tr>
<td>Paralyzed/disabled</td>
<td>1(10%)</td>
<td>-</td>
<td>1(16.6%)</td>
<td>2(11.1%)</td>
</tr>
<tr>
<td>Skin disease</td>
<td>1(10%)</td>
<td>-</td>
<td>-</td>
<td>1(5.5%)</td>
</tr>
<tr>
<td>Others</td>
<td>2(20%)</td>
<td>2(100%)</td>
<td>2(33.3%)</td>
<td>6(33.3%)</td>
</tr>
</tbody>
</table>

Health care-seeking bahaviour

Among the male floating population/street dwellers, 45.4% respondents visited drug shops for trauma/injury and 36.3% males visited drug shops for fever and respiratory illness. Only 27.2% and 18.1% male respondents visited public hospitals and NGOs for different categories illness. Reported illness and relevant health-seeking behaviour among the male floating population/street dwellers is shown in Table 9.

Table 9: Reported illness and relevant health-seeking behaviour among the male floating people/street dwellers

<table>
<thead>
<tr>
<th>Illness categories</th>
<th>Self-care</th>
<th>Traditional Healer</th>
<th>Drug shops</th>
<th>Public hospital</th>
<th>NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and respiratory illness</td>
<td>3(13.6%)</td>
<td>-</td>
<td>8(36.3%)</td>
<td>1(4.5%)</td>
<td>-</td>
</tr>
<tr>
<td>Skin disease</td>
<td>1(4.5%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1(4.5%)</td>
</tr>
<tr>
<td>Pains/aches</td>
<td>1(4.5%)</td>
<td>-</td>
<td>2(9.09%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gastrointestinal illness</td>
<td>1(4.5%)</td>
<td>1(4.5%)</td>
<td>3(13.63%)</td>
<td>1(4.5%)</td>
<td>-</td>
</tr>
<tr>
<td>NCDs</td>
<td>-</td>
<td>-</td>
<td>5(22.7%)</td>
<td>1(4.5%)</td>
<td>-</td>
</tr>
<tr>
<td>Trauma/injury</td>
<td>-</td>
<td>-</td>
<td>10(45.4%)</td>
<td>2(9.09%)</td>
<td>2(9.09%)</td>
</tr>
<tr>
<td>Others (Dizziness, Weakness)</td>
<td>-</td>
<td>-</td>
<td>6(27.2%)</td>
<td>1(4.5%)</td>
<td>1(4.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>6(27.2%)</td>
<td>1(4.5%)</td>
<td>34(154%)</td>
<td>6(27.2%)</td>
<td>4(18.1%)</td>
</tr>
</tbody>
</table>

Self-care= self-medication/taking rest/eating food or juice to improve the health condition; Traditional healer=Provide services using herbs, minerals, animal parts, e.g. Kabiraj; Drug shops= a retail store where medicines are sold, also called pharmacy.

#Multiple illnesses
Among all female floating population/street dwellers, 42.5% visited drug shops for fever and respiratory illness and among reproductive-aged woman, 40% visited drug shops for reproduced-aged illness. About 44.4% and 38.8% female respondents visited public hospitals and NGOs respectively for different categories of illnesses. Reported illness and relevant health-seeking bahaviour among the female floating people/street dwellers is depicted in Table 10.

Table 10: Reported illness and relevant health-seeking bahaviour among the female floating people/street dwellers

<table>
<thead>
<tr>
<th>Illness categories</th>
<th>Self-care n(%)</th>
<th>Traditional Healer</th>
<th>Drug shops</th>
<th>Public hospital</th>
<th>NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever and respiratory illness</td>
<td>2(11.1%)</td>
<td>1(5.5%)</td>
<td>9(42.5%)</td>
<td>1(5.5%)</td>
<td>-</td>
</tr>
<tr>
<td>Skin disease</td>
<td>1(5.5%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1(5.5%)</td>
</tr>
<tr>
<td>Pains/aches</td>
<td>1(5.5%)</td>
<td>-</td>
<td>1(5.5%)</td>
<td>1(5.5%)</td>
<td>-</td>
</tr>
<tr>
<td>Gastrointestinal illness</td>
<td>1(5.5%)</td>
<td>-</td>
<td>3(16.6%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NCDs</td>
<td>-</td>
<td>-</td>
<td>3(16.6%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trauma/injury</td>
<td>-</td>
<td>-</td>
<td>4(22.2%)</td>
<td>2(11.1%)</td>
<td>2(11.1%)</td>
</tr>
<tr>
<td>Reproductive age illness</td>
<td>-</td>
<td>-</td>
<td>4(40%)</td>
<td>3(16.6%)</td>
<td>3(16.6%)</td>
</tr>
<tr>
<td>and MNCH care</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Others (Dizziness, Weakness)</td>
<td>-</td>
<td>-</td>
<td>4(22.2%)</td>
<td>1(5.5%)</td>
<td>1(5.5%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5(27.7%)</strong></td>
<td><strong>1(5.5%)</strong></td>
<td><strong>28(173.3%)</strong>##</td>
<td><strong>8(44.4%)</strong></td>
<td><strong>7(38.8%)</strong></td>
</tr>
</tbody>
</table>

Self-care= self-medication/taking rest/eating food or juice to improve the health condition; Traditional healer=Provide services using herbs, minerals, animal parts, e.g. Kabiraj; Drug shops= a retail store where medicines are sold, also called pharmacy.

#Multiple illnesses

Usually the floating population/street dwellers did not consider the fever, common cold and cough as a severe illness and different age group of street dwellers and both male and female respondents do not seek care for such illnesses.

Regarding the common illness and their perception about the illness, two respondents (18 and 22 years old) from young adult male discussion group in Sadarghat mentioned:

“As long as I am staying here, I did not get any disease, sometimes I feel feverish, common cold, nothing serious.”
“I suffer mostly from fever, jaundice, and cough.”

An elderly respondent suffered from high blood pressure and gastric expressed-

“I have pressure and gastric, but these are common for me.” [Elderly male, 70 yrs, Kamalapur]

Most of our study respondents did not consider these illnesses as serious, so, most of the time they did not usually seek health care. Some of them believe that rather taking medicines or visiting doctors, taking rest or having healthy food could cure them of sickness. In an informal discussion with the young adult male mentioned-

“If we are sick, we do not do anything...we do not seek any treatment, we have no one to take care of us, we continue to sleep here... many here died from sickness, some of them died due to fever, some of died due to some disease, some of them are now in jail.”
[Young adult male, 30 yrs, Sadarghat]

Health systems experiences
They preferred visiting drug shops and self-treatments. Interestingly, the majority of the respondents (60%) including all age group of male and female did not seek health care from any formal hospitals unless they suffered from serious illness or they perceived the illness as serious. They mentioned a range of causes for not seeking health care e.g., financial inability, absence of identity card, long hospital queues etc.

Drug shop and self-treatment
If they perceived their illness as a bit serious, they used to go to the pharmacy or drug shop near their living areas or, have herbal treatment by themselves. Interestingly, most of our study respondents (87.5%), both male and female initially sought care from drug shops. Many of them expressed that as the drug shops were nearby their living place and so not take much time to get medicines from hem, so they preferred visiting the drug shops. Some of them also mentioned that they preferred self-treatments.
One elderly lady aged 60 years old mentioned with confidence-

“I prefer to go to the pharmacy shop. Sometimes, I tried with the local resources to recover my disease, for example, I eat ‘Telakochupata’ to recover from diabetes, instead of going to the doctor. I used to collect this ‘pata’ from different parts of this area.”

[ Elderly woman, 60 yrs, High court mazar area]

Regarding the preferences of visiting pharmacy or drug shops, a young adult male expressed-

“Most of the people like me prefer to go to the pharmacy for seeking health care. In the pharmacy, doctors provide suggestions and they act accordingly. People perceive, in the pharmacy, they will get the best medicine rather than the hospital. In terms of money, most of them are managing money either with begging, or, rickshaw pulling or, working as a van driver. ”

[ Young adult male, 21 yrs, High court mazar]

**Public health sector**

Interestingly, the majority of the male and female, did not seek health care in any formal hospitals unless they suffered from serious illness or they perceived the illness as serious. Only 25% respondents visited public hospital for different illness (Table 3). They mentioned a range of causes for not seeking health care e.g., financial inability to manage lab investigations and medicines, absence of identity card, long hospital queues etc.

**Financial hardship to manage the cost of care/lab investigation**

As most of the floating population/street dwellers spent their all money on food, and did not have saving so to visit a formal facility was difficult for them in terms for financial issues. Respondents mentioned that they needed to spend BDT 10 to buy a ticket to visit a doctor. However, sometimes this BDT 10 was in even unaffordable for them, when they did not have any source of income. In addition, they mentioned that public hospitals did not always provide free medicines. Most of them were afraid visiting a public facility as they experienced on spending a lot of money on medicines, diagnostic charges, and had to wait a long queue, which hampered their overall earning time. Therefore, all these issues had an impact on their livelihood. Some of them mentioned that due to absence of identity card, they faced challenges on seeking.
care from public hospital. Many of the respondents specifically mentioned that public hospitals did not provide all the medicines and prescribe a lot of medicines which they had to buy from outside drug shops. A female respondent residing in Sadarghat launch terminal stated-

“We face financial problem. After going to the hospital, they prescribe us some medicines, but we don’t get all the medicine from the hospital and we had to buy some medicine from outside which is costly and sometimes, we are unable to buy that.”

[Mother of an under-five child, Sadarghat launch terminal]

Among the floating population/street dwellers, who visited public hospitals also most of them pointed out that due to unaffordable diagnostic charges, they were unable to do the diagnostic tests and eventually could not continue the treatment. A male respondent who were living at Kamalapaur railway station mentioned that due to high diagnostic charges, he could not continue is daughter’s treatment from public medical college hospital. He cited-

“Although, public hospitals take BDT 10 to buy a ticket, but, when we have no income, we cannot afford this money and the charges of diagnostic tests are unaffordable for us... due to unaffordable diagnostic charges I could not continue my daughter’s treatment.”

[Adult male, Kamalapur rail station]

**Long waiting queue in public sectors**

Both male and female respondents experienced on waiting in the long queue in public medical college hospitals. They mentioned that the long queue in public hospital consumed their earning time. Moreover, they specified that the hospital queue was another reason behind visiting drug shops.

A reproductive aged woman, in an informal group discussion, vividly expressed that-

“Difficult to stand in the public hospital, there is too much crowd .... I face huge trouble... I needed to wait a long in the queue... once I visited a public hospital and it
took around 40 minutes in the queue...” [Reproductive-aged woman, 40 yrs, High Court Mazar premises]

**Absence of identity card and long waiting queue**

Some of the male and female respondents mentioned that in public hospitals, they face challenges on seeking care due to lack of the identity card. In case of any conflict issue they found or if the patient did not have any specific identity, provider usually did not want to provide services to the floating population/street dwellers. One of the female respondents said-

“Once the ghat leader beat me and my legs and head was injured... when I visited the public hospital, they asked me about my identity and address, they did not provide services to me... provider told me to visit police station and file a case against the leader.... After that we try not to tell them that we were abused rather we say that it was an accident.” [Reproductive-aged woman, 24 yrs, Sadarghat launch terminal]

**NGO sector**

Regarding the experiences from private facilities, the floating population/street dwellers shared their mixed experiences. Some of them said that service providers were well behaved, some of them expressed that service providers did not observed them properly and did not behave them well, some of them mentioned that providers did not treat them if they did not take someone influential in that specific area. In addition, they also mentioned that the service providers did not visit the admitted patient frequently or when an emergency problem arises they do not get the doctors.

**Different costs and different behavior of Service Providers**

Only a very few of our respondents had experiences of visiting the private sectors. They mentioned that private sectors charged more money than the public hospitals and that was unaffordable for almost all of them and doctors behaved differently with different patients as well. They mentioned that vising private sector was possible only when they either had some saving or can lend money from others for treatment. A reproductive-aged woman, partaking experience of visiting a private clinic said-
“During my delivery time, I was admitted at the Gynae ward of a private clinic. Most of the female doctors were good in terms of delivering care in the ward. But, I had to arrange money to buy my own medicine.” [Reproductive-aged woman, 25yrs, Sadarghat]

Our study respondents mentioned that however, private sectors took high consultation fee, but doctor did not always behave well. They got attention of providers when they visited the providers with a local influential person. One of the female woman vividly expressed–

“I have tumor in my uterus. Initially, when I went to the doctor by myself, at that time, the doctor misbehaved with me... Later on, I talked to one of my bhaia (a known brother), who took me to the doctor. Then, doctor talked to me nicely and prescribed me the ultrasound and medicine.” [Reproductive-aged female, 18 yrs, Sadarghat]

Opportunity costs
Apart from direct treatment cost or other health facility problems, respondents also mentioned that they face some personal or other challenges on visiting health facilities as well. As during visiting health facilities, they could not work or not begging and eventually could not earn money at that time. Furthermore, most of them could not afford the transportation cost for visiting the health facility. As one of our female respondents uttered her situation-

“I cannot afford the rickshaw fare to visit a health facility... if I had money, I could have think about visiting the hospitals.” [Adult male, 38yrs, Kamalapur rail station]

Use of Family Planning services
Most of our study respondents did not have any experience of using family planning methods. Male respondents of our study, did not have any experiences on seeking family planning services, and only a very few of our female respondents (10%) mentioned that they received family planning services from different health facilities. One of them expressed-
“Once I went to a clinic and they provided us a stick for three years and give us some money BDT 150 for taking that in Mirpur.” [Reproductive aged woman, 25 yrs, Sadraghat]

**Perspectives from Key Informant Interviews (KII)**

Interviews were conducted with the health care providers of two renowned Government Medical College Hospitals near the study sites, one Urban Primary Health Centers (UPHCs), and in two NGOs. Practitioners from Public health facilities mentioned that they did not provide any health services targeting these population, however, anyone could get any available services from public health sectors. On the other hand, providers from NGOs pointed out that there were some existing projects or programmes targeting the floating population/street dwellers in Dhaka city, but these projects were very small-scale projects with small duration.

**Public health sector**

**Available services**

Providers from public health facilities mentioned that they provided services for all, whoever visited the facility, they could receive the available services. However, no specific service was available for the targeting the floating population/street dwellers, but if any floating population/street dwellers came to visit their health facilities, they provided them services. Providers also mentioned that although most of the patients in public facilities were from lower socio-economic background, a very few of them were floating population/street dwellers. They provided services for fever, respiratory illness, trauma/injury, gastrointestinal illness, NCDs, pains/aches, skin diseases, reproductive women’s illness and MNCH care including antenatal care (ANC) and postnatal care (PNC) in outdoor. They also mentioned that in public hospitals indoor and emergency services are available for everyone as well. Provider of public hospital mentioned that patients come with different illness and they provided different services to them.

Our KII respondents mentioned that the floating population/street dwellers rarely visited the doctor or any formal health facility for consulting doctors during their illness. However, public hospitals provided low-cost services and anyone had access, still floating population/street
dwellers rarely visited to formal hospitals. They also said that floating population/street dwellers preferred visiting drug shops initially and spent all their money mainly at drug shops treatment. When their illness became severe or they perceived the illness is severe, only then they sought care from formal health sectors. One of the service provider from a medical college hospital explained the scenario –

“We have a very minimum number of patients who are coming to the hospital directly. Most of the patients initially seek care from the pharmacy and retail drug shops, from where they bought medicine and antibiotics and take it directly without any doctor’s consultation directly. Even, they are spending their money on buying medicine from the drug shop. But, when they found, their illness is not recovering, ultimately, they came to us to the hospital. For example, a poor person with limited income tried to recover from his illness with the maximum spending at the drug shop, but, at the end when they came to the hospital, they don’t have any money to spend here.” [Service provider, Government medical college hospital]

Providers form public medical college hospitals also mentioned that they tried to provide medicines to the patients with fee of cost, however, based on the availability of stock, they prescribed medicine to patients and then they needed to buy some medicines from outside drug shops.

Our key informant from the UPHCs delivery project explained that they provided services to the poor people as their overall cost was lower than many other facilities. She also pointed out that they did not have any specific services targeting the floating population/street dwellers, rather they provided free services to the slum dwellers. They provided red card to the slum people and identify hem based on their identity card and corresponding address. Due to lack of having identity, they could not provide red card facilities to the floating population/street dwellers. UPHCs provide subsidies on medicines and diagnostic charges for the red card holders (slum dwellers). They also provided satellite services for the poor people in community level. One of the providers explained-
“We do not have any specific system to identify the floating population/street dwellers. But when we ask the people about their address and they cannot tell or explain that they do not have any fixed place to live in, they may be live in the station, then we can understand that these are the floating population/street dwellers .... But slum people can give their address like the house number so that we can differentiate the floating and slum people.... we provide the red cards to the slum dwellers, and red card holders get free services from here.” [Service provider, Public health facility]

**Cost of services**

Service providers mentioned that they provided services with lowest cost, and no other facilities provided services with such low cost as outdoor ticket charge is only BDT 10 and they had different subsidy options for poor patients in indoor services. They also had social welfare department in Govt. Medical College Hospitals, which arrange money for the poor people who were unable to pay for their own treatment and could not admit at the inpatient unit of the hospital due to lack of money. Our key informant mentioned-

“Actually all the Govt. hospital have the social welfare department. Similarly, we have the social welfare department to help those patients. Besides that, we have a poor fund in every department to help our poor patient in doing investigations such as pathological test and other expensive tests if required. We are helping the ultra-poor patients with the fund” [Service provider, Government medical college hospital]

Regarding the floating population/street dwellers’ infrequent facility visit, public sector providers perceived that the floating population/street dwellers were not aware of their health issues, they thought the cost of care in formal facilities were unaffordable for them, as they were very poor therefore, probably they did not visit facilities as their earnings during visiting the facilities and sometimes they might not have the transportation cost to visit a facility.

**NGO sector**

**Available services**
We conducted interviews with the three NGOs services providers. They pointed out that few NGOs provided services specifically targeting floating population/street dwellers, however these were very small-scale programmes. They added that they provided treatments for fever, respiratory illness, gastrointestinal illness, NCDs including high blood pressure, heart disease and diabetes, pains/aches, skin diseases, reproductive women’s illness and MNCH care including STD, STI, ANC, PNC and delivery services. As like public health sector providers, they also mentioned that although most of their patients used to come from a poor socio-economic status, floating population/street dwellers rarely visit their NGOs and retail drug shops are the immediate point of their contact. They mentioned that they provide mobile health care services where that could reach some floating population/street dwellers.

Another NGO service provider mentioned they had a specific programme for the street women with a limited coverage. Under this programme, the street women keep their children to daycare centres and NGO paramedics took care of these children. In case of severe complications, they immediately referred the patient to public hospitals. They also counseled the street women regarding water, sanitation, hygiene, nutrition and gender based violence and also talked to Dhaka WASA and arranged source of water for them. They also mentioned that they provided services even at the evening sessions, so that people can reach them at their emergency needs.

Regarding the daycare centre, one of the service providers from an NGO expressed –

“Here, in our project we are mainly working for improving the life leading style of the people who are living on the road. We have a day care center here where floating/street women of this area are keeping their children and go for their work. We have 3 recruited paramedics here for taking care of these children’s.” [Service provider, NGO]

**Cost of services**

One of the NGO service providers pointed out that the consultation charges in their facility was only BDT 30, which was very low compared with other private health facility, and these low cost services were affordable for poor people, however, it was probably a high charge for the floating population/street dwellers. On the other hand, they provided mobile health care services to a limited people, which is free of cost.
Another NGO provider mentioned that they provided free day care centers to the street women and their children, however, they did not provide services to adult floating/street males. They provided free service to these women even if they were referred to any public facilities. Regarding their services, the provider uttered-

“Actually, we are providing primary health care here for example, fever, cold, cough etc. If any chronic disease is diagnosed by the doctor, doctor referred the patient to the tertiary level hospital and our representatives arranged the further treatment and bear the cost of treatment. We also arrange free delivery service for our members at different Govt. hospitals and NGO clinics.” [Service provider, NGO]

The NGO providers mentioned that probably thinking of higher cost in private facilities, street people were not interested to visit them and lack of knowledge regarding health issues, they did not feel like to visit a health facility.

**Policymakers**

We also conducted the key informant interviews with the policy level persons (high government officials), they had provided their insights regarding the floating population/street dwellers. Most of the policy level persons mentioned that as per their knowledge, they do not have any specific government policy for the floating population/street dwellers and health policy is the same for all. They also included that they did not have any idea whether there was any existing health programme from government level for these people, however, they knew that only a few programmes are provided by NGOs with having limited coverage.

**Available services**

Our KII respondents mentioned that perhaps there are no specific policies for floating population/street dwellers and ultimately there might be hardly any programmes for the floating population/street dwellers from the government level. They also mentioned that several health services in different facilities were available for poor people, so floating population/street dwellers could seek care from these health facilities. They also mentioned as per their knowledge some NGOs provided health and other service targeting the floating population/street dwellers.
One of the policymakers mentioned about the red card service provided by the city corporation targeting the slum dwellers.

Policy makers also thought that the floating population/street dwellers usually ddinot visit health centres unless the illness become severe. Regarding the health-seeking behaviour of street people, anther KII respondent said-

"I think they do not go anywhere for health seeking. Firstly, they trust on Allah, secondly, if they face severe difficulties, they visit the pharmacy shops and tell them to give tablets for fever, they can buy two tablets, even cannot afford to buy four tablets together. They apply sand in the injured area and they feel like they got cured.... I am telling these all from my own experiences. Currently, we do not have any programme or service for the street people.” [High Government Official]

**Cost of services**

Most of our policy makers mentioned that the cost of health services in public hospitals were lower than private facilities, sometimes even free and on special occasions or in an emergency (if any disease is epidemic or during/ after any calamity), free services were provided by the government to every patient in the community level. KII respondents mentioned that addressing the floating population/street dwellers were difficult for them as they were floating and had no specific addresses, which was the reason they could provide free health service only to slum dwellers. They also added about the ticket cost of public medical college hospital was BDT 10 and some NGOs provide services with BDT 30-40.

One of the policy level persons from our study mentioned that poor people could access services from public sectors at a low cost and should have visited the private facilities too. He expressed-

"The consultation fee is only BDT 10 for any patient in DMCH or other district hospital’s outdoor. Any private facilities can provide free services to 5% of their patient, there is a government rule, but I think poor patient do not visit private facilities either.”” [High Government Official]
Regarding the medicines and diagnostic tests they mentioned that the charges were high for the floating population/street dwellers. A very few NGOs provided discounts on medicines and diagnostic tests for poor people.

**Health policy**
Most of our KII respondents mentioned that as per their knowledge, there was no existing government policy or government health policy for the floating population/street dwellers. They also included that they did not have any idea whether government is going to establish any policy targeting this population. One of our KII respondents expressed-

“The health policy is common for everyone. To my knowledge, there is no policy for the floating population/street dwellers, maybe no one even thinks to have any policy for them.” [High Government Official]

**Programmes targeting floating population/street dwellers**
Our policy level persons mentioned that there are a very few existing programmes targeting these floating population/street dwellers, hence, the coverage need to be extended and more health interventions need to be provided focusing this group of people. One of our key informant mentioned about an upcoming project for floating population/street dwellers will be initiated by UNICEF with the collaboration of government within a short period of time. He said-

“….. From our city corporation, we are going to start a new project in collaboration with UNICEF to improve the health status of these group. We are going to start an evening health care programme for them from 3.00 pm to 9.00 pm. We already completed infrastructure for the project and going to launch the project soon. We are starting this service in ward no-33 and 36, on a pilot basis. Hopefully, this new service can improve the health status of some of the floating population/street dwellers.” [High Government Official]
Finally, he articulated that these types of programmes for floating population/street dwellers needed to be established earlier and such services hopefully improved the health status of floating population/street dwellers.

**Respondents’ recommendations (from IDIs and KIIIs) for improving services**

**Floating population/street dwellers**

Respondents shred their valuable thinking regarding improving the health systems for them. They expressed their different view of points to improve service delivery systems. Most of the respondents mentioned that they require affordable health care in terms of dealing with their illness. At the same time, they suggested starting mobile health care services for people like them so that they could easily access the services whenever emergency arises.

**Provision of free health care**

Most of the respondents expressed that due to cost of care they were not motivated to visit a formal facility. They perceived the cost of care was high in every formal health sectors. Most of them expressed that they needed a free and affordable health care provision system to access health care service properly. They also mentioned that street males and females both wants free of cost health care services. Regarding the provision of care, an elderly respondent said-

“I want free treatment for people like us and expect good behavior from the providers, so that, anyone like us can avail the service without facing any difficulty.” [Elder female, 60 yrs, High Court Mazar]

**Mobile health care services**

Some of the respondents mentioned that to improve the health status of the street people, needed to initiate mobile care services along with the of free health care provision. They mentioned that they face challenges on seeking care from formal facilities, hence, they prefer mobile health care, where service providers will come with medical equipment and medicines on regular basis, investigate their diseases and will provide them services on spot accordingly. Regarding mobile health care services, one of the respondents illustrated-
“Here women face most of the health problems...they have lots of problems! if there was a government female doctor, I have seen sometimes heroin addicts get treatment from the provider here, if there are 2/3 persons like that if few doctors come and provide services to women, that would be better.” [Young Adult Male, 20 yrs, living in Sadarghat launch terminal]

Establishing hospital /doctor’s chamber specifically for the floating population/street dwellers

As floating population/street dwellers suffered from several illnesses and could not afford the cost of care and could not visit health facilities due to lack of money and transportation cost. So few of them said they needed a separate hospital or a small corner in their living area so that in an emergency situation, they could access a quick health service. One of the respondents expressed-

“Need to established a hospital in the area or there should be a room where doctor will be seated, suppose someone’s nail has been broken, now if I have to take him to doctor in public hospital, it will take huge time and she will be bleeding a lot, if you are nearby us, we can go to you, then you can manage the treatment.” [Adult male, 48 yrs, Kamalapur]

Improve the street people’s lifestyle is important before providing a treatment

floating population/street dwellers mentioned that they were deprived from all basic amenities including food, nutrition, sanitation, and health-related issues. They suggested improving their overall lifestyle before improving or ensuring the health care issues. They also believed that improving overall lifestyles could reduce the overall illness pattern among street people. An adult male respondent expressed-

“Need to understand the street people’s lifestyle before providing treatment. Street people suffering from different types of diseases due to different issues, need to identify these causes, should provide the treatment accordingly, without improving the lifestyle what can health service do?” [Adult male, 48 yrs, Kamalapur]
Service providers

Our key informant has provided some recommendations to improve the quality of care to improve the health facilities. They prioritized on ensuring free health services for the poor people, moreover, regulation or control over using the antibiotics, health education sessions to improve their health awareness, reserve bed for floating population/street dwellers in the hospital, free medicines and establishing special hospital for this population. Some of them expressed that Government and NGOs together could implement a large-scale programme; where government could provide free medicines and NGOs can provide health services. They also suggested to aware the street people regarding their nutrition and personal hygiene.

Government and NGOs together can implement a large-scale programme

Our KII respondents suggested that government and NGOs together can initiate programmes for the floating population/street dwellers and large-scale programme can improve the health status of the street people as well. One of the service providers suggested to construct specific health policy for floating population/street dwellers and to retained two beds in indoor at public hospital only for this floating population/street dwellers. One of the policy level persons expressed-

“I think the Government can do something for the floating population/street dwellers. I have seen many NGOs provide service for them for a short time but Government and NGO together can take initiative to do something for floating population/street dwellers. The government can provide separate health services for floating population/street dwellers in the public hospital or they can make a separate center for the floating population/street dwellers.” [Service provider, Public health facility]

Policy makers

Our KII respondents suggested and recommended few services to improve the health delivery systems for floating population/street dwellers, for instance, they opined that needed specific policy including health policy especially for this group of people from government level, provision of services, initiation of mobile health care, increase the health workforces for serving this population, donation from wealthy society (rich people personally should donate money to
they recommended establishing health insurance (premium paid by Govt.) to ensure fully free services, referral system, ensuring 5% free services from private hospitals, publicity of existing public services and separate health centre/corner in the hospital

**Health education session**

Policy makers suggested to conduct health education training sessions for floating population/street dwellers to aware them regarding their health issues, maintaining personal hygiene, improving nutritional knowledge to reduce the illnesses prevalence and to improve the overall health-seeking behavior. One of the policymakers said-

“We need to arrange health education sessions for them at a different level for different groups. See, the need of different aged people is different in terms of health care. We need to provide health education training in different clusters, which can improve their care-seeking behavior and can motivate them to seek formal health care instead of kabiraj or, any other things.” [High Government Official]

**Donation from wealthy people of the society**

Some of our key respondents also suggested that rich people personally can donate money to the poor so that the poor people including floating population/street dwellers will be able to seek treatment utilizing that money. Regarding contributing everyone for improving the health services of floating population/street dwellers, one of the KII respondents said-

“I think we should be more conscious of them. I personally think whatever we all earn, we should spend 2% of our earnings for them, and with that money, it will be possible to provide them the health, treatment and education expenditure.” [High Government Official]

**Ensuring free services from private sectors**

Some of our policy level persons suggested that government should ensure quality health care services with fee of cost for poor people along with floating population/street dwellers from all private sectors. Our key informant also added that the government should make mandatory rules
for the private clinics to provide free health care services to the floating population/street dwellers. He said-

“I have an idea like if government order the private clinics that they will have to provide free health services to the floating population/street dwellers, it should be totally free… maybe government can pay the money on behave of floating population/street dwellers … they need free services nearby their living places.” [High Government Official]

**Triangulation of findings: floating populations/street dwellers, service providers and policy makers**

Floating population/street dwellers, health care service providers and policy makers shared their experiences, perceptions and suggestions regarding the health seeking behaviour and available services in different health sectors in Dhaka. To get a vibrant picture, we complied their information and compared the findings from floating population/street dwellers, Service Providers and Policy Makers, which is depicted in Table 11.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Floating populations/ street dwellers</th>
<th>Service Providers</th>
<th>Policy Makers</th>
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</thead>
<tbody>
<tr>
<td>1. Types of illness</td>
<td>Fever and respiratory illness was common among both male and female street dwellers, however they visit facilities if only the illness is severe. Males were mostly suffered and visit facilities for trauma/injuries and females visited formal facilities for reproductive-aged illness.</td>
<td>Provided almost all services in outdoor including treatments for fever, respiratory illness, gastrointestinal illness, NCDs, psychological disorder, treatments for trauma/injury, reproductive-aged illness, family planning services. Indoor and emergency services are also available in public hospitals. Street people mostly visited facilities due to gastrointestinal illnesses, sometimes with NCDs and trauma/injury. Probably they visited facility when they suffer from communicable disease like dengue and chikungunya, illness.</td>
<td>Provided treatments for fever, respiratory illness, gastrointestinal illness, NCDs, trauma/injury, reproductive-aged illness, pregnancy relevant services (ANC, PNC), family planning methods. Mostly females were visited with reproductive-aged complications. Public medical college hospitals were tertiary level hospitals; hence all services are available there. Street people probably visited hospital when the illness was severe. Different private hospital provided different health services, such as treatments for fever, respiratory illness, gastrointestinal illness, NCDs, trauma/injury, reproductive-aged illness, pregnancy relevant services (ANC, PNC) and family planning methods are available almost in all NGOs. However, few NGOs provided day care centres for street women’s children and adolescent health services are provided by few NGOs as well.</td>
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<tr>
<td>2. Types of health care</td>
<td>Most of the street people preferred visiting drug shops</td>
<td>Most of them preferred visiting drug shops, some of them preferred visiting</td>
<td>Most of the floating population/street dwellers</td>
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<tr>
<td>providers/health facilities visited</td>
<td>shops because of easy accessibility. Visited formal facilities if only they failed to cure from drug shops treatment.</td>
<td>drug shops. Whenever they failed to cure from drug shop treatment, they try to visit nearby facility. So sometime they visited public sectors.</td>
<td>might visited public hospitals. Rarely visited NGOs or other private sectors. But the scenario might varies, if the NGO provided services targeting these population.</td>
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<td><strong>3. Cost of services</strong></td>
<td>Ticket fee was BDT 10 in public sectors, sometimes it was even higher, when they did not have any income. Private sector charges were higher than public sectors.</td>
<td>BDT 10 for outdoor services. Few free beds were allotted for poor people in indoor.</td>
<td>Took more charges than public facilities. However, some NGOs provided low cost services or subsidies on services for floating population/street dwellers.</td>
</tr>
<tr>
<td><strong>4. Medicines</strong></td>
<td>Public sectors provided free medicines sometimes, but if the medicines were not available then needed to buy from all medicines outside. Private sectors did not provide free medicine.</td>
<td>If medicines were available in the stock, provided free medicines to all, otherwise prescribed medicines and patients bought medicines from outside.</td>
<td>Some NGO provided low medicines with discount price, but do not provided free medicines. Usually provided free medicines to all. Some NGOs might provide medicines with low cost.</td>
</tr>
<tr>
<td><strong>5. Diagnostic charges</strong></td>
<td>Both public and private sectors diagnostic</td>
<td>Diagnostic charges were lower compared with private sector,</td>
<td>Diagnostic charges were higher than public sectors, only red card</td>
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<td>charges were</td>
<td>Did not have any idea about Social</td>
<td>Most of the did not have any idea whether any specific</td>
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<td>unaffordable for them.</td>
<td>welfare service department.</td>
<td>programme for them in public/private sectors. Although, a</td>
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<td><strong>sometimes offered</strong></td>
<td>Social welfare service department</td>
<td>very few of them mentioned that some NGOs provided services</td>
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<td><strong>discount to poor</strong></td>
<td>provided low cost services (free</td>
<td>targeting them and they</td>
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<td><strong>people.</strong></td>
<td>medicines or minimal diagnostic costs)</td>
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<td>**holders (slum</td>
<td>to poor people. social welfare</td>
<td>As per their knowledge services of public facilities were</td>
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<td><strong>dwellers)</strong></td>
<td>representatives came to the ward for</td>
<td>same for all, no known specific programme was running</td>
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<td></td>
<td>visiting patients to assess socio-</td>
<td>targeting these group.</td>
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<td></td>
<td>economic status. After assessment,</td>
<td>Some NGOs provided small-scale programmes targeting this</td>
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<td></td>
<td>they allocated medicine to the patient</td>
<td>As per their knowledge in public facilities, services were</td>
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<td></td>
<td>as per their need, to prevent misuse</td>
<td>same for all, no specific programme was</td>
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<td>of the medicine, they followed the</td>
<td>Some NGOs provided small-scale programme targeting the</td>
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<td>procedure.</td>
<td>floating population/street dwellers.</td>
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received free services from these facilities.

### 6.3. Reproductive and STD services

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<tr>
<th>Description</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Most of them did not have idea about reproductive and STD services. Some of them mentioned public hospitals and some NGOs probably provide relevant services.</td>
<td>Reproductive and STD services were same for all. Some NGOs provided free reproductive and STD services at community level. Services were same for all in public sectors. Some NGOs provided reproductive and STD services at a low cost.</td>
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</table>

### 6.4. Daycare centre

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<th>Description</th>
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<tr>
<td>Only a very few women (10%) were known about a daycare provide services to street mother and children, others have no idea.</td>
<td>No daycare centres/services were available in public sectors. Some NGOs had daycare centre for female floating population/street dwellers and their children. Some NGOs had daycare centre for floating population/street dwellers.</td>
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</table>

### 6.5. Satellite clinic services

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<th>Description</th>
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<tr>
<td>Did not have idea about the satellite clinic services.</td>
<td>UPHCs provided some satellite clinic services, which was available for everyone. Some NGOs provided some satellite clinic services targeting poor people. Few NGOs provided satellite clinic services targeting poor people.</td>
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### 7. Experience of services

#### 7.1. Providers’ behaviour

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<th>Description</th>
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<td>Providers behaved well in public sectors. Private sector’s providers behaved differently in different times. Sometimes the providers of private facility behaved rude, sometimes they are cordial, when</td>
<td>Public sector providers use to behave well with every patient and listen carefully to poor patients, sometime because of overflow of patients, providers did</td>
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<td>section</td>
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<td>7.2. Identity card</td>
<td>Private and public both sectors asked for identity cards. Sometimes they faced difficulties on seeking problems in case of absence of ID card. e.g. if it a conflict issue such as abused by local people or police, providers suggested them to case a file against the criminal. Hence, floating population/street dwellers used to avoid filing case and lie to provider for getting treatments. Public sector providers provided services to them without ID card, however, in emergency case or conflict issues, hospital authority might ask of ID card, another point is for special programmes arranged by UPHCs like red card holder are only based on identity and needed an address, so these special offers cannot be provided to the floating population/street dwellers. Private providers usually did not usually ask for ID card, but in conflict issues like beaten by someone, or other accidents, they might need to provide the detailed information about themselves. Did not have clear idea about the ID card and providers’ activities regarding this issue. But in case of conflict issues such as police case or emergency issues like conducting emergency surgery, both public and private sectors providers might ask them for ID cards, and providers were aware on providing services to them in such circumstances. There was no system through which these floating population/street dwellers can be identified and can be treated differently.</td>
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<tr>
<td>7.3. Hospital queues</td>
<td>Long waiting queue in public sectors. These long queue was disrupting the source of income. Did not need to wait long in private sectors. Overcrowding of patients in the public hospitals was very common. Due to huge patient flows, patients had to await a long here, sometimes even for an hour. Less patients flow, so patients did not need to wait more than 5 minutes. Public hospitals usually faced a high patient flow, eventually, there can be a long waiting queue. Compared with public sectors, fewer patients visited private sectors, therefore, patients did not need to wait a long there.</td>
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<tr>
<td>7.4. Opportunity cost</td>
<td>During the hospital visiting time, hampered earnings. Due to lack of When services were available in one shift, opportunity cost like Opportunity cost may hampered in case of visiting both facilities, as it is based on patients need,</td>
</tr>
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</table>
earning they were unable to eat food and became more prone to illness. Some of them even could not visit a facility due to lack of money.

2pm, that time might not be convenient for the floating population/street dwellers. However, public hospital had 24/7 indoor services, but street people usually did not want to admit in the hospital because of lack of money.

earnings might hamperd but two-shifted services could reduce the burden of earning time. As some NGOs provided services in two shifts, that might be better for floating population/street dwellers.

vising hour and distances from their living areas.

Illustrative Case Studies

This qualitative data analysis provided us the insights regarding the floating population/street dwellers regarding their life stories and struggles. Thus, some remarkable case studies based on the floating population/street dwellers’ existences and experiences are presented here.
Case study 1 (Reproductive-aged woman)

A 29 years old lady, residing at the High court mazar premise, was pregnant during the interview. She was married off when she was only 11 years old and was studying at the primary level. She was a Hindu woman, and after getting married to her husband (who used to sell chanachur near her school), she had to convert the religion and currently practicing Islam. She had to leave her parents, as they did not accept her husband. She used to live with her in-law’s before coming the mazar area, but she had a conflict with her mother-law, and suddenly her husband got married to another woman, so she had to start living on the road and meanwhile her husband left his second wife and came back to the lady again and started living with her at the road. She already had five children (two sons and three daughters).

Regarding street life, she expressed-

“We face so many challenges, for example, our sleeping. Police comes at any time and evict us from our sleeping area. We face difficulty to eat food, bathing and using the toilet. I would not have called this life - this is not a life and a dog's life is similar, whatever you think. People used to beat dogs and they move here and there. We are doing the same. Sometimes, thief took our belongings and we have to buy again.”

She said that as the facilities charges high, so she did not usually seek care from formal health facilities and due to high diagnostics charges she could not examine her ultrasonography. All of her previous delivery was done at home and one of her delivery suddenly happened on the road, so someone from the road took her to DMCH. As she saved her life, she asked her for the newborn son and that son is currently adopted by that lady. Regarding the current health seeking behavior, she added-

“For blood test, I need BDT 500, for ultrasonography, I need BDT 300, which means total of BDT 800. I don’t have any source to get this huge money... eventually, I cannot continue my treatment”.

Finally, she expressed that however, they were struggling in living this road life, she believed that the situation will be changed, they would get a better life and they were surviving with dreams. She stated-
“I have 3 dreams- I want my elder daughter to be a doctor, second daughter to be a lawyer and younger daughter to be a dancer. I want my doctor daughter to treat the patient in free without taking money.”

**Case study 2 (Young Adult Male)**

A young adult respondent aged 32 years from Kamalapur rail station expressed his feelings of living on the street and revealed his health seeking behavior during illness. He mentioned that when he was 13/14 years old, was suffering from typhoid fever after that he did not cure completely and became paralyzed. Currently, he could not walk properly, and could not work as well. Due to having no family support and income, he had to choose this vulnerable life. He earned through begging and leading the miserable life till this physical condition. Regarding the health-seeking behavior, he mentioned that he did not visit formal health facilities. He expressed his experiences-

“.... Hmmm... I got cured of jaundice after receiving treatment from the spiritual healer (Kabiraj) at high court mazar.... The spiritual healer did not take any money from me. I had to spend BDT 60 for transportation.”

He also expressed that as they used to suffer from lots of difficulties including food, and shelter in street life, thus, health issues were not prioritized. He uttered-

“No one cares about us, no one even asks for us, even for a glass of water.... We do not get food to eat, do not have water, cannot take shower everyday... so health or illness cannot be an important issue for us... we want a life, this is not a life.”
Case study 3 (Adult Male)

An adult man, 55 years old, dwelling at the Sadarghat launch terminal expressed his experiences as a floating people/street dweller, challenges his faces in day-to-day life and he made some coping strategies. Due to having a huge conflict with family members, he had to leave his home, which makes him mentally depressed. With his limited earnings, it was difficult for him to maintain his livelihood properly, eventually, he had no other option other than living at an open place and as a result he had been living in the road for the last 35 years. He mentioned that he did not want to visit any hospital unless any severe illness. Although, fever, common cold, and cough are very common diseases for him and he did not take medicines for these hitches. As reasons behind not visiting health facilities or seeking any health care he expressed that he sufferd from lots of other problems rather health issues, he added that cost of medicines and other services charges are not affordable for him.

He stated-

“Here, I face problem during sleeping here. A group of young and mid-aged people are playing cards at different times of the day and do not stop even at night. They started shouting during playing. But, we could not say anything as they are from this area. If we say something, they may throw us from here and there is a possibility of losing the sleeping place”.
Case study 4 (Elderly Female)  

A 60 years old elderly woman living at the High court mazar area mentioned that like the thousand other floating population/street dwellers, she was facing the same difficulties existing in the street life, facing same problems such as lack of food, no sleeping place, maintaining hygiene and on earning money as well. She also pointed out that street life was not only a curse for them during their survival, rather when some of them were died no one was there to bury them in the graves. She expressed that she did not have any idea about the location of any health facility, therefore, during illness, she usually takes self-care or sometimes received medicines from nearby drug shops. She said-

“... it would be better if some doctor come to see us and give us medicine during our illness, and when people like us die someone should arrange our burial activities, that would be a great help for these floating population/street dwellers.”

Discussion and recommendations

Discussion

This study was conducted to explore the illness experiences of floating population/street dwellers and their health-seeking behavior including experiences of interaction with formal health systems and identify the gaps in policy and practices. The study findings disclose that the floating population/street dwellers in Dhaka city are deprived of their basic niceties and many of them cannot even partake their regular diet due to shortage of income or poverty, as a result, they do not consider the health as a priority issue, which demonstrates that they are enormously in danger in terms of their health needs and healthcare-seeking behaviors. On the other hand, the study also reveals that public health facilities do not have a mechanism of service delivery targeting floating population/street dwellers, although they have few programmes for other underprivileged groups such as slum dwellers, and only a few NGOs have some programmes with a limited coverage targeting these people. Moreover, our study also revealed that specific government policies targeting these populations are also not available in our country.
Socio-demographic characteristics
Most of our study participants never attended any school which is also seen in an earlier study (Uddin et al., 2012). Our study showed that half of the female respondents were widowed or separated, which is even higher than the previous study findings (Ahmed et al., 2011; Uddin et al., 2009). The main income-earning activities of our respondents is similar to what was observed in an earlier study (Uddin et al., 2012). Females were found to be amongst the long-time residents of the streets, which is also observed in the above studies e.g., 20+ years in Dhaka city (Uddin et al., 2012) and 10+ years at Jaipur city, India (Goyle et al., 2004).

Social determinants of health and illnesses
The challenge for these populations to find a covered space for sleeping is not unique (Rahman 2001; Ahmed et al., 2011). The poor water, sanitation and personal hygiene conditions as observed in this study, resonates well with earlier studies (Uddin et al., 2016; Ahmed et al., 2011). To save some money to cope with income-earning uncertainties is commonly practiced by our study participants. Earlier study finding also show that whatever the street people’s income, they have a tendency to save money for worse days (Ahmed et al., 2011).

Provocation from the police force is mentioned by these destitute people, which is consistent with what was found by Koehlmoos et al. (2009). She observed comparable harassment by the law-enforcing agencies among these floating population/street dwellers in Dhaka city. Besides, harassment from the political hoodlums including physical violence is commonly faced by these people. Our study also revealed that due to such harassments, majority of the male respondents were suffering from injury and trauma; similar finding is mentioned in the previous study conducted in Bangladesh (Ahmed et al., 2011)

Illness and health-seeking behavior
Common illness profile and relevant health care-seeking behavior observed in this study did not change over the years (Uddin et al., 2009; Ahmed et al., 2011). Illness profile nearly parallels to that of the underprivileged group of people in Bangladesh (Ahmed et al., 2005). The financial barrier to access health care services, even if subsidized, observed in this study is similar to what is found in high-income country for the homeless women (Teruya et al., 2010). Visiting the retail drug shops for seeking treatments including buying contraceptives are
also quite common (Uddin et al., 2016; Ahmed et al., 2011) and have not changed over time though the health facilities have expanded enormously over the years.

Limitations
This pilot study covered a limited number of spots for recruiting study participants from the streets due to constraints in time and resources and thus, results cannot be generalized for all of the floating population/street dwellers. Secondly, as the study only used qualitative approach and included a small sample, macro-level perspectives (e.g., approx. no. of this population, their distribution and clustering in different spots, presence of a health facility in the neighbourhood etc.) could not be captured in detail which is necessary for designing a customized integrated and uniform service package for them based on their needs and priorities.

However, this study is only one of a few studies on these marginalised groups where there is lack of requisite information for the policy makers and practitioners. We hope to fill-in some of the gaps in this area, especially through our purposive selection of the respondents from different age and sex groups to have an overall idea about their needs and priorities. Moreover, we also elicited the perspectives of the providers and decision makers about how to organize services for them including the types of services needed and delivery of services on priority basis. Finally, the KIIIs with the policymakers (high government official) portrait a vibrant picture regarding the existing and upcoming programmes and policies for the floating population/street dwellers in Bangladesh.

Conclusion
In consistence with Government’s avowed policy of ‘leaving no one behind’, and ‘achieve UHC by 2030’, out-of-box (innovative) measures are needed in policy and practice to ensure needed healthcare for these very marginalized, destitute population, without financial implications, on a priority basis. We hope that findings of this pilot study will help policymakers and practitioners to develop and design relevant policies and programmes, embedded in the mainstream health systems in the spirit of universal health coverage.

Recommendations
Based on our study findings, we suggest a few recommendations to improve the current conditions. These are grouped under service provision, programme, community and health system and policy.

A) Service provision

Mobile clinic: As the study findings reveal that despite provision of low cost services, especially at the public facilities visit by floating population/street dwellers are rare due to various issues e.g. lack of awareness, opportunity cost, diagnostic cost, accessibility and acceptance. To address these, mobile clinics can be initiated through public-private partnership (PPP) model to make the services available for street-dwellers in time and place convenient for them and providing services as needed e.g. SRHR, family planning, disability, diarrhoeal/skin/respiratory diseases, drug/substance abuse/addiction etc.

Health card for priority access: As the study findings disclose that floating population/street dwellers usually do not have any formal identity, thus face challenges in terms of availing basic constitutional rights including health. Special cards can be introduced (e.g. as done for slum dwellers by UPHC) to ease priority access and minimize the cost, especially of diagnostic and medicines.

B) Programme

Coordination of interventions to avoid duplication/ segregation of efforts: To improve the overall health status of the floating population/street dwellers, coordination of interventions involving relevant stakeholders are needed. For this, agencies involved can form coordination committees, preferably based on locality they serve, and supported by higher authority.

 Provision for basic amenities: As our study revealed that floating population/street dwellers are struggling with problems of safety and security and basic amenities. They do not have safe place to sleep, have no privacy, always at risk of theft of belongings and money, have to take unhygienic food from roadside makeshift food shops, and do not have access to safe water and sanitation. Hence, some interventions such as ‘Night Shelters’; ‘Day Care Centre’; ‘Locker Services’; ‘Low cost hygienic food shops’; ‘Free toilet/Wash Facility’ etc. can be organized, by for example, the NGOs in their living areas in cooperation with relevant ministries of the government.
C) Inform about available services: Our study revealed that most of the floating population/street dwellers are not aware of the existing low-cost services provided by public and private sectors including NGOs. This information gap needs to be addressed through coordinated awareness campaigns including motivation for use of these services to the maximum. NGOs can take this initiative as well.

D) Policy and health system

Map/census on floating population/street dwellers for informed policy and programme planning: To improve the health status and overall living conditions of the floating population/street dwellers, a census is needed to identify the location and number of floating people living in Dhaka city (and other big cities with substantial proportion of these population). This will help to organize needed healthcare and other services (related to social determinants of health) in a coordinated manner by the public and non-state sectors, complementing and supplementing each other.

Action/implementation research to assess scope of integrated interventions: Implementation research on the floating populations/street dwellers are needed to find out the best model for service provision for these populations including barriers and enablers that is accessible and acceptable to them, towards achieving UHC by 2030 as envisaged by the government, leaving no one behind.
References


ICDDR, B (2017). Health and Demographic Surveillance System: Slums of Dhaka (North and South) and Gazipur City Corporations Registration of Health and Demographic Events, 2016. Available from:


Annexes
Annex 1: Tools and Consent Form

In-depth Interview (IDI) Guideline
For
Floating Population/Street Dwellers
Study Title: Leave No One Behind
Exploring the health care seeking behavior of floating population/street dwellers in Dhaka City, Bangladesh: A pilot study

Basic Information

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<td>Consent status</td>
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Domain 1: Socio-demographic characteristics

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<td>Source of income</td>
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<td>Educational status</td>
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<td>Occupation (if any)</td>
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Domain 2: Being a floating people/street dweller

- Please share with us from where you are originally from (Probe: Origin)
- Please tell us since when you are living on streets (Probe: Duration of street life)
• Please share with us how you end you living here? (Probe: reason behind living in street, how became floating population/street dweller process that lead to turn into floating people/street dweller)

Domain 3: Living characteristics
• Please share with us about your living (Probe: Common places you spend day time, places where you sleep)
• Please tell us how you select/choose living place (Probe: Criteria of site selection, preferences, challenges etc.)
• Please tell us about your family (Probe: Lives alone on street or with family, family members)
• Please tell us about living arrangements (Probe: whether under open sky or have any shelter/cover, type of their belongings etc.)
• Please tell us how do you manage water/sanitation etc. (Probe: Source of drinking water, bathing, toilet etc)
• Where do you take your bath (Probe: How often and do you use soap during taking bath)?
• Do you brush your teeth everyday (Probe: What do you use for brushing teeth)?
• Please tell us how you move out from one place to another

Major challenges:
• What do you think is the most important challenge that you face while living as a floating population/street dwellers?

Domain 4: Livelihood characteristics
• Please tell us how do you earn your livelihood (Probe: whether have any occupation/work, duration of daily work hour/weekly, daily earning/weekly/monthly)
• Please tell us how do you spend you earning (Probe: Basic costs-food, settler, cloth, treatment, any ransom money they need to pay to anyone)
• Please tell us whether the livelihood are manageable (Probe: Challenges of the work, benefit if any, whether enough/deficit to manage living, whether can save etc)
• Do you save money (Probe: How and where do you keep your savings)?
• Did you borrow money in the last one month (Probe: Why and from where did you borrow)?
• Did you give your/money/other belongings to someone to keep (Probe: Whom did you give/did they do any dishonesty on this regard?)

Major challenges:
What do you think is the most important challenge regarding your livelihood?

Domain 5: Safety/security issue
• Please tell us about the safety/security issues while living in the streets (Probe: encounter with law enforcement authorities, encounter with others-ask to specify)
• Please tell us whether you have been harassed/abused (Probe: Physical/verbal)

Major challenge:
• What do you think is the most important challenge regarding Safety/security issue?

Domain 6: Health-care seeking behavior
Illness pattern:
• What are the common illness that you usually suffer?
• How often do you suffer from diseases? (Probe: Acute/chronic illness)

Care seeking behavior: (type of provider, facility visited, service received, service unavailable/not received)
• What you usually do if you notice any health problem? (Probe: Observe/self-remedy, do nothing etc.)
• From where do you seek health care in terms of your illness? (Probe: Reason)
• Is it common for you to visit the public/private health facility? (Probe: Reason of choosing/not choosing the facility)
• What type of service you usually receive from this provider/facility? (Probe: Access, service, quality, reliability, empathy/assurance, satisfaction/dissatisfaction, waiting time etc.)
• Please tell us type of services that you need but fail to get from the provider/facility
• Do anyone come to provide services to this area (Probe: name of the provider/facility, what services do they provide, how long do they come, quality of their services)
• Did you suffer from any disease in last one year, which is why you had to spent your all savings (Probe; which disease, where did you for treatment, how much did you spend, how was the quality of services)?

Responsiveness of health care service provider
• Please tell us about your experiences of the health care providers approach in illness (Probe: Approach of provider in public/private facility, friendliness, trustworthiness, respect)

Cost of care:
• What about cost of services of these facilities services (Probe: Are consultation fees and other charges (diagnostic tests) affordable for you?)
• Please tell us how you manage the cost of treatment in illness
• Is there any facility/provider who provides free of cost treatment/low cost services (Probe: where is the facility, what do they offer, please tell us your experience)?

Major challenges
• What do you think is the major/most important challenges that you face regarding your needed health care services?

Reproductive Health related (Only for the Women of Reproductive Age)
• Which reproductive health services do you receive including family planning services (Probe: Which service, how long are you using)?
• Where did you visit during pregnancy (Probe: Did you receive ANC, how many times you received ANC services, did you have any pregnancy/other complication?)
• Where did you visit for delivery service (Probe: Public/private facility? Why did you visit there?)
• Please share with us about your experience during delivery (Probe: Did the provider/facility maintain privacy, did they listen to your problem/ did they guide you properly, did you find them friendly)?
• Did you visit any facility after delivery (Probe: Did you face any problem after delivery, any illness/complications)?
Have you ever visited any provider/facility for your child’s health care (Probe: Why did you visit, what was the complications, how about the services you received)?

Have you ever been tortured/abused by your husband?

**Domain 7: Suggestion and Recommendation**

- Given your experiences, please suggest what healthcare services you would like to have and how/from where you would like to receive the services (Probe: services that they do not get/their health demand)
- Do you have any further recommendations regarding the improvement of health service for floating population/street dwellers?

Thank you for your time!

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**Key Informant Interview (KII) Guideline**

For

Health Care Providers/Facility Manager

Study Title: Leave No One Behind

Exploring the health care seeking behavior of floating population/street dwellers in Dhaka City, Bangladesh: A pilot study

**Basic Information**

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Present address (Current living area)  
Duration of living in current area  
Duration of working in this area:  
Present Designation:  
Highest level of education  
Facility/Programme:  
Contact detail with mobile no:
- What are your suggestions regarding the improvement of health service for floating population/street dwellers?
- Any other suggestion/recommendation?

Thank you for your time!

---

**Key Informant Interview (KII) Guideline**

**For**

**Policy Makers**

**Study Title: Leave No One Behind**

**Exploring the health care seeking behavior of floating population/street dwellers in Dhaka City, Bangladesh: A pilot study**

**Basic Information**

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**Domain 1: Regarding floating population/street dwellers**

- Please tell us about the living status of floating population/street dwellers (Probe: How long the floating population/street dwellers are staying in a this/a particular area)?
- Where do they come from?
• What are their income sources?
• How do they earn for food?
• How many days a week do they work?
• How do they spend their earning?

Domain 2: Health Care-Related Information
• Where do they (floating population/street dwellers) usually go for seeking care (private/public/other sectors)?
• What types of health facilities do they prefer for seeking health care (formal or informal provider/health facility)?
• What are the common diseases among the floating population/street dwellers?
• Please tell us about the consultation fee for the floating population/street dwellers in public private facilities?
• Is the consultation fee or other charges are affordable for them?
• Do the Service Provider/health care facilities provide any subsidy/low-cost service to them?
• Do they (floating population/street dwellers) face any challenge on receiving health care services?
• How do they overcome/cope up with these challenges?
• Do the Health Care Providers face any challenge/difficulties on providing health care services to the floating population/street dwellers (Probe: what are the challenges)?
• How do the Health Care Providers overcome the challenges they face during providing them health care?
• Do the floating population/street dwellers revisit the health facility (if needed)?

Domain 3: Policy-Related Information
• What are the existing health policies for floating population/street dwellers?
• Which policy has included policy for this group of people?

Domain 4: Suggestion and Recommendation
• In your opinion, where should the floating population/street dwellers go for health care services?
• What are your suggestions regarding the improvement of health service for floating population/street dwellers?
• Any other suggestion/recommendation?

Thank you for your time!

Leave No One Behind

Exploring the health care seeking behavior of floating population/street dwellers in Dhaka City, Bangladesh: A pilot study

Observation Guidelines

A. Basic Observation topics
1. Location and surrounding areas of the street/open places………… (where is it located………… how the environment is- crowded/quiet place?)
2. Type of people moving around the area…… (Who else are there…… what they are doing……
3. What the floating population/street dwellers are doing
   (taking/working/sleeping/other…………?)?
4. General interactions between people and floating population/street dwellers ………..
5. If the place is there sleeping place (observe there is any roof/no roof)
6. Type of their belongings…………… and where the floating population/street dwellers keep their belongings………………

B. Observation topics for Health facility/Service providers:
7. Location and surrounding areas of the health facility……………….. (Urban primary care centre/NGO/others………………)
8. Type of people visiting the facility (service providers, patients, others……………)
9. Whether any floating population/street dwellers are visiting the health facility………..
   (behaviour between the provider and floating population/street dwellers ………)
10. General interactions between people at health facility (between service providers and patients……………, between different service providers……………, between patients…………….)
11. Basic services of health facilities (e.g. how patients enroll for treatment, where do they wait, how they are called in, where they are sent for diagnostic tests)

Consent Form for KII

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Protocol/Study Title: **Leave No One Behind**

Exploring the health care seeking behavior of floating population/street dwellers in Dhaka City, Bangladesh: A pilot study

**Principal Investigator’s name:** Prof. Syed Masud Ahmed

**Organization:** BRAC, James P Grant School of Public Health, BRAC University

**Purpose of the research**

**Background** (brief introduction of the issue and the need for/ importance of the research)

Hello/Assalamualaikum My name is ______________________ and I work with BRAC JPGSPH, BRAC University at Mohakhali, Dhaka. We are conducting a research to explore the care seeking behavior of floating population/street dwellers in Dhaka city, Bangladesh. At least 30 million marginalized people are living in Bangladesh with diverse categories, cultural identities, races and ethnicities who have historically been prone to exclusion that make them extremely vulnerable. It is vital to explore their current health seeking behavior, type of health care provider they contact and gaps in existing policy regarding their health care to improve their care seeking behavior.

**Why are we inviting you to participate in the study?**
Since you are responsible for providing health care services/ public health system management/leadership, we would like to invite you to participate in the study.

**What is expected from the participants of the research study?**
We will ask questions that explore your views regarding the life style and care seeking behavior among floating population/street dwellers. If you agree, it will take maximum one hour for interview.

**Risk and benefits**
There is no risk from being in the study. We will only collect information. Staying engaged in an interview for one hour may be uncomfortable. However, we do not expect any harm to come to you. While there is no immediate benefit to you for participating in this study, the information you provide will help us better understand conditions in Bangladesh. This information may help to improve conditions in the future.
There is no cost to you for being in this study. You will not receive anything for being in the study.

**Privacy, anonymity and confidentiality**
We will keep all information that we collect strictly confidential. Only persons working on this study will have access. Your name will not be used in reporting the findings.

**Future use of information**
In case of future use of the information collected from the study, we may supply data to other researchers. However, in such case (if any) we will maintain confidentiality, for example, we will remove the identity of the participants so that the investigator does not have a chance to identify anyone.

**Right not to participate and withdraw**
You are free to decide whether or not to be in the study. If you start participating in the study, you can stop at any time. If you decide not to be in the study, you will not lose any benefits.
Principle of compensation
Since the participation is limited up to one hour, we are not considering any compensation for this.

Answering your questions/ Contact persons
If you have any question about this research, you may contact Samiun Nazrin Bente Kamal Tune (Senior Research Associate, BRAC JPGSPH, BRAC University). Her mobile number is 01798315210. If you have questions about your right in the study, you may call Rubaiya Riya Siddiqua, Committee Administrator, at 01910700442. Her office is located at 68, Shaheed Tajuddin Ahmed Sarani, BRAC JPGSPH, BRAC University, icddr,b building, 5th floor, Level-6, Mohakhali, Dhaka 1212

If you agree to our proposal of enrolling you in our study, please indicate that by putting your signature or your left thumb impression at the specified space below.

Thank you for your cooperation.

Name: ____________________________________________

Signature of participant ____________________________ Date ________________________

Signature of the PI or his/her representative _______________ Date ____________________
# Annex 2: Codes and sub-codes used for this study

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<th>Codes</th>
<th>Sub-codes</th>
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<td>• A-priori</td>
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<td>• Living alone or with family in the road</td>
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<td>Living Characteristics</td>
<td>• Experience of living in the street</td>
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<td>• Place of living and living arrangements</td>
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<td>• Scenario of self-care in the road</td>
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<td>• Process of saving extra money</td>
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<td>• Process of keeping savings</td>
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<td>• Source of income and hours of work</td>
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<td>• Common illness faced by the respondents</td>
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<td>• Cost of care (public/private)</td>
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<td>• Experience of using the service (public/private)</td>
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<td>• Preference for the health facility (public/private)</td>
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<td>• Preference of visiting drug shops</td>
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<td>• Responsiveness of the health care providers (public/private)</td>
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<td>• Types of services available for them</td>
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<td>• Common HSB for SRH problems</td>
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<td>• Theft of money and belongings</td>
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<td>Suggestions and recommendations</td>
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<td>• Responsiveness of other staffs (nurse, night guard etc.)</td>
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<td>• Suggestions on responsiveness of healthcare providers</td>
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<td>• Types of recommended services</td>
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Annex 3: Ethical Approval

Date: 04-02-2019

<table>
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<tr>
<th>IRB References No.</th>
<th>2019-001-IR</th>
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<tr>
<th>Project Title:</th>
<th>Exploring the health care seeking behavior of street dwellers/floating population in Dhaka City Corporation area, Bangladesh: A pilot study</th>
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<tr>
<td>Principal Investigator:</td>
<td>Prof. Syed Masud Ahmed</td>
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Thank you for your application, which was considered by the Institutional Review Board (IRB) of the BRAC James P Grant School of Public Health, BRAC University. The following documents were reviewed:

1. Protocol
2. IRB Checklist
3. Consent Forms (Bangla and English)
4. Study tools (Bangla and English)

The Institutional Review Board approves this study from an ethical point of view. The researchers have satisfactorily addressed the concerns raised by the IRB members and the reviewers.

Approval is given for one year. Projects, which have not commenced within one year of original approval, must be re-submitted to the IRB. You must submit project progress and completion report. Serious adverse events or significant changes in connection with this study must be reported immediately to the IRB.

Approval is given on the understanding that the ‘Guidelines for the BRAC JSPGH IRB’ will be adhered to.

Yours sincerely,

Malay Kanti Mridha
Chairperson, Institutional Review Board
BRAC James P Grant School of Public Health
BRAC University
Annex 4: Photographs

Caption: Top Left: floating population/street dwellers are sleeping at High Court Mazar arena; Top Middle: Our Field Data Collector conducting informal group discussion with reproductive-aged women at High court mazar premise. Top right: An elderly man is sleeping in an open place at Sadarghat launch terminal; Middle Left: An elderly woman working nearby the Sadarghat launch terminal; Middle Middle: An informal group discussion with a group of floating/street sex workers at Sadarghat. Middle Right: IDI with an adult male at Kamalapur rail station; Bottom Left: Informal group discussion with elderly women at Kamalapur rail station; Bottom Middle: IDI with a reproductive-aged woman at Sadarghat; Bottom Right: floating population/street dwellers are warming themselves by flame of fire in a winter evening.
Annex 5: Maps drawn by the Field Data Collectors

Map of High Court mazar area showing concentrations of street-dwelling population*

*NB. Similar maps were made for all the study areas