2014:8 Sida Decentralised Evaluation

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Evaluation of the Reality Check Approach in Bangladesh

Final Report

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Abbreviations and Acronyms

ADB	Asian Development Bank
AEU	Aid Effectiveness Unit
APR	Annual Programme Reviews (APR)
CAMPE	Campaign for Popular Education
CHC	Community Health Centre
DAC	Development Assistance Community
DC	Development Cooperation
DFATD	Foreign Affairs, Trade and Development Canada[1]
DFID	Department for International Development, UK
DGFP	Directorate General of Family Planning
DGHS	Director General of Health Services
DP	Development Partners
DPE	Department of Education
ECL	Each Child Learns
EFT	Evaluation Field Team
ELCG	Local Consultative Group
EoS	Embassy of Sweden, Dhaka
ERD	Economic Relations Division
FAO	Food and Agricultural Organisation
FHH	Focus Household in RC Study
FMRP	Financial Management Reform Programme
GEVATG	Gender, Equity, Voice and Accountability Task Group
GIZ	Gesellschaft für Internationale Zusammenarbeit
GoB	Government of Bangladesh
HEU	Health Economics Unit
HH	Household
HHH	Host Household in RC Study
HNPSP	Health, Nutrition and Population Sector Programme
HPNC	Health, Population and Nutrition Consortium

[1] Formerly CIDA (Canadian International Development Agency)

HPNSDP	Health, Population and Nutrition Sector Development Programme
HPSP	Health and Population Sector Programme
HQs	Headquarters
IDS	Institute of Development Studies
JSC	Joint Cooperation Strategy
LCG	Local Consultative Group
M&E	Monitoring and Evaluation
MDG	Millenium Development Goals
MIS	Management Information System
MoHCW	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MOPME	Ministry of Primary and Mass Education
MTR	Mid-Term Review
NGO	Non-Governmental Organisation
PEPD II	Second Primary Education Development Programme
PEPD III	Third Primary Education Development Programme
PLA	Participatory Learning and Action
PNTA	Principles of participation, non-discrimination, transparency and accountability
PRA	Participatory Rural Appraisal
RC	Reality Check Study
RCA	Reality Check Approach
SDC	Swiss Development Cooperation
Sida	Swedish International Development Cooperation Agency
SIPU	Swedish Institute for Public Administration
SWAPs	Sector Wide Approach Programme
TBA	Traditional Birth Attendants
ToR	Terms of Reference
U5	Under Five
UHC	Upazila Health Complexes
UHFWC	Union Health and Family Welfare Centres
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

Preface

In April 2013, the Embassy of Sweden in Dhada, Bangladesh, commisioned an Evaluation of the Reality Check Approach of the in health and education sectors in Bangladesh 2007-2011. Indevelop was contracted to carry out the evaluation under Sida's framework agreement for reviews and evaluations. The purpose of the evaluation is to draw lessons and learn from the five years of the Reality Check Approach in Bangladesh, and from other similar approaches carried out in other contexts.

The draft evaluation report was submitted in December 2013 and the final evaluation report has incorporated comments from Embassy of Sweden and Sida.

The review was carried out by Dr Adam Pain (team leader), Lotta Nycander (evaluator) and Khairul Islam (national consultant). Quality assurance was provided by Ian Christoplos while Anna Liljelund Hedqvist was responsible for the project management throughout the evaluation process.

Executive Summary

The Reality Check (RC) study was commissioned in 2007 by the Embassy of Sweden (EoS) in Dhaka to support its engagement in primary education and health service delivery in Bangladesh. The five year study (2007 to 2011) undertook an annual 4-5 day residence by the study team with the same 27 host households in three localities of Bangladesh with the nine households in each locality being subdivided between rural, peri-urban and urban settings. The fieldworkers observed and listened in on the daily lives of these households. Other households and service providers were also talked to. The study aim was to provide the EoS with the perspectives and experience of people living in poverty on primary education and health access. The findings were to be used to support the EoS in its policy dialogues with government and its development partners. The RC was also seen as a key component in promoting Sweden's rights based approach within the EoS and in its policy influencing. Five annual reports were produced by the study along with a final reflection report. Additional briefing activities were undertaken.

This evaluation has been commissioned to assess the RC and has had two purposes. The first has been to evaluate the results of the RC and the lessons that can be drawn from it. The second has been to draw attention to the lessons that might be learnt from the RC approach in introducing enhanced understanding and the experience of people living in poverty in policy and programme design. Three of the five DAC evaluation criteria - relevance, effectiveness and impact - have been considered.

The RC study has produced plausible, credible and valuable understanding of the experience of people living in poverty and the challenges that they face in accessing health and education public services. The study has been seen to be highly relevant. Its effectiveness and impact have been more mixed, although there are some very positive outcomes. But the lack of systematic documentation of primary data and other information both within the RC study and by the embassy in relation to policy influencing activities points to the absence of a robust information management system for the study. This has limited what the evaluation has been able to assess.

The study has suffered from design flaws in the terms of reference that were not addressed, the lack of attention to gender and a monitoring system in relation to policy influencing being significant gaps. There was also a lack of clarity with respect to how the RC study would help operationalise Sweden's rights based approach.

There have been weaknesses in the reporting. The findings in the annual reports have at times showna tendency towards unwarranted generalisation beyond the evidence. Furthermore, the sources of evidence are at times not clearly specified or contextualised. There are particular concerns in the reporting that what people said is

presented as quotations. More attention to context and longitudinal change would have grounded the evidence and strengthened the use of case studies. In sum the evaluation considers that greater precision in relation to evidence, arguments and claims would have strengthened the reporting.

The evaluation has faced major challenges in attributing actions by the EoS staff to results and findings from the RC study. There is strong evidence of EoS staff commitment to Sweden's human rights principles, but the evaluation does not consider that the RC generated this. The RC certainly generated a constituency of support within the EoS with key individuals commited to it. But this was not institutionalised and strongly divergent views around the RC were not handled and addressed. There certainly was a strong interest in the RC findings by key programme staff but these tended to be valued more for what they confirmed, rather than findings providing new understanding. However the reporting form posed significant challenges to accessing these findings. It remains unclear what the RC study contributed to Sida Stockholm's knowledge and understanding. It is even less evident what RC findings contributed to policy debates but the EoS programme staff are seen to have been influential and respected in policy making circles, particularly in connection with the evolution and development of the government's primary education programme.

In contrast it is also clear that the RC has had an important constituency of support beyond the EoS with many donor staff speaking extremely positively about what the RC had contributed to their understanding. The RC study as an approach has also provided inspiration to other international studies investigating people in poverty's experience of shocks.

The evaluation recommends further development of an RC approach. However, in the future much greater attention needs to be paid to developing a robust information management system linked to a well elaborated monitoring framework for assessing policy influence. There also needs to be a more critical understanding of policy making practices, greater realism about where the possibilities for engagement in the formal policy arena might be and efforst made to find alternative ways of working to influence policy. Finally it has to be recognised that Sweden's principled position on rights represents something of a gold standard. It is not a good guide to practice and learning from the 'good enough' governance agenda which argues for a more incremental approach might be more fruitful. However there may be a more fundamental problem in that the framework of rights and social justice does not fit with the everyday political practices of Bangladesh and the challenge may be less about building demand and accountability and more about solving the collective action challenge that permeates Bangladeshi society.

1 Introduction

The Reality Check (RC) Study was commissioned in 2007 by the Embassy of Sweden (EoS) in Dhaka to support its engagement in the donor consortium established for primary education and health service delivery in Bangladesh. The study ran for five years from 2007 to 2011. The aim of the RC was to provide to the EoS the perspectives of people living in poverty and their demands for and access to education and health. This was to be used to help support the EoS in its policy dialogue with government and its development partners. In addition the RC was seen as a key component of a rights based approach and the principles of participation, non-discrimination, transparency and accountability (PNTA) advocated by Sweden. Although support to the Bangladesh health and education sector wider approach programmes (SWAPs) was a major component of Sweden's aid programme in Bangladesh, Sweden has been financially a minor player within each SWAP. Thus the RCA was seen as an opportunity for the EoS to bring something specific to the various dialogues and thus gain influence to support its principles of operation beyond what its financial contribution might have warranted.

The EoS has commissioned an evaluation of the RC (see Annex 1) and this document presents the evaluation's findings and conclusions. The evaluation has had two purposes. The first was to provide an assessment of the results of the RC, the lessons that could be drawn from its approach and an appraisal of how these might be seen in the light of comparable studies elsewhere. This has included an assessment of any long term intended or unintended effects of the study. This first purpose is anticipated to contribute to EoS's considerations as to whether to continue the RC and if so in what form. The second purpose of the evaluation has been to draw attention to the lessons that might be learnt from the RC approach to a wider audience interested in ways of more effectively introducing enhanced understandings and experience of people living in poverty in policy and programme design. The analysis of the results has been undertaken within the framework of three of the five DAC criteria looking specifically at relevance, effectiveness and impact.

This evaluation report on key findings is structured in six parts including this introduction. Part 2 outlines the context within which the RC has been implemented. Part 3 describes the methods used in this evaluation. In Part 4 the report discusses the findings on the the results of the RC study, reviewing first its terms of reference. The results of the RC can be distinguished at three levels (see Figure 1). First there are the results of the study in terms of its findings; second are the use of these results to contribute new knowledge and understanding to staff at the EoS and Sida Stockholm and third are the use of these results to communicate in policy dialogue processes. These three levels of results are reviewed in the subsections of part 4 which concludes with a final subsection relating the RC to similar initiatives. Part 5 presents the

evaluation's conclusions with respect to the DAC criteria and Part 6 summarises the lessons learnt from the evaluation and its recommendations.

Figure 1: Schematic Results Framework for the Reality Check Study

<table>
<tr><th>Results level 1
Short term</th><th></th><th>Results level 2
Short term</th><th></th><th>Results level 3
Intermediate</th><th></th><th>Outcomes : longer term</th></tr>
<tr><td>RCA Study</td><td></td><td>(a) Learning by EoS Staff</td><td></td><td>(a) Dialogue by EoS Staff</td><td></td><td></td></tr>
<tr><td rowspan="2">- Effective and relevant methods, linked with PNTA, developed and used to 'hear' and represent the views and experiences of the poor in relation to access and use of primary health and education facilities in Bangladesh</td><td rowspan="2">▸</td><td>- New knowledge and understanding gained of the experience of the poor in accessing and using primary health and education facilities
- Strengthening of staff capacity on the deployment of the PNTA concept</td><td rowspan="2">▸</td><td rowspan="2">- Effective communication of the voice of poor people to relevant sector policy making practices</td><td rowspan="2">▸</td><td rowspan="2">Contribution to the strengthening of voice of people living in poverty in Bangladesh</td></tr>
<tr><td>(b) Learning by Sida HQ Staff
- New knowledge and understanding gained of the methods to capture the voice of the poor , linked with the PNTA concept</td></tr>
<tr><td></td><td>▸</td><td>(b) Learning by Sida HQ Staff
- New knowledge and understanding gained of the methods to capture the voice of the poor , linked with the PNTA concept</td><td>▸</td><td>(b) Dialogue by Sida HQ
- Effective communication of the voice of poor people to relevant sector policy making practices</td><td>▸</td><td>Contribution to the strengthening of voice of people living in poverty in Swedish focus countries</td></tr>
</table>

2 The Context of the Reality Check Study

Bangladesh's progress in key social development indicators, particularly in health and education, presents something of an enigma. On the one hand there is evidence of rapid improvements in many of the key indicators related to the Millenium Development Goals (MDGs). There has been a sharp decline in infant and child mortality; gender disparities in access to primary and secondary education have been reduced and there is near universal basic education (see Annexes 4 & 5). But on the other, these changes have happened despite poor governance, low spending on education and health as percent of Gross Domestic Product (GDP), and social inequalities. The changes in the social development indicators have neither been 'income mediated' nor 'support led' [2]. India, for example has much stronger economic indicators (a GNP per capita of US$1770 compared with US$590 of Bangladesh) but a child under five mortality rate of 66 per thousand compared with the 52 per thousand in Bangladesh. The reasons for the rapid improvements in Bangladesh may be more linked to low cost solutions, social mobilisation, improved infrastructure and NGO activity rather than rising income or substantial government investment and governance reforms[3].

Thus although there is a narrative of success with respect to Bangladesh's progress there are also many challenges. Progress has been achieved by bypassing the problems of poor governance and there are continuing issues of poor accountability for delivery, poor utilisation of health services, absent doctors and low education quality amongst others, issues highly relevant to the objectives of the RC. The challenges remain of increasing government level commitment and spending in these sectors and of improving governance.

In the education and health sectors a sector wide approach has evolved since the late 1990s and both sector SWAPs are currently in their third phase. In education the first phase of the Primary Education Development Programme (PEDP 1) 1997 – 2003 was essentially a package of unharmonised projects; the second phase (PEDP II) 2004 – 2010 was more of a sector approach with a trust fund led by the Asian Development Bank and the third phase PEDP III (2011- 2016) is currently under implementation as

[2] Sen, A and Dreze,D (1999) *India: Economic Development and Social Opportunity*. New Delhi, Oxford University Press

[3] Mahmud,W., Asadullah, M.D., and A.Savoia (2013). Bangladesh's Achievements in Social Indicators. Explaining the Puzzle. *Economic and Political Weekly*. Vol XLVIII No 44, 26-28

a programme for the whole primary education sector[4]. For PEDP II which largely covers the RCA implementation period there were 11 donors and Sweden contributed 1.6% of the donor budget with government providing nearly 85% of the total programme budget. In the case of the three phases of the health programme HPSP (1998-2003), HNPSP (2003-2011) and HPNSDP (2011-2016) the HNPSP phase covered the whole period of RC implementation. Several donors, like Sweden, have allocated their funding for HPNSDP through a Trust Fund administered by the World Bank. As with the education sector Sweden has been a relatively minor donor contributing 2.1% of the donor component with the government providing nearly 75% of the overall programme budget.

Thus not only is Sweden a relatively small provider to the overall donor support but the government is the major funder of both programmes. While these are large programmes and the donor contribution in absolute terms is significant, there are nevertheless limits to which financial leverage can provide a point of influence for donors. This is relevant to the discussions on policy influencing. In both sectors there were transitions between the different phases of each sector SWAPs several years after the RC was established. The transition period between PEDP 2 and PEDP 3 was over one and a half years – between the ending of PEDP 2 on June 30th 2011 and the start of PEDP 3 in August 2012. These transition points marked by programme reviews and appraisals potentially offered an opportunity for the RC findings to influence sector policy.

[4] Interview, Programme Staff,EoS

3 Evaluation Methods

The evaluation was undertaken in three phases. The first phase, undertaken by Adam Pain and Lotta Nycander during July and August 2013 reviewed the RC documentation and interviewed key Eureopean based actors in the RC study from the RC team members and Sida Stockholm (see Annex 3a). In Sweden visits by Lotta Nycander were made to Sida Stockholm to interview key staff with a connection to the RC programme (both as advisers within the Embassy and as staff in headquarters who were interacted with. Additional documentation was sought. In addition phone and skype interviews were held with former staff who have either left Sida or who were stationed elsewhere. The interviews largely focused on the questions associated with results level 2 and 3.

In the UK Adam Pain interviewed key RC team international staff and advisers. He also interviewed in Malmö the former Sida staff member responsible for the commissioning of the RC study. Literature on comparative studies on reality checks was searched for and reviewed. This included contact with informants from organisations (Christian Michelsen Institute and Orgut) responsible for the RCA study in Mozambique. The data gathering largely focused on data relevant to results level 1 but also included elements of the other two.

The second phase, undertaken in September by Khairul Islam with an assistant, consisted of field visits to the three RC field locations and sub-sites. Interviews were held with a subset of the host households used in the study and service providers in their localities (see Annex 3b).

The third phase, undertaken by the full team from late October in Dhaka, involved interviews with a wide range of interested parties from the EoS, government officers, donor officials and NGO personel and review of additional documentation (see Annex 3c).

The data on which this evaluation draws comes from both a critical reading of the documentary record of the RC study, interviews with key informants both from the RC team and Sida staff in Stockholm and embassy staff in Dhaka as well as field interviews in Bangladesh with some of the case households and other informants who were the source material for the RC reports. In addition the evaluation has drawn where relevant on academic literature. Inevitably the evaluation has had to be selective in its focus.

4 Findings

4.1 THE TERMS OF REFERENCE OF THE RC

The evaluation team was originally under the impression that there was only one ToR for the RC study which was drawn up in 2007. Since this explicitly stated that it was designed to address only the first two years of the planned 5 years of the study it was puzzling that there seemed to be no ToR to address the subsequent 3 years. The 2007 ToR use the term 'phase' in two distinct ways: the first way talked of 'phase' with respect to two phases of study with the first phase being for years 1-2 and the second phase for the years 3-5. But the 2007 ToR also used term 'phase' as a subdivision of time within years 1-2 with 'phase 1' as an inception period to be followed by a 'phase 2' to cover two implementation cycles for the study in 2007 and 2008. These 2007 ToR are seen to have set the ground rules of the RC study.

However it emerged during the second week of the review that two additional ToRs existed, drawing on the second use of the term 'phase'. The second ToRs, dated October 2008 (30/11/08) are termed 'Bangladesh Reality Check – Phase III, 2009 – 2012. The third ToRs dated November 2009 (12/11/09) are termed 'Bangladesh Reality Check Phase IV, 2010-2012', thus overlapping with the last two years of the second ToR. For the purposes of this discussion we will refer to the 2007 ToRs as ToR_v1, the 2008 tor as ToR_v2 and the 2009 tor as ToR_v3.

The ToR_v1 established the principles of the study, situating it within the context of EoS support to the education and health programmes. They state that it should be seen as exploratory in its focus and longitudinal in its implementation to capture 'change'. Further the intention of the study was to bring an understanding of how people living in poverty access and use health and education services and inform policy debates. Thus the notion of 'reality' can be seen as describing the lived experience of people living in poverty with respect to education and health service provision and the 'check' as taking policy making beyond its normative frameworks based on numbers and service delivery. The RC was to provide evidence of how people living in poverty experience access to and use of these public goods. This was seen to be a way of bringing demand side pressure to the policy table through the EoS, allowing the EoS to bring something unique to the debate and as a way of supporting Sweden in its advocacy of the principles of participation, non-discrimination, transparency and accountabilitiy (PNTA).

However there is lack of clarity in the ToR_v1 with respect to the RC objectives. At times it talks of the purpose of the study as seeking to gain understanding. At others it talks about seeking to represent voice and enhance the influence of people living in poverty. Equally there is reference to learning how a demand side pressure for

services is developed. While these are clearly related dimensions, it is far from clear how such objectives could simultaneously be achieved by the RC. There is also reference to the use of Sweden's principles with respect to PNTA and how these should be emphasised - but how principles can be linked to the practice of representing, enhancing or learning is not elaborated. By definition the RC study given its methods and objectives is a reflection of the PNTA principles[5] but as a study it can hardly be seen as operationalising the practice of PNTA, and ToR_V1 offers no guidance in this respect. The RC annual reports have struggled with how to respond to the PNTA principles since, given the state of governance in Bangladesh, and as the field evidence indicates, the reality is far from Sweden's position of what it should be. A discussion on how PNTA could be operationalised is returned to in Part 6.

What is surprising, given Sweden's stated principles with respect to gender equality and gender as a cross-cutting issues, is that there is no clear demand for a focus on gender within the ToR_V1 (or in ToR_V2 or ToR_V3). This is a significant absence given the gendered dimensions of health and educational access. As discussed in part 4.2.2 the RC annual reports also do not have a systematic focus on gender.

There is also a lack of clarity and underspecification of the detail. The RC was seen as ' part of a capacity building and strengthening of the PNTA concept' (ToR_V1:4) in the EoS but it does not state who will do that and how. It is stated that 'generally the method should be discussed in close cooperation with the Embassy' but how and with whom is not known. It further states that 'significant efforts shall be made to create a strong ownership and participation by Embassy personnel' but the substance of this and the responsibility is not given. It suggests that 'a communication plan on how best to use and disseminate the findings along the way will be developed after the first year, possibly by other consultants' but this vagueness meant that it did not happen. A vision of using the findings from below to support the embassy dialogue 'from above' with development partners and government and 'from within' the respective sector programmes is elaborated. But this is not supported by any critical consideration about the nature of policy making in these sectors or how this will be done and by whom. Nor is thought given to how the nature of the evidence that might be generated from the RC could be used to engage with the evidence frameworks that drive policy making. Finally the aspects of capacity building, ownership and policy influencing have no monitoring or evaluation plan attached to them so a framework for assessment of these dimensions was not in place.

[5] As the ToR 2007:4 essentially says: 'the four principles of participation, non-discrimination, transparency and accountability (PNTA) in relation to primary health care and primary education is the nexus where the reality checks will take place'. ToR_V2 reinforces this stating the PNTA are the backdrop to the exploration.

This lack of clarity not only had implications for the RC study itself but it was also not subsequently addressed. There was not a clear management home for steering the RC as an innovation and managing the challenges that it generated. There clearly were strong drivers for the RC study but these seem to have been more attached to individuals rather than a strong organisational commitment. A constituency of support to take this experiment forward seems not to have been generated and the emergence of strongly divided views on the RC not handled and addressed. It is surprising, not least given the statement in TOR_V1 that reads: 'a second yearly report is expected but content and scope is depending on the possible continuation of the reality check initative that at the end of the first two years', that a mid term review to assess the RC does not appear to have been considered given the view of at least one embassy official that he would have shut down the study if he could have[6].

The ToR_V2 and ToR_V3 read more coherently as terms of reference and identified the position of a focal person for the RC within the EoS. There is no reference in either of these ToRs to ownership or capacity building within the embassy. The main objectives remain the same as those of ToR_V1 but there are two additional ones: the first concerning the role of the RC in identifying issues that might need further study and the second the role of the Reference Groups in supporting and reviewing the RC. A responsibility is put on the consultants for being informed about the progress and difficulties of the sector programmes and to make reference to 'other relevant studies' (ToR_V2:6) in the annual report. As with the ToR_V1 the annual report had a stipulated length of 30 pages. Further ToR_V2 notes that given the transition from Phase II to Phase III in both of the sector programmes in 2010, the 2010 RC annual report should specifically highlight issues to be considered in its design. The ToR_V3 identifies the consultant as having responsibility for an annual communication/ dissemination plan for Bangladesh and an international audience in collaboration with the Embassy but this is not included in ToR_V2. Finally reference is made to the requirement for a Reflection Report in addition to the fifth annual report to be produced in year five.

It is noted that there is no consideration in any of the ToRs to locating the study within a Bangladesh organisation or seeking to build capacity of such an organisation to undertake similar studies in the future.

Finding 1: The lack of clarity and assumptions made in the 2007 ToRs for the RC study with respect to gender and PNTA are likely to have influenced how these aspects were considered in RC reporting. The lack of specification of how the RC study results were to be taken up and engaged with are likely to have had a

[6] Interview former Embassy Official, Sida, Stockholm

detrimental effect on the extent to which (a) the RC study could be drawn on systematically within the Embassy and (b) how the Embassy was able to draw on the lessons for policy engagement purposes.

4.2 THE RC STUDY

4.2.1 Procurement, Design, Methods and Implementation

The team for the RC study was hand selected by the lead Embassy officer for the study and the Socio-Cultural Adviser in Sida Stockholm. Initial suggestions on the design and approach were done in consultation with the leader of the prospective team and a company, Opto International AB, identified to receive the contract and undertake the study. Two external academic advisers, one connected to Opto and the other with a background in Bangladesh were identified. The team was recruited through a single resource procurement. In 2007 Opto International AB was taken over by GRM International which held the contract until the end of the study.

The ToR_V1 identified the broad design of the study stating that it should be carried out in three different geographical locations in Bangladesh with three contrasting sites (urban, peri-urban and rural) per location. It also required that each site had a specific focus around a PEDPII public school and a HNPSP public health clinic. It stated that the study would be carried out on an annual basis with field visits of 5-6 days for each locality. The locations were selected on the basis of capturing diverse conditions in the country but were anonymised as North, South and Central as part of the principles of confidentiality of the study.

The inception report for the study (Opto, 2007) developed this framework proposing that three host households per site (nine per locality and thus 27 host households or HHH in total), would be tracked over time with an additional 3-5 focal households (FHH) living near each HHH who would be engaged with for secondary but in-depth discussions. In addition as the study proceeded service providers in health and education, formal and informal were also talked with. The households were selected on a purposive basis from amongst the poorest households of the community. These were identified based on discussions with local people, observation and key informants although the methods varied between the teams[7].

As purposively selected case studies, the 29 HHH were not intended to be representative or as a means of learning about a wide population of case studies. Rather the approach drew from a different theoretical position to case study data and

[7] David Lewis with the Reality Check Team. (2012). Reality Check Reflection Report, Stockholm, Sida:14

evidence in order to explore context, context processes and norms[8] and to work from the field upwards. Efforts were made to include households with children and also to incorporate minority households and those with disabilities. Thus the evidence can only speak for these case studies and a different selection might have generated different findings. This is simply an observation and not a judgment and does not, in the view of the evaluation, in principle weaken the evidence base from these case studies. Key issues were also raised with the FHH were to see if findings from the HHH corresponded with the views or experience of other households.

The methods[9] combined a number of dimensions. At the centre was an approach whereby the researcher lived with the HHH, returning to the same household each year observing and holding conversations with the various members of the household. Each year a simple checklist of issues was used, identified in a pre-field workshop and informed by issues raised by the Dhaka Reference Group to focus the conversations. The study drew broadly and flexibly on a range of participatory learning and action (PLA) techniques.

A range of documentation practices were used. These included taking notes in a field note book but in principle done in private at a later stage in the day. Photos, drawing and video clips were also used. On the completion of visits at each site the three team members, one of whom was the team leader, would meet to synthesise the findings into a field report for the site. These would be combined with reports from the other two sites from the locality into a set of formal field notes, that are available. These field notes provided the basis for debriefing for each locality field team by the RC team leader and the basis for cross locality field team discussions. These discussions provided the material for the annual report written by the team leader. This was received in draft form by the Embassy, commented on and revised.

Before each year's field study there would be a meeting with a Dhaka reference group, convened by the EoS for each sector. The reference group drew its membership from government, donor and other relevant organisations. This helped identify key issues within the sector to be focused on. In addition the RC team convened its own meetings with specific actors to seek guidance on key issues. Following the annual study there would then be a debriefing with the reference groups highlighting findings before the annual report was drafted, commented on and

[8] This draws on what has been termed the Manchester School Approach to Case Study data, see http://www.methods.manchester.ac.uk/methods/casestudymethod/index.shtml , accessed 01/02/2014

[9] A description of the methods is to be found in Sida and Opto International AB,(2007). Bangladesh Reality Check: A Listening Study: Realities of people living in poverty concerning healthcare and primary education. Initial Report. Dhaka, Embassy of Sweden; and in more summarised form in Lewis et al, 2012.

finalised. Comments on the annual report draft were provided by EoS staff and a Sida Stockholm reference group for the study.

A range of dissemination activities were carried out around the field findings and release of the annual report, and in addition it is evident that the RC team also provided informal briefings to interested parties. A full record of all the dissemination meetings, formal and informal does not appear to have been kept, but it is evident that during the middle period of the study exhibitions and events linked to the RC were organised. After the completion of the final round of field studies and release of the fifth annual report, a reflection report was also produced by the RC team, led by one of the external advisers that reflected on the lessons learnt from the study, the findings and challenges of the approach. Dissemination activities were held on the final annual report and reflection report in separate events during one week in 2012 with Embassy Staff, Civil Society, and Health Consortium members and Health Government Officials. However meetings could not be held with the education sector because of other commitments in this sector.

4.2.2 Ethical Issues

The RC inception report makes very clear, and it was a practice that was adhered to throughout the five years, that the exact locations of the three study sites and the identity of the households were to be kept anonymous as a core principle of the study. This principle of confidentiality is consistent with established ethical research guidelines[10] and the evaluation fully supports this. There clearly were individuals who were frustrated by not knowing where the study sites were and were inclined to dismiss the findings on that account, in part it would appear linked to issues as to whether the sites were representative or not; but this reflects a lack of understanding of the case study approach. It was also made clear[11] in establishing the relationship with the households that no material benefits would accrue from involvement, although (Lewis et al. 2012:42) there clearly were some expectations. But as they put it 'it was not the intention of the RCA to try to change the realities of the lives of people who are poor, but try to understand and document them' although households might well have an interest in how that understanding has been used and with what effects. The issue of the evaluation team interviewing these household was a subject of debate and this is returned to in section 4.2.4. But as discussed in the following section there were also ethical dilemmas intrinsic to the study approach.

[10] See for example the ethical guidelines of the Association of Social Anthropologists of the UK and the Commonwealth (ASA) which talk of the interests of the research participants being paramount. http://www.theasa.org/downloads/ASA%20ethics%20guidelines%202011.pdf

[11] Opto 2007 Bangladesh Initial report; Lewis et al, 2012. Reality Check Reflection Report

4.2.3 Issues of method, evidence, argument and claims.

The evaluation has several observations to make with respect to design, method, evidence, arguments and claims. These comments however are prefaced with the general conclusion that the RC study has produced both plausible and credible understanding of the experience of people living in poverty and the challenges that they face in accessing health and education public services. The evaluation finds that the weight of evidence supports the key findings which are well represented in the RC Reflection report[12] (and see Annex 6 for a selective discussion of these) in relation to education (school drop outs, teacher training and the terminal exam) and health (quality of health facilities, public health and salt intake and traditional birth attendants). Thus the results of the RC at level 1 (see Figure 1) have been achieved, although there are qualifications attached to this conclusion which are now discussed.

Finding 2: the review has found that RC study on the whole has produced both plausible and credible understanding of the experience of people living in poverty and the challenges that they face in accessing health and education public services. This is seen to be of value.

Issues on 'voice' and evidence

There are clearly a range of perspectives on the nature of the RC. For some, including the founding champion of the RC it was not to be seen as research:

> '*Reality Checks are certainly not research, even though the intention to produce relevant and complex data exists, but it is primarily a tool to improve development cooperation*'[13]

For the implementers of the RC it was neither formal monitoring and evaluation nor theoretically driven research. Rather it was seen as occupying a different ground drawing on the ethics of participatory research and some of its methods to achieve effective listening through spending time with people in poverty to capture what they thought. The RC role was seen as providing bottom-up people-centred information to policy makers that was not transformed through theory and complicated analysis.

For policy makers working to particular knowledge frameworks and simplified linear models of cause and effect (embodied in the results based management model), what the RC had to offer fitted neither their normative model of what constitutes evidence nor evidence that was amenable to their policy making practices. One dimension of resistance to what the RC had to offer was the fact that because the evidence generated was seen not to come from a representative sample or sufficient sample

[12] Lewis et al., 2012, pp 21-32

[13] Source: Interview with former Sida staff member.

size it simply carried no weight. This was further compounded by the fact that the evidence was 'qualitative' and therefore easily labelled as anecdotal. In part this was simply a lack of understanding of how case study material and qualitative research more generally can be used or of other theoretically informed approaches to case study data. However the RC failed to establish a strong position with respect to its sources being case study material and of how it could be used. Further in its reporting it laid itself open to criticism in the ways in which it often appears to generalise from case study material[14], a point which will be returned to below. In sum, while the RC may not be research it nevertheless generated 'evidence' and evidence as in a Court of Law has to be argued and justified to be convincing. Evidence can always be interpreted in different ways.

Thus issues of representing 'voice' and what is heard through 'listening' as evidence are methodological challenges that are present in the RC study, both within its practices, its analyses, reporting and in its dissemination. There clearly were unresolved tensions in approach within the team. One deep impression, and this is a judgment that comes from a reading of the documentation, annual reports and interviews, is of a certain almost fundamentalist position about what is being represented in the RC annual reports is an unmediated 'truth' about those living in poverty which is unquestionable[15].

But it was evident in talking to one of the academic advisers to the team who saw value in using anthropological approaches to drive a different sort of policy engagement, that even 'light' anthropological approaches do require a certain attention to theory, concepts and methods. Indeed one of the team leaders subsequently published a paper[16] drawing on empirical material from the RC study pointing to critical issues that needed attention in the approach, ethical concerns over mixed motives and challenges in interpreting responses:

> *These include the combining of ethical and instrumental motivations in the research framework and ambivalent roles and conflicting ethics, highlighted in the conflictual notions of 'giving someone space to talk' and 'making someone talk'.*

[14] In the 4th Annual report (GRM, 2011:26) for example it states 'we noted that people have very little information on where to for various medical conditions'. A more precise statement would state that a given number of informants had commented that they had little information.

[15] One informant from an NGO interviewed in Dhaka commented that she found the style of writing at times confrontational. As she put it there are ways of writing and speaking that can invite support and there are styles that can invite rejection.

[16] Arvidson,M. 2013 Ethics, intimacy and distance in longitudinal qualitative research: Experiences from Reality Check Bangladesh. *Progress in Development Studies*, **13** (4) 279-293

Furthermore, speech and testimony is but one form of communication that cannot be taken at face value[17]. The forms and techniques of talking, the silences and other ways of communication through body language and so forth, make voice and its representation complicated. Voices cannot just be 'heard' and 'quoted' , as the RC reporting had a tendency to do[18], without careful consideration of how and why things are being said and the degree to which what is being said is corroborated by others sources. This critical consideration and a more theoretically informed discussion of how interpretations are being made is missing from the RC reporting.

Finding 3: The evaluation considers that a more critical reflection of method and the representation of voice within the RC would have strengthened the evidence it presents.

Issues of documentation

Thus while the RC may not be research in the sense of being informed by evidence and driven by theory, or even applied research which may take theory as given, the handling and interpretation of evidence and data, requires critical and reflective practices. While it is clear that in the processes of debriefing after field work the academic advisers played a vital and appreciated role in encouraging critical reflection on the evidence base from which interpretations and claims were being drawn, this review has, as will be discussed below, reservations on the extent to which this has been carried through in the annual reports.

At this point it is necessary to lay out the various stages of data collection and analysis and the issues around them. There are essentially four stages:

- Stage 1: The observation, listening and discussion with the informants
- Stage 2: The recording of observations, discussions and quotations in note books. This is the primary data.
- Stage 3: The production of a field report or Field Notes Report by the team based on discussion of the primary data. This is the secondary data
- Stage 4: The production of the annual report based both on the primary and secondary sources.

The only access the evaluation would potentially have to stage 1 is a review of field notebooks and the nature of note taking and recording within them. Any quality assurance around the documentation of observations and conversations would require

[17] Jackson, C (2013). Speech, Gender and Power: Beyond Testimony. *Development and Change* **43** (5) 999-1023.

[18] See for example GRM, 2011, 4th annual report:20/21 'We asked is some of the UHCs should close and were told '*we would not miss them'* and others suggested that the Government should put the failing ones in '*private hand but provide subsidy for the poor'* . Who was doing the telling and were all of them saying the same thing?

an independent observor in stage 1 who recorded what happened and how it was reported. For self evident reasons this was not done but given the fact of nine researchers undertaking independent interviews there are bound to have been differences in observation and recording driven both by language skills, observational powers, predispositions and competences. It is noted here that the field books are not part of the documentary archive and therefore have not been accessible to this evaluation[19]. While the significant challenges of managing information and the need for formalisation of information systems in the RC study has been fully recognised[20] as a lesson to be learnt, the stipulation in ToR_V1 (p5) that 'transparency in the method, the process and the results is essential' has not been met[21]. The earlier comment on finding additional terms of reference during the evaluation, the absence of systematic documentation on policy engagement discussed later in Part 4.4, combined with the absence of a monitoring and evaluation plan noted earlier, in the view of the evaluation leads to a more general finding.

Finding 4: There has been a lack of systematic documentation and archiving of data, sources, records of meetings and other activities in relation to the RC study. This incomplete documentary record limits the extent to which it can be fully evaluated. For what was designed to be an experimental process, this is a significant weakness.

Issues of evidence, argument and claims

The principle of the field work was that notes would not be taken in front of informants or household members and would be written up later[22]. A central issue here then is the extent to which recording after the event is selective, if even only on grounds of interest to the study, and accurate i.e what is heard or seen (and not seen and heard) and how that is reported. Given the centrality of the use of quotes - what people said – in the annual reports – selectivity and accuracy becomes an important issue. Description and recording by definition is selective and with training and experience a suprising amount can be downloaded from memory at the end of the day. However we have no way of assessing the fidelity of reporting at this stage.

We do however have the Field Notes Report for each of the locations (three sites per location. The report on each location is structured by first site and then within each site, context, and then by service sector (health and education). They give details on HHH changes. Sometimes quotes are attributed to specific informants, sometimes to

[19] One of the field notes books used by Dee Judd has been accessed but it is not in a form that allows review.

[20] Lewis et al, 2012: 46-48

[21] It should also be noted that it was reported by the RC team that documentation stored in the Embassy of Sweden during the study was at one stage destroyed.

[22] Interviews of the RC team during the second phase of the evaluation elicited the comment that they sometimes used computers to take notes during the day.

informant type (e.g. HHH or FHH. Sometimes the quotations are unattributed or generalised as coming from both Focal and Host households[23].

The annual reports as noted earlier draw on these field notes reports as well as other discussions and sources of information. Despite a stipulated length of about 30 pages in the terms of reference all of the annual reports greatly exceed this length. The five annual reports are respectively 52, 132, 146, 80, and 72 pages. The Reflection Report of 50 pages (a longer allowance) came close to its specifications with 62 pages. This observation is not a bureaucratic accounting complaint but indicates to the evaluation a lack of attention by the RC to carefully think through what it was trying to communicate and to whom and how this should best be done. Few donor officials or government officers have the time or appetite to absorb reports of this length.

Indeed the challenges of handling the volume of material led to a demand, which most see as unfortunate in retrospect, for recommendations to be included in the report[24]. The RC team tried to resist this demand (rightly in the opinion of the evaluation) but complied. Case study evidence that the RC was working with does not lend itself to generalisable recommendations and seeking recommendations compounded the danger of speaking beyond the evidence, thus lacking credibilty.

The key point that the evaluation wishes to make at this stage concerns issues of evidence, arguments and claims in the annual reports. Whether or not the RC is research, the claims have to be evidenced, evidence has to be shown and arguments have to be robust. The evaluation has concerns about the reporting in these respects.

One issue is that of evidence and where evidence is sourced from. Particularly in the first annual reports it is often not clear where the evidence is drawn from and which particular HHH, FHH or informant, quotations are drawn from. This is improved on in the second and subsequent reports in that the locations and sites (urban, peri-urban and rural) are given but this is not always consistent. In the final report (5th report:18) five quotations are used on one page in the margins – one of which is attributed to a household, one is stated to be a comment frequently heard in all areas and the remaining three are simply sourced in terms of location and site. We do not know who in the household is quoted in the first case (a point returned to below), a frequent

[23] For example the Field Report 2009 for the Central Peri-Urban Site (2) states '**Others** feel that the use of mobile phones is '*unnecessary for the young who are not involved in business. They don't need them for education so they use them for 'criminal activities' and 'romantic liaisons*' (Bolded added)

[24] These were included in the 3rd and 4th Annual reports (Sida Bangladesh, (2010) Reality Check Bangladesh 2009 – Listening to Poor People's Realities about Primary Healthcare and Primary Education, Year 3; Sida Bangladesh, (2011) Reality Check Bangladesh 2010 – Listening to Poor People's Realities about Primary Healthcare and Primary Education, Year 4). The request for recommendations is revealing for what is says about how the purpose and role of the RC was seen within the EoS.

view heard in all areas (by different researchers) cannot credibly be a universal quote and location and site do not tell us who the informant is. This may seem picky but evidence has to be attributed, particularly if it is case study material. A coding system for informants universally applied across the study would have addressed this issue without compromising confidentiality.

A second issue is the degree to which generalisations are made which go well beyond the evidence base. In the first annual report for example, repeated claims are made in the margins about 'people living in poverty say'[25] implying a generalisation well beyond what can be claimed based on the case studies used. In the second annual report this becomes 'highlights heard'[26] but by whom and from where and by definition a highlight is a selection. In the 5th annual report (p18) there are generalisations about what people felt or were worried about. A comment made by programme staff in the EoS to the evaluation team concerned the degree to which claims that were made were justified by the evidence. The evaluation agrees that greater care should have been taken to not generalise beyond the case sources.

A third issue concerns linking evidence to the specific context. Household case studies were drawn not only from different locations but also different sites within a location. Access to education and health are both location and site specific and therefore comments by informants have to be interpreted in the light of the specificity of place and public good availability. Indeed the 2007 ToR_V1 (p.6) specified that each site would have a focus around a PEDPII school and a HNPSP. However the reports do not really use context as an analytical lens relating specific changes at a site level in public good provision to particular demands/ needs or questions of access by specific members of particular households. Generalised description of changes and contrasts are provided both at location and site level (see for example the second annual report) but these are more general descriptive background than analytical probes. In the view of the evaluation this weakens the value that can be made of site specific case households and has reinforced the tendency to generalisation.

A fourth issue is that of time and there are two dimensions to this. The first is that poverty has seasonal dimensions, particularly in rural areas, which may link to health demands. The regular timing of the annual study at a particular time of the year appears to have failed to capture this. The second aspect of time concerns the longitudinal dimensions of the study which was one of its key justifications. Not only are there longitudinal dimensions to the changes in health and education provision, there are longitudinal dimensions in relation to household life cycles and trajectories.

[25] GRM 2008, RCA Annual Report 2007 Year 1:25
[26] GRM 2009 RCA Annual Report 2008 Year 2:25

The annual reports do document overall changes in the economic fortunes of the households in an annex but we do not get a systematic account or story of the intersection between case study household trajectories, health and education needs and demands and service provision.

Finding 5: The evaluation finds that greater care and attention to evidence, arguments and claims would have strengthened the reporting. More attention to context, seasonality and longitudinal change would have further grounded the evidence and strengthened the use of the case studies.

While this is a matter of judgment and approach, the evaluation considers that a different structure to the annual report might have generated a more convincing and accessible document. This could have consisted of an annex in which analytical stories from each case household were presented (so that the evidence sources were clear) with a more focused, selective and thematic overview presented in the main body of the report, with the evidence carefully referenced to its sources.

Both ToR_V2 (p4) and ToR_V3 specify that the RC study should be well engaged with the sector programmes and informed about issues although this is not stated in ToR_V1. Further the ToR_V1 makes it clear that the findings from the RC will be used by the Embassy in dialogue within the consortium. What remains unspecified and unclear is how the process of translation[27] of the findings from the RC to the wider sector programmes (and its knowledge frameworks) would be done and who would do it. Ideally that translation of findings should have been done within the annual reports but the evaluation understands, given that it was not asked for, why this was not done.

Representing the household: issues of gender and age

As section 4.1 noted, addressing gender was not specified as a key objective in the ToRs (in any of the versions). However as the 2nd annual report (p:18) makes clear the team was asked to pay greater attention to age and gender in field work and reporting (as well as sourcing its evidence). As Annex 7 discusses in more detail, from the second annual report onwards there are issues related to gender and youth and relevant case study material. The third annual report has a specific discussion on drop out from school by boys. By the fifth annual report there is scarely any mentioning of gender. The challenges that the old and disabled face are again touched on but not drawn together. The evaluation concludes that although aspects of gender

[27] By translation we mean presenting findings in a way which engages with the understanding and approach of the intended audience; this requires a comprehensive and sympathetic understanding of the methodological and knowledge frameworks within which the audience works and is written in a way that invites attention (see footnote 15 on this point)

was considered, it was not a core analytical focus in the RC reporting. Equally attention to the old and young and their positions in relation to access to health and education has not been systematically addressed.

Finding 6. The evaluation finds that although the RC reports are relatively rich in gender and age specific narratives, a gender and age specific analysis has not been a systematic focus. Part of the reason for this can be attributed to the neglect of gender dimensions in the terms of reference.

4.2.4 The experience of the Host Households

The terms of reference for the evaluation (Annex 1) asked that the evaluation should capture the views of the Host Households on the study by direct interviews. There was reluctance on the part of the evaluation to do this given the principles of the study in the first place but the request was agreed to subject to the voluntary agreement of the Host Households to be interviewed.

The Reflection report[28] offered an assessment of how the host households reflected on the experience over the five years. It reported that a relationship of trust and friendship had been built up over time, although household members had been surprised that the team would want to stay with them and had no expectations of special treatment. However the report suggested that the households were not exactly clear as to the purpose of the exercise or what would necessarily come out of it. But the experience of having an audience which was interested in hearing what they had to say was clearly a positive experience for many.

The assessement made by the review (see Annex 7) confirms the findings of the Reflection Report. Five of the nine sites were visited and out of the potential 15 HHH that could be interviewed, 10 could be located, others having moved. Eight FHH were also found. Most HHHs reported expectations that the RC team would bring some benefits. But they came to realise that they would not. The RC had not affected their lives although they were unclear as to the purpose of the study. However, one family in Central region was motivated to resend their disabled child to school. He is now going to college regularly. Almost all HHH felt uncomfortable initially to host unknown outsiders. They had very few facilities or space to accommodate ‘an educated rich unknown guest’, let alone providing good food to them although the RC team members requested them not do anything extra. However, relations and affinity increased overtime and they had came to value the friendship. There were no indications that they would have wanted the study done in a different way.

[28] Lewis et al, (2012)

Finding the Service providers whom the RC had interacted with was even more difficult as majority of the government and NGO officials had been posted elsewhere. Moreover, the RC Team members, reflecting the methodological approach of the RC, did not advertise the study in their engagement with the community and service providers, and as a result there were many who were unaware of the purpose of the RC. There were a few exceptions like local teachers, village doctors and TBAs who remembered the RC team. Those who did know, regarded the RC as a good method of raising voices of the poor. Some service providers mentioned that they had became more aware about providing quality services when they came to know that somebody was following their activities and performance. This suggests the RC team presence may have had an unintended but positive consequence but this cannot be corroborated. Most of the service providers believe that there has been a positive change in terms of increasing awareness of community about education and health, though the quality of service had not improved much.

Some of the service providers attended a RC workshop and found it interesting as problems of health and primary education (of both service receivers and providers) were discussed. They said that more of such meetings at different levels (Upazila, Union etc.) would have been more useful and effective.

Finding 7: As reported in the RC Reflection Report the focal households while mostly unclear as to the purpose of the study had a very positive view of the study. It appears to have been understood that there would be no personal or community benefits but they valued the friendship and gained from the experience of being listened to.

4.3 INFORMING THE EMBASSY AND SIDA STOCKHOLM

As identified in Figure 1, different results might be anticipated at level 2 for the EoS staff and for Sida Stockholm staff. For the EoS staff 'new knowledge and understanding gained of the experience of the poor in accessing and using primary health and education facilities' and 'strengthening of staff capacity on the deployment of the PNTA concept'. For Sida Stockholm staff 'new knowledge and understanding gained of methods to capture the voice of the poor, linked with the PNTA concept'.

A key objective of the RC as stated in ToR_V1 was to build ownership of the RC within the embassy and contribute to the building of capacity of its programme staff with respect to the PNTA principles. Ownership for the purposes of discussion here is seen in terms of building an appetite and demand for the findings coming out of the RC, the findings contributing to new knowledge and understanding and an appreciation of the ways in which these findings could be deployed in policy engagement. Such a demand and appetite of course would be dependent on the value of the findings from the RC and the ways in which they were presented.

4.3.1 Capacity building in relation to PNTA principles

As noted earlier, although ToR_V1 saw the RC as contributing to capacity building with respect to PNTA , this aim was not based on any obvious assessment of existing capacity of Embassy staff nor a monitoring framework to assess whether it was being achieved, nor what the contribution from the RC would be. Nor was it clear whether this referred to individual, organisational or institutional capacities or a combination of all three dimensions of capacity building[29]. This reference to the capacity building aims of the RC with respect to PNTA are not included in ToR_V2 or V3.
The evaluation is thus unable to assess whether or not there have been any actions in relation to the RC and PNTA to build this capacity. It notes however that it was struck by the obvious commitment of EoS staff to these principles. For example, in the interview with the Education Programme Officer her long standing engagement with problems of access and exclusion of people living in poverty to education was self-evident. While she may not have necessarily specifically expressed it in the terms of PTNA , the commitment has been undoubtedly present. Further as seen by other donors both the education officer and Swedish programme staff are clearly recognised to be coming from strong principled positions on rights, participation, accountabiltiy and transparency. But a clear link between the RC and PNTA and the operationalisation of PNTA remains uncertain and will be returned to in part 6.

Finding 8. There is strong evidence of EoS staff commitment to the principles of the PNTA concept. It is unlikely however that the RC has generated this. The challenge of the operationalising PNTA has not been resolved.

4.3.2 The RC and Ownership by the EoS

It order to explore the questions of ownership it is necessary to trace the RC back to its origins within the EOS. The RC initiative originated with the Social Analyst posted at the EoS between 2005 and 2008. She developed the concept and the methodology in close cooperation with the former Socio-Cultural Adviser at the Policy Unit, Sida Stockholm. The EoS programme staff can recall that they were asked to give comments on the design/preparations of the initial RC ToR and were well aware of it. Indeed the national Education programme officer reported a real interest in it. Equally the former national Health Programme Officer expressed a strong interest in it, but also admitted to finding the working relationship with the Social Analyst challenging. Many of the informants who were in direct contact with the Social Analyst referred to her strong drive in introducing the RC as an innovative project of the EoS.

[29] ECDPM 2008. Capacity Change and Performance: Insights and implications for development cooperation. (Policy Management Brief no 21): Maastricht: ECDPM

A Sida staff (First Secretary posted at the Embassy between 2007 - August 2010) took over the responsibility for the RC. It is clear from interviews with her and with the national programme officers she worked with that she strongly bought into the RC, drew the programme officers into it and so formed a group within the EoS that had a strong commitment to the RC. In this sense there was a demand and interest in the RC. However it was not an Embassy wide enthusiasm and it is clear that other staff within the Embassy had deep reservations about the RC. It would be difficult to argue that there was deep institutional commitment within the Embassy.

The existence of the RC is acknowledged in a limited way in the reporting from the embassy. The country strategy[30] has a footnote to the Reality Checks as an example of qualitative studies to be undertaken by the Embassy in order to 'study selected villages and urban areas to gain information about how the programmes and actions work and how people are affected by them in their daily lives' (translation from Swedish). The RC is briefly mentioned in the Embassy Country Report, 2008. In background documentation for the country strategy MTR[31], the RC is one among nine bulleted points: However in the Promemoria[32] of the MTR report, the RC is not mentioned in sections on Sida´s involvement in health and education sector programmes, or elsewhere.

Finding 9: The evaluation considers that the RC acquired a constituency of support within the EoS but this was confined to individuals rather than institutionalised in the embassy as a whole.

4.3.3 Did the RC generate new knowledge and understanding for the EoS?

The discussion here focusses on content issues in relation to health and education. The wider implications of what the RC study revealed with respect to rights is returned to in part 6.

It is clear from the detailed comments provided by the national education programme officer to the annual reports that she was fully engaged with the issues that the RC was bringing up and could relate them to other sources of evidence. The current health programme officer could also speak to the issues raised by the RC but was perhaps more critical of it as an approach.

As to whether the RC generated any new learning and understanding resulting from the study is unclear and it has not been easy to determine. None of the EoS staff

[30] *Samarbetsstrategi för utvecklingssamarbetet med Bangladesh januari 2008 – december 2012, Sida,* p.8.

[31] Contribution Paper for the MTR (dated 1st February 2010), by Embassy of Sweden, p.6.

[32] *Halvtidsöversyn av Sveriges utvecklingssamarbete med Bangladesh*, dated 10 October, 2010.

posted in Dhaka during the five years who participated in the evaluation interviews pointed directly to new learning, or increased understanding resulting from RC. Rather, many stated ‘we already knew that’or ‘there was nothing new‘ or at best ‘it corroborated what we had suspected‘.

In a few cases staff expressed serious doubts about the correctness of the information brought up by the RC teams or the generalisations being made[33]. For example that report that the HHH had increased their intake of salt over the years and the notion that salt was used other than as a flavour added on fruits generated comments such as ‘we couldn´t believe this‘ and ‘this was not possible‘ in interviews.

Some RC findings created disagreement between the Embassy staff and the RC team. A case in point was the RC team reports on women’s preference for Traditional Birth Attendants (TBAs). This was a problematic matter for the Embassy staff, since it appeared to counter Swedish government policy and they saw no possibility of influencing decisions made earlier by the GoB to promote Skilled Birth Attendants[34]. On the other hand, and as discussed in the reflection report[35], the RC findings on the drop out by boys from school challenged the view that it was simply due to poverty. Rather, the RC argued it reflected more the quality of education, the self-confidence and motivations of boys, and the fact that some children grow ‘too old‘ in their class making them feel uncomfortable and therefore they opt out of class[36]. This finding, and also the findings with respect to the terminal exam found traction both within the EoS and beyond although there were concerns on the evidence base[37].

EoS programme officers however commented on the challenge of analysing and processing the information in the annual reports, and the length of the annual reports certainly contributed to this. Indeed the push, as seen in the 4th annual reports for the RC team to make recommendations from the findings can be seen as reflecting the difficulties that Embassy staff had in finding policy implications and translating these into a form that they could use. There were some who felt that the RC study was rich in policy implications. One Sida official argued[38] that ‘there were loads of policy implications every year from the RC but the information gathered could not be used. We could not package in such a way that the donor consortia could embrace it’.

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[33] See ‘Comments on Draft Reality Check (RD) Report 2011’ from the Education Programme Officer, 22/03/12

[34] Ibid.

[35] Lewis et al, 2012 :p 21-12

[36] Lewis et al, 2012.

[37] See ‘Comments on the Draft Reality Check Bangladesh 2010 report – Primary Education part’ 20/03/11 from the Education Programme Officer

[38] Interview, Sida Official, Stockholm (an active supporter of the RC)

This comment touches on the deeper issue. The findings from the RC study were generated from a specific methodological approach and evidence base. The form of the findings – narrative based, and case study specific – are drawn from a knowledge framework that is clearly different from the knowledge frameworks with which policy making in Bangladesh and elsewhere works with. To leverage the RC findings into a different knowledge framework requires an exercise in translation and a willingness to engage between these different knowledge frameworks. This is no easy task and the resistance of normative policy frameworks to other forms of 'evidence' is well documented[39]. That said and as discussed in Part 4.4, there has clearly been a strong constituency of support for the RC findings in specific circles in Dhaka and case studies can be enormously powerful in inducing change. But neither the RC team or the EoS systematically undertook this task of translation of the RC findings into a form that could readily engage with policy making practices in Dhaka. Whether they were able to, or should have done this, is another issue.

Finding 10: It is difficult to be certain what new knowledge was generated by the RC although some of its finding challenged preconceptions. However the value of the RC in confirming or corroborating other findings was appreciated. Nevertheless the RC Annual report form and structure posed significant challenges to the effective use of the findings.

4.3.4 Learning by Sida Stockholm Staff

The initiation of the RC was closely linked to Sweden´s Policy for Global Development[40] (PGD); namely that people's own perspectives on poverty/ development and their rights should permeate Sida´s work. As part of the effort to institutionalise learning within Sida a Stockholm based reference group was established to engage with the RC study and provide comments on the annual reports.

However, in 2008 Sida´s funding for policy and analysis work ceased and the Policy Unit, the home of the RC was dismantled. The RC was placed under Sida´s Evaluation Unit, although the RC was not designed as an evaluation instrument[41]. While a Sida based reference group continued to exist and commented on the RC annual reports, there is evidence that it was active in drawing lessons from the study.

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[39] See for example Pip Bevan (2007). *Researching wellbeing across the disciplines: some key intellectual problems and ways forward*. In Gough, I and McGregor, J.A (eds) Wellbeing in Developing Countries. From Theory to Research. Cambridge, Cambridge University Press,:283-315

[40] In 2003, the Swedish Policy for Global Development (PGD) was adopted, through which Sweden stated that all policy areas should comply with the goal of an equitable and sustainable global development. To achieve this, poor peoples' perspective on development and a rights perspective should permeate the actions by all actors.

[41] Interview with the former Social-Cultural Adviser, Sida, Stockholm, now working in another unit

Many informants noted the organisational upheavals in Sida from 2008 contributed to a decreasing attention on the RC.

Interviews with Sida Stockholm staff, not all of whom were directly involved in the RC, revealed a range of views about it. A common critique was that the study was not representative of the larger population so generalisations could not be made from the 'small sample' about the rest of the country. There were comments on the perceived inappropriateness of consultants staying with people who live in poverty. Objections were made to the length of the annual reports, the problems of using the information, the costs in relation to the returns. One interviewee commented that 'RC was 'the Bible' at Sida headquarters, as well as immersions - if you criticised it you were completely told off – it was very politically sensitive'.

Others were more positive: 'the RCA is a very important method – as it is essential to identify what people need and want'; 'the RCA can be an excellent tool supplementing quantitative data gathering in evaluations'; The RC consultants did a fantastic job; and 'large organisations in general are not good at listening to ordinary people; therefore RCA was an excellent opportunity.

There is no clear indication that Sida as an organisation has gained new knowledge or understanding about methods to capture voice as a result of the RC implementation in Bangladesh, or that it has strengthened the use of the PNTA concept. On the other hand Sida has acknowledged (see annex 10) and supported RC related studies and activities initiated by Swedish Embassies in other countries and has come to see it as one tool for evaluation that can compliment other conventional evaluation instruments. The Sida Annual Report (2012) for example indicated that RC approach was viewed as a method of gathering qualitative information that should supplement and be linked with quantitative data. However the claims made by Sida on the use of RC findings are not supported by the evidence from the RC study in Bangladesh.

Finding 11: There is some evidence that the RC study has contributed new knowledge and understanding on methods to capture the voice of the poor linked with the PNTA concept to Sida Stockholm. This may have been institutionalised as an approach. There is clearly a constituency of support for it.

4.4 ADVOCACY BY EMBASSY OF SWEDEN STAFF – THE POLICY DIALOGUE

A first point that needs to be made is that no monitoring plan was ever developed to assess processes of change within the Embassy or the effects of advocacy of the findings on policy and what policy effects were sought. Each of the RC annual reports from the 2nd year onwards contains a section reporting on the dissemination activities undertaken and the response to these, although there appears to have been less to report on in the final years of the study. But there has been no systematic documentation and accordingly the documentary evidence on advocacy and the

communication of the voice of poor people to relevant sector policy making is somewhat *ad hoc* and limited.

Further it appears that the idea in preliminary planning discussions with the donor and government SWAP senior managers was that the RC findings would always be seen as indicative. If case study evidence emerged that seemed to be contrary to current thinking, then it would then be used to 'trigger' further more detailed 'research' studies or new indicators included into M&E processes. This apparently did not happen in part because the SWAPs and government did not have the data management systems for doing this but the issue of the reliability of the RC data became more of a focus.

Most of the government staff contacted had no knowledge of the RC. There were some exceptions. One GoB official, a member of the RC Reference Group (education) expressed the view that the reality check study was strikingly different from any other studies previously done in the primary education sector, and that like a mirror it reflected the impact of different policy actions of the government. He said that Sida gave a lot of importance to the study and this helped raise the significance of it to all stakeholders. The study was very informative and he referred to the findings of the study in many of his deliberations as the Joint Program Director of PEDP II. He claimed that it influenced the implementation practice in primary education – for example in the feedback the Ministry received on the Grade 5 Terminal Examination from the RC study. He stated that the following:

- The Government had been surprised to know about the pervasive influence of guidebooks to private tuition in primary education; and
- The introduction of Each Child Learns[42] (ECL) programme was partially influenced by the feedback from the RC studies.

He considered that a reality check-style study could be repeated in primary education sector, e.g. in collaboration with PEDP III, and be designed in such a fashion that the impact of PEDP III could be assessed through the study. He felt that more ownership of the GoB should be ensured by actively involving the field and headquarter level officials of the Ministry of Primary and Mass Education (MOPME) and the Department of Primary Education (DPE) right from the planning stage. A mechanism could be devised so that the yearly findings of the study appeared before the Joint Annual Review Mission of PEDP III and are presented and discussed during the Joint Annual Review Mission[43].

[42] The ECL program requires that children learn inside the classroom through activity based learning.
[43] Reply to written questions in an e-mail.

A high level GOB official influential in the Ministry of Health stated that the Ministry was very interested in qualitative data and information and in the RC studies. But she expressed strong criticism of the reports in that she perceived them to be making claims for the whole country and there were too many negative points in them. A key message was that the next time a reality check study was initiated it should be developed in close cooperation with the Government[44].

Most of the development partners interviewed were well acquainted with the RC and the fact that EoS has been behind the study. Many DPs were aware of the RC reports and were able to recall specific examples brought to light in the RC annual reports, presentations and discussions in workshops, as well as exhibitions and children's art competitions. A significant number of officials in donor agencies expressed strong interest in the RC. Strong and very positive statements about the RC were found in DFID, the Australian Embassy, the Canadian High Commission, SDC and the EU delegation, amongst others. For some, as outsiders and new to the country it was the only source that gave some understanding of the daily experience of those living in poverty and it was valued for that. Even for those who had longer experience of the country the findings of the RC were valued and new insights found.

There is also evidence that some donor agencies have drawn on findings from the RC to use in the development of proposals and an example of this was provided from DFID. There is interest in the World Bank in some of the secondary data on mobile phone access to help design a new initiative in health.

There is also evidence that the RC approach has had influence beyond Bangladesh. In part this has been due to GRM marketing this as an approach but it has also found support through donor agencies. AusAid for example appears to have taken the approach from Bangladesh and applied it in Indonesia. GRM has advocated the approach, established a Reality Check website[45] and won contracts in Nepal which have included reality check dimensions in an assessment of impact of a long term project funded by DFID. It has recently secured contracts for additional studies that include a Reality Check approach. It is also evident as reported in the reflection report (p38), that the approach has drawn a wider interest and been a source of inspiration. Specifically two studies on the effects of the economic crisis in which the Institute of Development Studies, UK have been involved have drawn from the approach.[46]

[44] A discussion with the Joint Secretary, Planning, and two colleagues, Ministry of Health, Dhaka.

[45] http://reality-check-approach.com

[46] See Helberg, Hossain and Reva, (2012). Living Through Crises:How the Food,Fuel and Financial Shocks Affect the Poor. World Bank.; Hossain et at al. (2013). Squeezed. Life in a time of food volatility. First Year Results

But there is a bigger question of the extent and how the EoS has been able to draw on the study for advocacy purposes in policy making. At this point it is necessary to consider the nature of policy making in the two sectors, the debates between donors and engagement with government. While the evaluation team did not have sufficient time to build a full understanding of the policy making environment in health and education a number of observations can be made.

First, formal engagement with government and building rapport is challenging. At the senior level of secretaries and heads of departments or directorates there is a rapid turnover of staff and institutional memory at this level is limited. Second, systematised data collection and monitoring practices within government are not well established and it was widely reported that analytical capacities in relation to this data are limited although they have improved. Third, many of the policy relevant discussions take place in large consortium meetings with multiple partners or in sub-group meetings and therefore direct opportunities to influence are limited.

Fourth, since both education and health have sector wide approaches running on approximately a five year or longer cycle other than at the design and mid term review stage, much of the discussion centres around implementation issues. Even in the education sector, which could be seen to be ahead of the health one in certain respects, much of PEDPII (which operated over the RC period) was concerned with getting on board a results based management system. It reportedly took the donors two years to agree on a set of indicators to be used in this.

These issues alone indicate just how challenging a policy making environment it is to engage with, let alone influence. It also raises questions as to whether or not seeking to leverage RC findings at the national level is necessarily the best place to engage, a point which will be returned to in 4.5.

However it also became clear that the way that policy influencing does work is through informal and well networked connections and it is here that the EoS has had a very significant advantage. It was evident that the EoS, through the Senior Programme Education officer has played a critical role in the evolving education sector programmes. She is seen by most outsiders to have been deeply important both for her understanding of the sector and the influence that she brought to bear in policy discussions. Further her long standing, reputation and informal connections has enabled privelidged access to government that she has been able to draw on. The EoS is not alone in having key national staff that can play a critical role in policy making. Another long term adviser pointed to a number of national staff in other donor embassies as being significant players in the policy debates.

What cannot be disentangled, however, is the capability of EoS programme staff to influence policy in general from specific policy influencing drawing on lessons from the RC, but the latter is likely to depend on the former. Further it is more likely that the results from the RC that were drawn on in policy debates drew from the RC's

substantive findings e.g. the terminal examination, rather than with the less tangible dimensions of accountability, transparency, equity and non-discrimination.

Findings 12: The lack of a communication plan, the absence of a critical analysis of actual policy making practices and the failure to consider how RC findings could be translated to engage with policy debates have been a critical weakness. This has limited the leveraging of the RC findings into policy engagement, although even under the best of conditions it would not have been easy. That said the critical role and effectiveness of EoS national staff with deep institutional history, informal networks and commitment to public service access, has given the EoS an enormous influence and respect in policy making practices, particularly within education. To the extent that they have been able to draw on findings from the RC study, they have been able to deploy them to best effect.

4.5 RELATING THE RCA TO SIMILAR INITIATIVES

A key issue that the review was asked to address was the extent to which lessons could be drawn from other RC like approaches with a similar methodology and objectives. To some extent the discussion in section 4.2.2 on questions of voice, understanding the views and perceptions of the poor and the use of case studies raises some of the methodological issues already. But the evaluation has not been able to critically examine the other RC related studies to explore how these issues have been handled there.

It is certainly the case that other studies under the RC label have been carried out and six specific studies have been or are being undertaken (see Annex 10). Four of these have been undertaken by GRM, a fifth by Orgut and the sixth, commissioned by the Civil Society Support Unit of Sida, has been implemented through SIPU, IDS (UK) and IOS PARC (UK). Three have been funded by Sida (including the Bangladesh study) and the other three by AusAid, DFID and EU. If one takes the Reality Check in the sense of its design and purpose (policy engagement) in Bangladesh and its longitudinal dimensions, then none of the other studies are directly comparable. They are either short term (of the three other GRM studies, two were one year studies and two are 2 year studies), or not designed to specifically engage with policy, or both. The Sida-funded Mozambique RC study is part of a mixed methods study and in that sense not comparable to the Bangladesh RC study. Its qualitative dimensions are rather more classic interview type than a listening study.

For the studies that have drawn inspiration from the RC approach (the IDS studies for example) the approach, as with the Sida funded Mozambique RC has been more part of a mixed methods study where the design has deliberately sought to engage different knowledge frameworks and link qualitative with quantitative data. Again these are not specifically linked to policy engagement. There certainly are lesssons that can be drawn from the Sida funded Mozambique RC study and the IDS studies on linking qualitative with quantitative data and their complementary role. This engagement of different knowledge frameworks suggests how qualitative data can

speak to other data forms which indirectly shows how such data could be made more palatable to policy. But the studies do not address the use of such data for policy influencing.

It was suggested in the terms of reference that other initiatives of interest to be looked at could include a DFID study on how to evaluate empowerment through community engagement in development projects which speaks more to the issues of operationalising PNTA. The review team was specifically pointed to the study commission by DFID in Bangladesh on assessing voice and accountability in the health sector in Bangladesh[47]. While the study made reference to the RC study it also had the following comment on this and similar initiatives: (p23)

> *While these are important initiatives, there is a danger – particularly within the political culture of Bangladesh – that rather than reports and comments being welcomed by the government of the day as constructive contributions to the policy dialogue that they are seen as providing unwelcome ammunition to the opposition or producing negative attitudes among DPs.*

This comment speaks to the political realities of Bangladesh and the challenges of working at a national level with issues of PNTA. The report thus focused more on individual examples of NGOs working at a local scale and suggested that a more local and site specific focus on voice and accountability might yield greater actual dividends for the rights based agenda.

Finding 13: Although there are a number of others studies that have been undertaken under the RC label, and others have drawn from the RC approach, none are strictly comparable in method or objectives to the Bangladesh RC. However a recently commissioned review by DFID on voice and accountability in Bangladesh argues for a more local approach to building demand and accountability in health service provision.

[47] Naylor et al (2013). Assessing Voice and Accountability in Health, Population and Nutrition Sector Development Programme 2011-2016. Dhaka, Department for International Development. The study focussed on mapping current V&A initiatives, including those initiated outside the GoB structures, which build upon the scope of the health sector programme; preparing case studies with analyses of the strengths and limitations of influential V&A initiatives and the circumstances, factors and levers that increase their effectiveness and impact; and identifying feasible and constructive lessons learned and recommendations on V&A of relevance to HPNSDP and to DFID health sector programming in Bangladesh.

5 Evaluative Conclusions

This evaluation has had two main purposes. The first has been to provide an assessment of the results of the RCA, the lessons that might be drawn from this approach and how these might be seen in the light of comparable studies done elsewhere. This assessment is to contribute to consideration by the Embassy of Sweden in Dhaka as to whether to continue the RC and if so in what form.

The second and related purpose has been to draw attention to the lessons that might be learnt from the RC approach to a wider audience interested in ways of more effectively engaging the understandings and experience of poor people in policy and programme design.

The assessment has been undertaken within the frame of three of the five DAC[48] evaluation criteria, looking specifically at relevance, effectiveness and impact. Sustainability is not relevant and efficiency cannot be assessed as comparative data on costs of comparable studies (of which there are few) have not be obtained. We present here the conclusions with respect to the DAC criteria and discuss in part 6 lessons that might be carried forward.

5.1 RELEVANCE

There can be no doubt that the RC has been strongly relevant to Swedish government policy, Swedish sector funding objectives in health and education and to the principles of participation , transparency, accountability and non discrimination. It also seems to have been particularly appropriate to the governance challenges that Bangladesh faces in these two particular sectors.

5.2 EFFECTIVENESS

The picture on effectiveness is more mixed but this is not necessarily directly linked to implementation weaknesses of the RC. There were clearly design flaws in the terms of reference and it is suprising that a mid term review of a 5 year study was not undertaken. This would have provided the opportunity to address these issues. There

[48] Development Assistance Committee (DAC)

were also major issues of personality and institutional ownership leading to polarised views on the RC study. This probably means that as an experiment the programme was not as proactively managed as it should have been to ensure learning. There are certainly issues of implementation and reporting that in retrospect might have been done differently. But the study has contributed findings and understanding that have rightly, in the view of the evaluation, been appreciated. Thus in respect of findings about how people living in poverty have engaged with delivery of primary health and education the results have been achieved.

5.3 IMPACT

The RC has clearly had impact and generated an interest both within and beyond Bangladesh. As an experimental method as this evaluation has argued there is clearly room for improvement, both in ensuring more systematic documentation of the process, giving greater attention to and reporting on the specific sources of evidence and exercising caution in the use of quotations and representing 'voice'. But it has evidently provided a source of inspiration to other studies and that is a significant achievement. It has contributed understanding within Bangladesh which has been drawn on. However the fact that the RC study has been implemented with no engagement to build capacity within a Bangladesh organisation is seen to be a weakness.

The impact on the Embassy of Sweden is less clear and that on policy making even less certain but it is noted that documentation of these processes has been limited. It could have been more effectively managed by the Embassy of Sweden leading to greater dividends if there had been a deeper institutional commitment to it. And, it should be noted, the challenge of operationalising the principles of participation, non-discrimination, transparency and accountability remain.

6 Lessons and Implications

Finally there is a need to consider what lessons might be drawn from the RC exercise if it is to be developed in the future. The RC study could be considered as one component of EoS efforts to support processes of institutional change through the use of evidence and argument: to facilitate a shift from what is seen to be the current position of poor governance to something that is closer to the ideals that Sweden believes in. There are three specific lessons that this report wishes to draw from the RC evaluation relating to what has been learnt from the practice.

First; as an experimental approach greater attention should have been given to the documentation, archiving and information management of both the management record of the experiment as well as the data from the study itself. The RC Reflection Report acknowledges[49] this and there are lessons to be drawn by the EoS as well.

Second; and related to the above, the absence of any monitoring and learning system in relation to the use of evidence coming from the RC study – within the EoS and outside it – has been an acute weakness. This has been a significant design fault of the study. It has prevented a systematic evaluation of the effects of the RC study on the embassy and policy making. The development of such a monitoring system would have forced greater attention to the assumptions being made both about how evidence is drawn on within the embassy and wider policy making practices. The use of outcome mapping would be one way to proceed in the future.

Third; building on a theme that runs through this report and which the previous two points focus on, there are lessons to be drawn on how the embassy / Sida manages innovation. It has to be recognised that the RC study was characterised by clashes over personality, substance and approach and at times these seem to have become inseparable. Both personality clashes and critical debate over method and evidence is normal and to be expected, particularly when new approaches challenge established procedures. The weakness was that these were not institutionally addressed and managed. The evaluation reiterates that it is surprising that there was no mid term review of the RC study that could have addressed some of the design weaknesses and brought about debate about the institutional issues.

[49] Lewis et al, (2012):47 'The need for more clarification and formalisation of information systems is a key lesson that has been learned"

There are also two broader lessons that might be drawn with repect to the aspiration of the RC to contribute to bringing about institutional change.

First; *even if* the RC study had been exemplary in the form and content of the evidence that it delivered and *even if* the embassy had been able to process, absorb and draw fully on this evidence in its policy discussions, would this have influenced policy? There is room for doubt. Policy making is driven by simple narratives that at the best of times struggle to handle complexity. Further the dominant practices around policy making, evident in both the education and health programmes, have a pervasive results based management model, grounded on evidence that can be quantified, with specific assumptions about cause-effect relations, incentives that drive change and what constitutes improved performance[50]. As has been observed with respect to the World Bank study on the voice of the poor[51] , even where there has been a certain openness to what 'the poor have to say' the way in which that has been interpreted and used has been highly selective. As one study notes[52]:

> *The voices are editorialised so as to tune out any discordant sounds and present an overarching narrative that is in perfect harmony with the World Bank's own policies: their 'cries for change' are harnessed to support a particular set of prescriptions.*

Such policy practices offer little opportunity for the perspectives of the RC study to engage. One lesson might be that the evidence generated from a RC type study might need to look elsewhere as well for engagement. This does not mean abandoning policy influencing at this level and one should engage where one can. But a realism about where the possibilities for engagement in the formal policy arena might be limited and might lead to the establishhment of a different set of ground rules and ways of working to influence. This of course would be outside what an international consultancy firm might be able to manage. But working through a more activist organisation or NGO that can operate in a more strategic and opportunistic way would be one way to proceed.

Second; and this brings us to the core challenge of operationalising PNTA principles that has run through this report- while the RC study was not as such about implementing PNTA or about operationalising accountability, nevertheless PNTA

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[50] Rosalind Eyben, (2013) *Uncovering the Politics of 'Evidence'and 'Results'. A Framing Paper for Development Practitioners*. www.bigpushforward.net

[51] D. Narayan, R. Chambers, M. Shah and P. Petesch, (2000) *Crying Out for Change*, Oxford: Oxford University Press/World Bank.

[52] A. Cornwall and M. Fujito, 2012 Ventriloquising the 'poor' ? Of voice, choices and the politics of 'participatory' knowledge production. *Third World Quarterly*, **33**:9, 1751-1765

principles informed its design. As this evaluation sees it, there are basically two challenges that need further thought. The first challenge is that PNTA basically sets a 'gold' standard and is a statement of principle. That is all very well but it is a very poor guide to action. Exactly the same problem has bedevilled the good governance agenda with its assumptions of best practice, its tendencies to institutional monocropping[53] and a view that one can 'skip to Weber'[54] by drawing on the outcomes of development in the west (democracy, good governance etc.) and assuming that these outcomes provide the means by which weak states can be built to ideal states. One response to this challenge has been the argument for developing a 'good enough' governance agenda[55] and recognising that a graduated step wise approach to building participation, non-discrimination, transparency and accountability might be more realistic. This requires an assessment of where things currently stand with respect to the PNTA ideal and identification of what the next steps might be in relation to strengthening these and what these might specifically mean in relation to the health and education sectors.

The second challenge relates to how one might bring about change. The EoS essentially has a twin track approach to the issues of public good provision in health and education. On one hand it is focussing with other development partners on the supply side of governance in the belief that the Bangladesh government aims to deliver education and health provision honestly and effectively. On the other the RC approach to capture and represent the views of households living in poverty presumes a disinterested view on public service delivery and space for building demand. This assumes that Bangladesh's citizens and civil society have an interest, although these may be homogenous, in holding government to account for their performance and 'voice' will strengthen this.

But as the RC reflection report[56] commented 'there are serious difficulties achieving a good 'fit' between …a framework of rights and social justice developed outside donors …and local understandings and realities of these issues in terms of peoples' everyday politics'. Developing this point further, there may be a fundamental problem with the twin track or the supply/demand model that the Embassy works to.

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[53] A term to describe the presumption of developed countries that they have discovered the one best institutional blueprint for development and it should be applied across all cultures and circumstances.

[54] Pritchett, L and M.Woolcock, (2002) 'Solutions when the Solution is the Problem: Arraying the Disarray in Development. Centre for Global Development, Working Paper 10) It refers to efforts to quickly reach service delivery performance goals by simply mimicking the organisational forms of a well-functioning state (while ignoring why and under what circumstances these organisational forms developed the way they did).

[55] Grindle, M. (2007) 'Good Enough Governance Revisited'. *Development Policy Review* **25**(5): 553-574.

[56] Lewis et al, 2012: 28

It assumes that there are actors who are commited in a disinterested way to public good delivery and the challenge is to get the other actors to comply or generate the demand to ensure that this happens. This assumption is based on a conception of the issue being 'a principle-agent' problem[57] and the need to get one group of people to act in the best interests of another rather than their own.

But as Booth suggests the issue is more about both groups of people finding ways to act together in their own interests. In other words it is a collective action problem in which multiple individuals would all benefit from a certain action but the costs and risks of making the transition no one person or party can afford on their own. One need look no further than the failure of the two main political parties to cooperate to realise the deeply entrenched nature of the collective action problem in Bangladesh. This may be an argument for a future RC type study to work much more locally in terms of seeking to influence change rather than at a national level, a position that the Naylor study cited earlier would support. This would require an agency to act as an intermediary between the parties to address the collective action challenge, a role that by definition the EoS could not play. But it would also give recognition to the fact that the issues of rights, transparency and accountability are fundamentally political and not technical and therefore not amenable to managerial approaches.

In conclusion this evaluation, although it has had reservations about specific aspects of the RC implementation, strongly supports the development of an RC-like approach drawing on anthropological case study methods to policy engagement. The evaluation is not in a position to assess the use of RC approaches for other purposes. Much of the RC data evidences the struggles that people have to get the best they can. The approach has the potential to challenge policy makers driven by managerialist approaches to evidence based policy making with the realities of people living in poverty. However a much greater and considered engagement in policy making practices would be required. The scale at which a future RC study would operate, its methods, focus, management will need to be carefully thought through in the design process and carefully monitored. The one recommendation that the evaluation would make is that a future study should be embedded in a national organisation or NGO, if necessary with external support, to facilitate context specific engagement.

[57] David Booth (2012) *Development as a collective action problem: addressing the real challenges of African Governance*. Synthesis report of the Africa Power and Politics Programme. London, Overseas Development Institute.

Annex 1 – Terms of Reference

This is a Terms of Reference for an evaluation of the Reality Checks conducted in the health and education sectors in Bangladesh 2007-2011, commissioned by the Embassy of Sweden in Dhaka.

Introducing the Reality Check Approach
In 2007 the Embassy of Sweden in Dhaka commissioned a five year longitudinal study, *The Reality Check*. The Reality Check (RC) is a bottom-up approach at micro level that aims to provide the Embassy, the Government of Bangladesh and other stakeholders with poor people's own perspectives on primary education and primary health care. This information is intended to serve as a tool that enables the voices of people living in poverty to be heard, and for these to influence policy. A five year time-span was applied in order to track trends and changes over time.

The overall objective of the Reality Check Approach (RCA) is to listen to, try to understand and to convey, poor people's perspectives on development, particularly in relation to the supply and quality of local services within the health and education sectors, and with special focus on the service delivered by the sector programmes in health (HNPSP and HPNSDP[58]) and primary education (PEDPII and PEDPIII[59]).

Sweden has supported the health and primary education sectors since decades in Bangladesh. In 2011 Sweden signed new agreements with Bangladesh for continued support in both these sectors, covering the period 2011-2016. Hence, although primarily a "listening study", the RCA has an evaluative element and aims to answer questions such as: how do the sector programmes improve the lives of people living in poverty?; Do the Ministries live up to the goal of the sectors to provide good health care and basic primary education to the most needed in Bangladesh?

In line with the Strategy for Swedish Development Co-operation with Bangladesh, the RCA seeks to integrate a rights perspective. The RCA should explore to what extent and how people in poverty perceive themselves as rights holders. The four principles (participation, non-discrimination, transparency and accountability) should moreover guide the manner in which the study is carried out.

[58] Health Sector Programmes.
[59] Second and Third Primary Education Development Program.

The methodology used is qualitative with a focus on ´how` and ´why` rather than ´what`, ´when`, and ´how many`. It deliberately tries to explore the range of experiences concerning health and education of people living in poverty. It aims to complement other forms of research by providing valid, up to date, people-centred information.

A team[60] of international and local researchers, consultants and students visit a total of nine locations each year (three locations in each a rural, urban and peri-urban district) located in the south, north and central parts of Bangladesh. Each year the team spends four nights and five days with the same family. They also visit the local community, in particular services related to education and health.

Two reference groups are established as part of the RC, one in Dhaka by the Embassy of Sweden consisting of the government, development partners, civil society and NGO:s and one at Sida Stockholm furnished by relevant Sida colleagues. The reference group in Dhaka aims to provide the team with input on what specific trends or areas to look into during each field visit as well as comments directly after each field visit.

The Embassy also organises dissemination seminars yearly where the results of the annual report are discussed and disseminated.

The RC has (among other things) resulted in five Annual Reports based on the five field visits, and a Reflection Report summarising the RC Team's experiences and lessons learnt.

Purpose, Rationale & Intended Use

The purpose of the evaluation is to draw lessons and learn from the five years of Reality Checks in Bangladesh, as well as from other similar approaches carried out in other contexts. The lessons learnt will directly inform the decision on a possible continuation of a RC-like initiative, i.e. an approach designed to strengthen the voices of people living in poverty within development co-operation in Bangladesh. The primary intended users of the evaluation are the staff at the Swedish Embassy in Dhaka, involved in the deliberations on a possible continuation.

A secondary purpose of the evaluation is to enable the communication of the RC experiences to a wider audience. Individuals and organisations within the development co-operation community, and specifically within Sida, with an interest

[60] The RC has been carried out by GRM International AB.

in further developing methods and approaches to better capture the experiences, views, observations and attitudes of people living in poverty are hence regarded as secondary intended users.

Specific Objective
The evaluation has the objective to ascertain the results of the RCA, and to account for those results. The *relevance* of the RCA should be assessed, as well as it *effectiveness*, i.e. to what extent the approach has achieved its objectives as described in the ToR. The evaluation should also assess any long-term intended or unintended, positive or negative effects (*impact*) of the RCA. The evaluation shall in particular strive to explain both positive and negative (unintended as well as intended) results of the RCA.

In order to generate lessons for future initiatives, experiences from other relevant approaches shall be used to complement the analysis on what has worked and what has not, with regard to the RCA.

The evaluation shall provide conclusions as to how different aspects of the RCA has worked as well as clear recommendations on how elements of the RCA could be developed further in order to better understand the experiences and observations of the poor and use those experiences and observations to influence development policy in Bangladesh.

Evaluation Scope
The evaluation will encompass all five years of the RCA and assess both the process of conducting the RC and its results.

The core of the evaluation consists of assessing the RCA in Bangladesh in relation to the objectives described in the RC Terms of Reference. In order to generate lessons for the future the evaluation will however also assess impact as well as draw on experiences from similar methodological endeavours. Similar methodological endeavours should be understood as studies that have made use of qualitative methods of different kind in order to both understand the voices of the poor better and to use that knowledge to influence development programmes and policy. The Sida initiative in Mozambique and within the Civil Society Unit to apply RC-like approaches should be part of this assessment.

The evaluation shall also strive to voice the experiences of the participating households. Part of the evaluation shall elaborate on how these households, living in poverty, perceive their participation in RCs as well as any prospective results.

Out of the five evaluation criteria, the evaluation shall explicitly assess relevance, effectiveness and impact. The evaluation will not assess the sustainability of the RCA. Cost-efficiency will only be assessed to the extent that something of relevance can be said about the costs of similar initiatives analysed in the evaluation.

Evaluation Questions

The evaluation questions to be answered aim at ascertaining results (as well as unintended effects) and accounting for results. They should moreover probe the lessons learnt from similar initiatives and the experiences of participating the households.

The results of the RCA:

The evaluation shall address questions in relation to all the main objectives of the RC ToR. We would however like to stress three broad categories of questions.

1. Questions on the extent to which the RCA has contributed to a better understanding and knowledge about the perceptions, experiences, observations and demand of people living in poverty.
2. Questions on the use of the RC findings in terms of flagging up issues for further study and in particular influencing policy making in the two concerned sectors. The evaluation shall in particular analyse the process through which the voices of the poor have been transformed into policy recommendations and how those recommendations in turn have been used to actually influence policy making in the two sectors.
3. Questions relating to how a rights perspective (the principles of PTNA) and gender have been integrated into the RCA.

Accounting for RC results:

The second set of questions to be answered aim at explaining ascertained results – both positive and negative. What conditions and factors explain the achievement of (certain) objectives and the (possible) non-achievement of others? All relevant aspects shall be analysed but we would like to stress questions within three broad areas.

1. Questions on how the methodology used has affected the results, both in term of the RC being an effective tool for the voice of the poor and the RC findings being used for different purposes.
2. Questions on how the process of conducting the RC affected the achievement of different objective. This will include probing, among other things, the timing and frequency of the filed visits and reports, the relations between different stakeholders and the structures created to link them, and the definition of roles among stakeholders.
3. Questions on how different aspects of the development co-operation context in Bangladesh affected the results, including aid relations in the two sectors.

Relating the RCA to similar initiatives:
The third set of questions concerns lessons to be drawn from other approaches with a similar methodology and objectives[61]. The questions shall probe experiences on both voicing and understanding the views and perception of people in poverty, as well as means for using those voices to influence policy.

Experiences of the RCs among those living in poverty:
A final set of questions should address how the participating households perceive the RCs. Their expectations, experiences and perception of results from the RCs should be probed.

Approach & Methodology
The detailed methodological approach shall be elaborated during the inception phase of the evaluation. The evaluation must be carried out in accordance with the OECD/DAC Evaluation Quality standards.[62] We would however like to stress a number of points relating methodological rigour. Different techniques for data collection must be used. Interviews with informants/respondents must be complemented with other relevant sources (review of documents, media reports, administrative data, literature etc). The evaluation must cross-validate the information sources and critically assesses the validity and reliability of the data. Criteria for all kinds of selection must be made explicit. There must be an explicit logic where recommendations and lessons learnt build on the conclusions. Conclusions shall be substantiated by findings, which in turn can be understood from the analysis of observations (made explicit).

The methodology used must be described and explained in the evaluation report. Any limitations shall be made explicit and their consequences discussed.

Resources
The evaluation is expected to encompass approximately 70 working days. The evaluation team is expected to make use of qualified local consultant(s) as much as possible to ensure a strong contextual knowledge and to limit (unnecessary) international travel.

[61] Including similar Sida initiatives. Another initiative of interest *could* be the evaluation planned by DFID on "Methods and Approaches for evaluating empowerment through community engagement in development projects. A Synthesis Study and Mapping".

[62] It should be noted that the evaluation will be assessed and approved based on its adherence to the OECD/DAC Evaluation Quality Standards.

The evaluation shall have a strong emphasis on data collection and the use of different sources. The time spent on in-country data collection shall hence not fall short of (but may well exceed) 30 working days.

The Outputs of the Evaluation and the Process Outlined

- Initiation Meeting
- Inception Report[63] - approval by Embassy required for continuation
- Draft Evaluation Report
- Stakeholder/Emerging Findings Workshop – *tbd*
- Second Draft Evaluation Report
- Final Report - to be approved according to the OECD/DAC Evaluation Quality Standards
- Dissemination Seminar in Dhaka
- Dissemination Seminar in Stockholm together with the RC Team

The Final Evaluation Report shall be written in English and be professionally proof read and publishable when handed in to the Embassy of Sweden. The Report shall not exceed 40 pages (excluding the Executive Summaries and annexes). An Executive Summary should be written in both English and Bangla. The Executive Summary will provide an overview of the evaluation and highlight the main findings, conclusions, recommendations and lessons learnt.

Governance and Management of the Evaluation

The Evaluation will be managed by a Management Group led by staff at the Embassy of Sweden in Dhaka. The Management Group will be responsible for all communication with the Evaluation team and formally approve all outputs. A Reference Group will be set up comprising of stakeholders in both Bangladesh and the Sida HQ. The role of the reference group is to offer advice and input to the Management Group.

Evaluation Team: Competencies & Required Experience

The evaluation team should within it possess the following demonstrated qualifications and experiences:

- Experience of complex evaluations – incl. policy evaluation
- Experience of working with or evaluating process of policy influence (advocacy or dialogue)
- Research experience within social sciences.

[63] The Inception Report shall elaborate on and make explicit all aspects of the methodological approach chosen to carry out the evaluation. The Inception Report shall not exceed 20 pages and have a clear work plan attached.

- Experience of working in or analysing the development context in Bangladesh.
- Experience of working with different methods for grass root participation.
- Experience of team leading.
- Fluency in English and in Bangla.

ToR Annex 1: Involved Stakeholders

This should not be seen as an exhaustive list of all relevant stakeholders. It is the responsibility of the evaluation team to ensure that relevant stakeholders are identified.

Government of Bangladesh:
Ministry of Primary & Mass Education (MOPME)
Ministry of Health, Family and Welfare (MOHFW)
District/Local level both sectors (please fill in)

Development Partners of Health Consortium:
AusAID
CIDA
DFID
JICA
EKN
GIZ
WB
ADB
UNFPA
UNDP
Sida

Development Partners of PEDP Consortium:
WB
ADB
AusAid
JICA
DFID
EU
CIDA
UNICEF
Sida

Reference groups:
Dhaka and Stockholm
Civil Society/NGO; UBENIG, CAMPE, ICDDR,B

Embassy of Sweden, Dhaka:

Monica Malakar
Ylva Sorman Nath
Zahirul Islam
Rehana Khan
Karin Rohlin
Tomas Bergenholtz (no longer with Emb)
Helena Thorfinn (no longer with Emb)
Britta Nordstrom (no longer with Emb)

Sida Stockholm:
Esse Nilsson
Brigitte Junker
Göran Paulsson
Anders Molin
Anneka Knutsson

Researchers:
RC Team members

Participants:
Families visited in the nine locations.

Service institutions visited: Schools & Health clinics.

Annex 2A – List of Persons interviewed /consulted in Europe/Dubai (August 2013)

Name	Designation	Unit/Organisation
Esse Nilsson	Senior Policy Adviser, Department for InternationalOrganisations and Policy Support (INTEM)	Sida, Stockholm
Britta Nordström	Medical Doctor	(Independent)
Brigitte Junker	Evaluation Specialist	Sida, Stockholm
Lennart Peck	Evaluator, Monitoring and Evaluation Unit	UTV, Sida
Thomas Bergenholtz	Development Analyst	Sida, Stockholm
GöranPaulsson[64]	Head of Health Team and Social Security	Sida, Stockholm
Samuel Hurtig	Head of Division, Department for Programme Cooperation	Sida,Stockholm
Anders Molin	Senior Advisor, Health	Sida,Stockholm
David Lewis	Professor and Adviser to the RC	London School of Economic, London
Dee Jupp	Team Leader, RC Team	Independent, Norfolk
Mavin Avidson[1]	RC Team Member	Lund, Sweden
Helena Torfinn	Formerly Sida / Embassy of Sweden	Malmo, Sweden
Joost Verwilghen	Regional Manager, GRM	Dubai, UAE

[64]Information received through e-mail and subsequent Skype discussion

Annex 2B – Field interviews, Bangladesh, September 2013

Location	Category of Respondent	Position/Reference
Peri Urban, North		
1.	Host Household	Enamul Huda's(TL) HHH
2.	Focal Household-1 of peri-urban area of North team	Do
3.	Focal HH-2 of Mr. Huda	Do
4.	Host House Hold	Dil Afroj
5.	Focal Household of peri-urban area	Dil Afroj
6.	Focal Household-2 of peri-urban area	Dil Afroj
	Service Providers of North Peri Urban	
7.	Community Health Care Provider (CHCP), Community Clinic	North Team
8.	CHCP, Community Clinic,	Enamul Huda
9.	Physician, Drug House,	North Team
10.	Sub-Assistant Community medical Officer (SACMO), Union Health and Family Welfare Centre, behind FIVDB head office	North Team
11.	Local TBA, Khadim Nagar	Dil Afroj
12.	Teachers, Government Model Primary School	North Team
13.	Project Coordinator, FIVDB,	North Team
14.	Chairman, SMC, Primary school	Enamul Huda
15.	Imam, Madrasha	Enamul Huda
Central Rural		
16.	HHH of Dr. Nasrin Jahan	
17	HHH of Dee Jupp and Arif	
Service Providers of Central Rural		
18.	Teacher Govt. Primary School	
19	TBA	
20	Village Doctor- Health Service Provider	
Central Peri Urban		
21	HHH of Dee Jupp and Arif	Rabiul Hassan Arif
22	Local TBA	Do

23	Head Master of a private School	Do
Central Urban		
24	HHH of Dee Jupp	Do
25	FHH/ HHH of Dee Jupp/ Arif	Do
Service Providers of Central Urban		
26	TBA as well as FHH of Dee Jupp	Do
27	Residential Medical Officer (RMO), Hospital (Govt.),	Do
28	Executive Director of health service providing NGO:	
29	Teacher, i Kindergarten,	Do
Rural South		
30	HHH of Syed Rukanuddin	Syed Rukanuddin
31	HHH of Mr. Kibria	Do
32	HHH of all RC Member	Do
33	FHH-1 of Mr. Kibria	Do
34	FHH-2 of Kibria	Do
35	HHH of Nurjahan	Do
36	FHH of Nurjahan	Do
Service provider of South Rural		
37	UP Member cum Homeopath Doctor	Do
38	Chief of Upazilla Health Complex and Hospital,	Do
39	Head Master of Registered Primary School	Do
40	Volunteers (3) of ommunity Clinic	Do
41	Head Master of Government Primary School:	Do
42	Pharmacist, in front of Hospital	Do

Annex 2C – Evaluation meeting schedule, October 27 – November 10 2013

Oct 27		Agency	
14.00	Karolina Hulterstrom & Nafeesa	EoS	Team
15.00	Fazle Rabanni, Education Adviser,	Dfid	Team
Oct 28			
08.30	Naved Chowdhury, Poverty & Social Protection Adviser	Dfid	Team
14.00	Catherine Chirwa and Anjana Mangalagiri	UNICEF	Team
16.00	M.Emmanuel Haq ,Senior Adviser and Dr Paul Rueckert, Principal Adviser Priority AREA health	GIZ	Team
Oct 29			
11.00	Dr. Mohammad Zahirul Islam, PO, Health	EoS	Team
12.00	Lalita Bhattacharjee, PhD Nutritionist,	FAO	Team
14.00	Ella De Voogd, First Secretary, SRHR;	Netherlands Embassy	Team
Oct 30			
08.30	Franck Rasmussen, PO, Education;	EoS	AP & LN
10.00	James Jennings, Regional Education Adviser,AusAID Laura Savage, Education Specialist, AusAID	Australian High Commission	AP & LN
10.30	Mr. Faizul Kabir, Joint Secretary, Primary Education, PEDP III	GoB	KI
14.00	Karolina Hulterström,First Secretary/Analyst & Karin Rohlin, Head of Development Cooperation	EoS	Team
16.30	Dr. Syed Abu Jafar Md Musa, Director PHC & Line Director, Maternal, Neonatal and Child	GoB	KI
Oct 31			
09.00	Ms. Libuše SOUKUPOVÁ , Second Secretary and Head of Human and Social Development	EU	AP
10.00	Monica Malakar, Senior PO, Embassy of Sweden	EoS	LN & AP
14.00	Tracey Marie Lane, Senior Economist Jacqueline T.F Mahon, Senior Economist, Health Jonathan Rose, Public Sector Specialist	World Bank	AP
15.00	Md. Zahir Uddin Babar, Director (MIS) & LD, MIS-FP DGFP	GoB	KI & LN
Nov 3			

08.45	Monica Malakar, Senior Programme Officer, Education	EoS	AP & LN
9.30	Mr. Md. Asadul Islam, DG, HUE &L, HEF Health Economics Unit	GoB	KI
10.00	Sohel Ibn Ali, Local Governance Advisor SDC	Embassy of Switzerland	LN
14.00	Ylva Sörman Nath, Deputy Head of Dev Coop.	EoS	Team
16.30	Prof. Dr. Abul Kalam Azad, ADG (Planning & Development) & LD	GoB	KI
Nov 4			
10.00	Tehera Jabeen, Senior Development Advisor & Education team,	Canadian High. Comm	AP
11.30	Rehana Khan, PO	EoS	LN & KI
15.00	Khaled Ahsan, WB	EoS	AP & LN
Nov 5			
09.45	Kazuaki Hashimoto, Primary Education Advisor,	JICA	Team
13.00	Rasheda K. Choudhury, ED, CAMPE	CAMPE	Team
14.00	Yumiko Yamakawa, Education Advisor, WB	World Bank	AP
15.00	Dhiraj Nath, Staff Consultant, Urban Health,	ADB	KI
17.30	Rudi Van Dael, Senior Social Sector Specialist,	ADB	AP & LN
Nov 6			
09.00	Peggy Thorpe, First Secretary (Development), Dr Momena Khatun, Health Advisor, PSU, Kiril Iordanov, Foreign Affairs, Trade and Development (Headquarters), Canada.	Candian High. Comm	LN & KI
Nov 7			
10.00	Niru Shamsun Nahar, Joint Secretary (Planning)& Md. Abdul Mannan, former Joint Chief	Health	LN & KI
14.00	Presentation on Preliminary findings to EoS		Team
16.00	Dr M Abdus Sabur, Senior Advisor, Health	UNDP	LN & KI
Nov 10			
10	Briefing for donors and others on RC Findings		Team
24	E mail communication with Mr Chodhury Mufad Ahmed,	former Joint Programme Director PEDP2	AP

Annex 3 - Documentation consulted

Formal Reports (Chronological)

Opto International (2007) Bangladesh Reality Check: A Listening Study. Realities of people living in poverty concerning healthcare and primary education. Initial Report, Sida.

GRM International (2008) Listening to Poor People's Realities about Primary Healthcare and Primary Education. Bangladesh Reality Check Annual Report 2007. Sida.

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David Lewis et al (2012) Reality Check Reflection Report. Sida.

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GRM International (2007) Field Report North Primary Education. Mimeo

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GRM International (2008) Minutes of Meeting at GRM, Stockholm 15th April 2008.

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GRM International (2008) Central Area – Urban. Reality Check Field Notes. Mimeo

GRM International (2008) Bangladesh Reality Check: Listening to Poor People's Realities about Primary Healthcare and Primary Education. Field Notes. North, Central and South

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Comparative Literature

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Other Literature

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Bevan,P (2007). *Researching wellbeing across the disciplines: some key intellectual problems and ways forward*. In Gough, I and McGregor, J.A (eds) Wellbeing in Developing Countries. From Theory to Research. Cambridge, Cambridge University Press,:283-315

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Programme. London, Overseas Development Institute.

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Naylor et al (2013). Assessing Voice and Accountability in Health, Population and Nutrition Sector Development Programme 2011-2016. Dhaka, Department for International Development

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Sen, A and Dreze,D (1999) *India: Economic Development and Social Opportunity*. New Delhi, Oxford University Press

Annex 4 – Background on Education

Bangladesh has an estimated 16.4 million primary school aged children (6 to 10 years). There are 365,925 primary school teachers (approximately 53% of teachers and 23% of head teachers are women), working in more than 82,218 different types of schools including *Madrasahs*). Primary education has been free since 1990 and is compulsory for all children up to Grade 5[65]. More than 500 NGOs operate primary education programmes in non-formal education. They target children from disadvantaged areas or social groups – with the aim of having them admitted into formal schools from grade 3. BRAC has the largest programme with about 740,000 students in schools/centres managed BRAC or by their small partner NGOs[66].

Bangladesh's recent progress in human development is a well-documented and the improvement in educational access is a major achievement. The MDG target of achieving gender parity in primary and secondary enrolment has already been met although the budget share in education in the country is one of the lowest in South Asia. Access to primary education had improved with a raised net enrolment rate from 87.2% in 2005 to 93.9% in 2009 and gender parity[67] has also been achieved. Gender parity challenges are now mainly found to be at tertiary level. More students are completing the entire five-year primary education program. Management committees have been formed in most schools.

Many challenges remain. Many children drop out before completing grade five and many remain out of school. Improvement in the quality of primary education and the need to introduce and ensure access to quality education for all (which was one of the MDG 2015 targets) is not likely to be achieved in the near future. The quality of the teaching-learning process, the school environment and children's learning achievements are thus major issues. Further, the level of student learning is very low in the rural parts of Bangladesh and the primary schools in the country are severely resource constrained; classrooms are overcrowded and double shift operation of

[65] Quality Education in Bangladesh, UNICEF, 2009.

[66] UNICEF, Quality Education in Bangladesh, 2009.

[67] The Gender Parity Index (GPI) – in its simplest form, is the quotient of the number of females by the number of males enrolled in a given stage of education (primary, secondary, etc.) (Education Watch 2009-2010).

classes in order to minimise costs are common[68]. Many teachers are poorly qualified and motivated.

There are major inequities in access to education between different social and ethnic groups of the population and the poor educational performance in certain geographical areas –which have attracted wide attention[69]. Examples are children living in hilly areas inhabited by ethnic minorities, *char* areas, and *haor* areas in the North such as in Sylhet. Sylhet is a low performing division not only in terms of education outcomes, but also in social development in general *despite* the fact the general economic conditions are better than average in the country and despite its rich natural resources[70]. Children with disabilities are particularly vulnerable to exclusion from educational opportunities[71]. Other challenges relate to budget allocations to improve the funding and quality of adolescent and adult literacy programmes.

Policies and programmes

Bangladesh aims to reach the six goals of Education For All[72] (EFA) - meeting the learning needs of all children, youth and adults by 2015. The EFA goals also contribute to the global pursuit of the eight MDGs, particularly MDG 2 (universal primary education) and MDG 3 (gender equality in education) by 2015. The national Education Policy of 2010 (not yet enacted) has ambitious goals, such as increasing teacher posts and increase the duration of primary education from five to eight grades nationwide, while achieving a 1:30 teacher-pupil ratio by 2018[73]. It was reported that primary education will be renamed "basic education" when the Act is in place and will cover grades 1-8, of which grade 7 and 8 will be pre-vocational.

Bangladesh has had three Primary Education Development Programmes. **PEDP I** (1997 - 2003) was comprised of several projects managed and financed separately by eight development partners . **PEDP II** (2004- 2011) was coordinated and integrated as a sub-sector programme within the directorate of primary education (DPE). It

[68] The State of Governance in Bangladesh 2012, Institute of Governance (IGS), November 2013 (Chapter 3.).

[69] Education Watch 2009-10. Exploring Low Performance in Education. The Case of Sylhet Division, Campaign for Popular Education (CAMPE), Bangladesh, April 2011.

[70] Education Watch 2009-10. Exploring Low Performance in Education. The Case of Sylhet Division, Campaign for Popular Education (CAMPE), Bangladesh, April 2011. From the part of civil society, the nation wide network of CAMPE is one of the most influential movements undertaking research and using findings in its advocacy vis-à-vis the government.

[71] Quality Education in Bangladesh, UNICEF 2009.

[72] EFA is a global movement led by UNESCO, which is mandated to lead the movement and coordinate the international efforts. UNESCO produces the annual Education for All Global Monitoring Report. See http://www.unesco.org/en/efareport.

[73] The contact hours (teachers-students) in schools is reportedly among the lowest in the world. One reason is the double shift running of classes in primary schools (source: Embassy).

aimed for quality improvement, institutional capacity building and systemic reform. PEDP II was funded by the government and eleven development partners, and a lead agency assumed the role of coordination.

The current primary education programme, **PEDP III**, (2011 – 2016), aims to increase education access, improve quality, effectiveness and undertake institutional as well as systemic reforms introduced under the previous programme[74]. Its main objective is to establish "an efficient, inclusive and equitable primary education system delivering effective and relevant child-friendly learning to all Bangladesh's children from pre-primary through Grade 5 of primary[75]." The Department of Primary Education (DPE) is implementing the programme under the supervision of the Ministry of Primary and Mass Education (MoPME). The total budget is USD 8.3 billion programme – with 85 percent coming from the revenue budget (Sida´s part of the overall budget is 0.5 percent only).

Coordination among development partners

The donor consortium for PEDP-III (consisting of the WB, ADB, UNICEF, JICA, CIDA, Sida, EU, AUSAID and DFID) aims to communicate with the GoB with one voice and coordinate the external support to the Government (Ministry of Education) [76]. The support provided to the GoB is in the form of loans and grants from seven of the DPs. All the 9 DPs supporting PEDP III - regardless of mode of funding – have agreed to nine Disbursement Linked Indicators (DLIs) i.e. certain conditions have to be met on an annual basis for the disbursement of DLI funding; the other condition/mechanism for the disbursement of DPs funding is the status of the annual performance based on Key Performance Indicators (KPIs - in PEDP 2 and PEDP 3). This is assessed during the joint annual review missions (JARMs) based on ASPRs and many other government reports. Individual DPs have different modes of funding based on these two types of disbursement indicators – some fund only based on DLIs, others fund based on both DLIs and KPIs. The Sida- Swedish funds for example are disbursed based on 50% for DLIs and 50% for KPIs.

The DPs work through programme/project consortiums and ELCG which is a dialogue platform for the discussions with the Government and the other partners. This is one of the sub-groups of the main LCG engaging in, and supporting specific

[74] The Sector-wide Approach in Bangladesh Primary Education: A Critical View Manzoor Ahmed, Research Monograph No. 57, January 2011 Institute of Education and Development, BRAC University.

[75] Second Joint Annual Review Mission (JARM) June 2013 of Third Primary Education Development Program (PEDP3).

[76] The DPs are: ADB, AusAID, BRAC, CIDA, CAMPE , DFID, EU, ILO, Japan, EKN, Sida, Oxfam NovibSave the Children, SDC, World Bank , USAID, UNICEF, UNESCO, WFP and UNDP (http://www.lcgbangladesh.org/education_members.php)

thematic areas of the sector. The Embassy of Sweden/Sida has been an active player supporting the education programmes for many years and is represented in the ELCG where one staff member (Sr. Education Programme Officer) has been a co-chairperson leading the work of the development partners (the chair is the government). The preparation for the MTR of the PEDP III has been initiated and is likely to be completed in April 2014.

Annex 5 – Background on Health

There has been a general improvement in many of the basic health status indicators. The infant mortality rate has fallen from 92 per 1000 live births in 1990/1991 to 39 in 2009, and the target of 31 in 2015 is likely to be achieved. The MDG Goal 4[77] for reduced child mortality (48 per 1000 live births) is also in sight. In 1990/1991 the under-five mortality rate (per 1000 live birth) was 146 and by 2009 had fallen to 50. The maternal mortality ratio (per 100,000 live births) was 574 in 1990/1991 and had fallen to 194 in 2010 and is also on track to meet the MDG Goal 5[78] of 143 in 2015. Life expectancy at birth now stands at 69 and 70 respectively for men and women (WHO[79]).

Bangladesh has made some progress with the number of cases of malaria dropping from 776.9 cases per 100,000 in 2008 to 512.6 in 2010. Considerable progress has been made for MDG 7 in terms of access to safe drinking water and sanitation in urban areas, but major problems remain in rural areas[80] and this has particular implications for the health status of women and girls. Regional differences in health outcomes have in general decreased. Increase in incomes and reduced population growth are major factors leading to these changes.

The utilization of the public health facilities is low in Bangladesh - as urban and rural primary health care services are characterised by poor delivery[81] At Upazila Health Complexes (UHCs), the World Bank has reported that 40% of doctors are regularly absent and at the smaller Union Health and Family Welfare Centres (UHFWCs) the sole doctor is absent 74% of the time.[82] Private clinics have expanded as a consequence, particularly in larger cities. Management Information System (MIS) and Monitoring and Evaluation (M&E) systems are seen to be weak[83] and the health sector is seen to be characterised by poor governance[84].

[77] http://www.undp.org.bd/mdgs/goals/MDG%20Goal4.pdf
[78] http://www.undp.org.bd/mdgs/goals/MDG%20Goal5.pdf
[79] The figures are from 2009. WHO web site updated 2013: http://www.who.int/countries/bgd/en/
[80] Bangladesh MDGs progress report 2011, summarized on the on http://www.undp.org.bd/mdgs.php).
[81] http://www.mohfw.gov.bd.
[82] Absenteeism in Bangladesh Health Facilities, World Bank, 2003, p. 11.
[83] Ibid.
[84] "Moving towards universal health coverage in Bangladesh", Bangladesh Health Watch, 2011.

Some of the recurrent problems discussed among actors working in this sector are the absenteeism of doctors and nurses; uneven distribution of health providers in the different parts of the country and difficulties to fill posts of physicians and nurses in remote areas, e.g. Chittagong Hill Tracts and Barisal district; and shortage of skills among midwives/birth attendants. The increase of (provider driven) Caesarean sections in the private is alarmingly high in come clinics and particularly where there are both Obstetricians and Gynaecologists in one clinic. Another concern is access to health service for people with disabilities.

Policies and programmes

The current National Health Policy in Bangladesh of 2011 is intended to guide the Government of Bangladesh (GoB) to reform the health sector. Stimulating demand and increasing people's access and utilisation of health related services is stated as the priority, to reach the objectives of reduced morbidity, mortality and population growth rate - and improve nutritional status - particularly of women and children[85]. The Ministry of Health and Family Welfare (MoHFW)[86], the Director General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) are currently implementing the third sector-wide health reform programme with a number of other agencies.

The Government of Bangladesh is implementing the **Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011 to 2016**, now running on its third year. The development objective of this sector wide programme is to "improve access to and utilization of essential health, population and nutrition services, particularly by the poor"[87]. GoB has stated that it seeks to create conditions whereby its people have the opportunity to reach and maintain the highest attainable level of health as a fundamental human right and social justice.

The programme that preceded the current one, was the **Health Nutrition and Population Sector Programme (HNPSP) 2005-2010**. In 2008 it was found that progress had been made in extending high coverage of main interventions for reducing under five (U5) mortality had continued, and some improvements had been made in maternal health. The total fertility rate had continued to come down, although the overall contraceptive prevalence rate had not increased. Regarding malnutrition, Bangladesh has continued to achieve good progress in reducing stunting viewed as the best indicator of chronic malnutrition, and the main cause of long-term damage.

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[85] A new National Population Policy was also made final recently, in 2012 (http://www.mohfw.gov.bd).

[86] The Strategy for the Ministry as such is in *Bangla*, not yet disseminated in English.

[87] Program Implementation Plan, Volume – I July 2011. HPNSDP Health, Population and Nutrition Sector Development Program (2011-2016). Planning Wing Ministry of Health and Family Welfare Government of the People's Republic of Bangladesh.

However, it was found that there had been no improvement in the low utilisation of curative health services, especially by the poor. Utilisation is strongly associated with the availability of drugs, but provision for drugs at lower levels of the system has long been insufficient and even in decline. Low utilisation also reflects lack of staff (especially in the more remote facilities), and absence of basic equipment. Further, it as confirmed that the geographical allocation of MOHFW spending continues to be biased against the poorest districts. The only significant progress has been the scaling up of the maternal voucher scheme, but the contracting of non-public providers and decentralisation has not advanced[88].

The first health programme, **HNP, was implemented in the period 1998-2003** being the first and largest health sector wide programme in South Asia.

Coordination among development partners

Coordination between the GoB and Development Partners (DPs) increased over the years. There are three coordination mechanisms between GoB and DPs; i) the Local Consultative Group (LCG) Plenary, ii) the Aid Effectiveness Unit (AEU) in Economic Relations Division (ERD); and iii) Ministry of Finance, as well as 18 Local Consultative Group (LCG) Working Groups[89] of which health and education each have their own LCG.

Annual Programme Reviews (APR) are held each year during the period September – October (the financial cycle is July to June)[90]. Following the APR in November each year, policy dialogue and planning takes place and analytical work and studies lead up to the Mid-Term Reviews, which are held in March/April every year[91].

In 2010 GoB and 18 Development Partners signed a Joint Cooperation Strategy (JCS) to institutionalise a mechanism for mutual accountability between the GOB and DPs and to measure the progress towards improved aid effectiveness. The Health, Population and Nutrition (HPNC) Consortium[92] was formed and has been operating

[88] Annual Programme Review, Volume I Main consolidated report. Key Findings, Conclusions and Recommendations by the Independent Review Team (IRT), 10th May 2009.

[89] http://www.lcgbangladesh.org/LCG_Mechanism.php.

[90] The APR October 2013 was almost completed at the time of the evaluation team's visit and the report was to be presented in November.

[91] Health Annual Performance Review 2013, Speech by Peggy Thorpe (DFATD - Canada), Co-Chair Local Consultative Group on Health 30 October 2013.

[92] This follows the Paris Declaration on Aid Effectiveness of 2005. The assistance from the development partners over the last decade has been in the range of 30% to 40% of the health, nutrition and population sector expenditure.

as the working group of the Local Consultative Group (LCG) for Health, which is the main platform for GoB – DP dialogue[93].

Among the roles of the Consortium is to promote policy dialogue with the GoB in identifying priority issues and building consensus among DPs. It should advocate for and facilitating resource allocation to the sector and coordinate inputs of the DPs with those of GoB, civil society organisations and other actors in the sector.

Since 1998, it has been the main working group for the Development Partners' coordination within the framework of the Sector Wide Approach in the health sector[94]. The Consortium meets almost every month and brings together twenty-one DPs (bi-lateral and multi-lateral agencies, and development banks). It aims to have a single pool of funds, a joint strategy vis-à-vis the government and a continuous dialogue with the MoHFW regarding health, nutrition and population issues – and has a common results monitoring framework.

The LCG (Health) is chaired by the GoB and currently co-chaired by the First Secretary, Health of DFATD, Canada, one of the DPs to the HPNSDP. The role of the co-chair representing the DPs should be that of an impartial broker. It is the **main platform for dialogue between DPs and GOB on improved aid effectiveness in the sector** - while the Consortium as such is seen as the forum for the DPs to *prepare themselves for the dialogue* at the working group and higher levels.

The LCG (donors and government) meets every 2 months. Under the LCG, there are many task groups working with many different themes. The Gender equality voice and accountability Task Group (GEVATG) is one of these groups, chaired by the Director General, Health Economics Unit (HEU) from the side of the Government and the First Secretary, Health, Embassy of Sweden, representing the DPs as co-chair[95].

[93] Terms of Reference for LCG Working Groups.
[94] Terms of Reference HPNSDP Consortium Bangladesh, 2011.
[95] http://www.heu.gov.bd/index.php/gender-equity/geva-task-group.html

Annex 6 – Observations and responses to two RC findings

Below is an account of two issues that caused controversy among Embassy staff as well as among government staff and were items often mentioned in discussions and interviews about Sida´s support in the area of health.

Enhanced salt intake

By year three, the RC team found that there was a serious gap in public provision in the form of any subsidized treatment for non-communicable diseases such as high blood pressure, cancers, diabetes and stress. The medical establishment tended to regard these as affecting only 'better-off' people (not people living in poverty)[96].

The issue of (perceived) increased salt intake in the study areas was first brought up in the annual RC report published in 2011, as a matter that could have a policy implication in the area of health. RC team members had observed that host households had increasing levels of salt consumption with food (p. 9) ("the food we are eating with our families has been getting saltier over the years"). The example of large quantities of salt being added to the water in which rice is boiled was referred to, and the comment added that this is not a conventional practice in Bangladesh. RC team members had also been observed that a tablespoonful of salt was placed on the side of the each person's dish whenever food was served and that the vegetables and curry were very salty. It was narrated that the five-year old girl would complain if her mother did not put a large mound of salt on her plate when she was eating (an example from the central peri-urban study area).

The salt intake observation became part of the message that there was an **urgent need for targeted public health messages to address the many new lifestyle** issues - among them "increased snacking among children and enhanced salt intake". It was believed that there could be a link between the changing pattern of salt consumption and the incidence of hypertension and related high blood pressure problems that also had been observed. The team had their observation/reflection confirmed by MD (Researcher) who stated that he also was aware that salt consumption has increased alarmingly. There are various theories about the reasons for the salt intake in the report, such as people being influenced by the promotion of iodised salt and/or the desire to flavour the rice (p. 57). It is also mentioned that the declining affordability

[96] Reflection report, David Lewis.

of good quality food – may have led people to add more salt to accompany prepared food (p. 114). There were differing views expressed by DPs in interviews by the evaluation on the salt story:

Differing views from the DPs interviewed on the salt issue

- A few persons consdiered that this was about the only new or interesting information from the RC studies and that all other information was either already well known, or could in fact have been gotten from making "field visits".
- Others stated that the description of the way salt had been consumed was not credible – as this is not the way Bangladeshis use salt in connection with food (fresh fruits could be dipped in salt but not otherwise used..) and the sample size was too small.
- Some indicated that a study should be undertaken to check the salt-intake issue, as it could have implications for health status, e.g. for artery diseases but "who would undertake such a study and how would it be done?"
- A development partner to the HPNSDP consortium, a Nutritionist whose work relates to food security said that the excess salt intake might "have been a mistake" and that "it was very odd". She had asked the RC team which district it was found – but she did not get any reply. There had been a plan to make some studies in the field regarding this issue but this had not materialised. (She also expressed doubts regarding RC´s reporting that people consume very small fishes, which, she said, was "not realistic")

Women's preference to use services of the Traditional Birth Attendants

Another issue that caused discussions and raised eye-brows in Dhaka was the findings made in the study areas regarding Traditional Birth Attendants[97] (TBAs) and the preference among women to use their services during delivery and that these should receive further skills training.

It was reported that TBAs are well known in the local communities and greatly trusted. They also preferred home births and generally distrusted the impersonal care offered in hospitals. The RC study interpreted the policy reforms within health reforms as being designed to displace community-based TBAs with a new cadre of "skilled birth attendants" who would provide better care against a fee. It also reported that people in the study areas were less positive about the skilled birth attendants as they were less known by people in the local communities and were seen sometimes to place commercial considerations above social considerations in their work[98].

[97] A TBA is a midwife, also known as '*Dhatri*' or '*dai*' or '*dai ma'*.

[98] Reflection report, David Lewis, p. 27.

The RC documented what they had found, namely that that a number of factors made women choose the (free) services of the TBA, such as them seeming confident, often taking on the role of being spokesperson for others; obvious affection and respect for these women in the community and among the host households. The report quotes one woman who had said: The *dai ma* is a reliable friend. As long as there are poor people there will be *dai mas*' (South rural). Another remarked: "Seeking assistance from the *dai ma* – it saves money and it helps to keep the tension away. I trusted she could do a good job" (p. 61).

Another observation in the report in favour of the TBAs was that they increasingly used mobile phones, which greatly had improved their accessibility and effectiveness and enables other local health providers to make referrals (p.8).

The RC team also reported the observation that the TBAs often were subjected to systematic reputational smearing by the spreading of rumours by other medical staff, speaking disparagingly about their competence (p. 9 and p. 111). Their discussions with the SBAs, on the other hand, led the RC team to report that they had good training - but they were nervous about their limited practical experience. The RC teams learnt that SBAs had come to the TBAs for advice and assistance at births. One TBA in the Central urban area is routinely requested to take trainee SBAs out for practical experience in the slum areas, as she was very concerned by the lack of direct experience the SBAs get before being allowed to practice (p. 62). There were varying positions presented in the evaluation issues on the TBAs isse in Stockholm and Dhaka:

Different views on the TBA issue

- The Government´s policy to train and recruit SBAs is necessary (as TBAs are illiterate and cannot be further trained) but TBAs and literate Skilled Birth Attendants should work together, in pairs, in providing maternal care (former Senior Government Official, Health Ministry, Dhaka).
- TBAs could become more qualified/skilled through training, and they could be provided with tools as they have very valuable experience and are known by local people (Sida Official, Stockholm);
- The issue of TBAs was problematic. There was no possibility of trying to influence decisions made earlier by the government and the World Bank to abandon TBAs. The issue was over and done with in Bangladesh – and no use bringing it up to discussion (former Sida Official).

Annex 7 – How did the RC approach address gender issues?

The ToRs for this evaluation only mentions gender issues (p. 4., point 3) as one of the three broad categories of questions and grouped together with rights issues: "Questions relating to how a rights perspective (the principles of PTNA) and gender have been integrated into the RCA". The evaluation team has attempted to assess the extent to which the RCA collected and presented gender disaggregated information and how they integrated perspectives from women, men, girls and boys in all its endeavours.

What direction did the ToR give the RC study teams regarding gender issues?
The ToR (V1) mentions in one sentence that the rights perspective of Sida includes democracy, good governance and human rights, with gender equality and the rights of the child as key areas (p. 1) – but there is no direction to the consultants about what Sida actually wanted to know in relation to gender, leaving it to the discretion of the consultants. In the subsequent ToRs (V2 and V3) the term gender, which was mentioned in a general statement in the first ToR, is missing.

How were gender issues addressed in the RCA study reports?
The evaluation team has attempted to assess how gender issues were addressed and/or mainstreamed and documented by the RC teams from the start of its field studies in 2007 to its end in 2011-2012:

In a preparatory document[99] from 2007, the RC consultants state that the "RC will document the voices, opinions and experiences of poor people in relation to provision of services within the health and education sectors" and the "focus will be on understanding the basis for poor people's choice of service provider". Gender as a concept is absent and is mentioned only once referring to the need for the study to "explore gender relations in schools, and the recent growth of women-only madrasas".

In the first year the study team states that there will be a mix of gender, age, occupations of the persons to be approached in the villages[100]. A small booklet was

[99] Basic Approach and Methods for the Bangladesh 'Reality Check' 23 March 2007 (draft).

[100] Bangladesh Reality Check A Listening Study. Realities of people living in poverty concerning healthcare and primary education, Initial Report, Final version, September 2007.

published in 2008 (summarising the findings of 2007). This aimed at providing a snapshot of what the study team observed and encountered during their stay in nine different villages. It is here stated that the booklet is an attempt to compile poor people's stories about their experiences of primary education and healthcare and that voices of elderly, young, people with disabilities and minorities will be included, but no reference is found to gender specific preferences, needs, roles or views of boys/men versus girls/women in the text[101].

In the second year the study team started registering and documenting what they observe about gender division of roles and disparities in the villages – but did not bring their observations to any conclusion. There are numerous gender-specific references and detailed narratives on what the teams have observed and picked up through discussions about e.g. boys and girls e.g. the higher drop-out rates of boys compared to girls and the perceived reasons (a theme which is recurrent in the report)[102].

In the third year, the term gender appears only once in the 113 pages annual report[103]. The RCA now aims to connect its findings to the broader framework linked to one of the four principles PNTA[104], namely non-discrimination. Here the example on gender, in relation to *discrimination*, is the observations made that boys are "excluded by the system", as they increasingly drop out from schools. The report indicates, among other factors, that this situation has made worse by the positive discrimination implemented by pre-schools which promotes enrolment of twice as many girls as boys and female stipend programme at secondary level (Report 2008, published 2009, page 9).

Among the RC findings related to the dropout issue, and which are gender-specific are[105]:

- Boys opt out of school despite their parents wish for them to be educated, particularly where job prospects are limited or where there are good job prospects, which do not require education;
- Boys prefer recreational activities and pick up casual work to fund these;
- Boys feel outshone by girls and their experience of school is often poor; and

[101] A Summary Bangladesh Reality Check, Annual Report 2007 (GRM International, April 2008. This small reader-friendly booklet with photographs.)

[102] Bangladesh Reality Check 2008. A Listening Study. Realities of people living in poverty concerning healthcare and primary education (GRM, 2009).

[103] Page 111, Bangladesh Reality Check 2009. A Listening Study. Realities of people living in poverty concerning healthcare and primary education (Sida, published 2010).

[104] PNTA (Participation, Non-discrimination, Transparency and Accountability), underpinning Sida´s development policy of poor people´s perspectives and the rights perspective.

[105] RC report 2008, published 2009, page 11.

- Some children (in North study area) are taken out of school for economic reasons; but it is also noted that reasons for the high dropouts among boys often are not directly due to low income/economic status of the families.

The RC team links the situation to the policies that have favoured girls' education in order to redress longstanding gender discrimination and that attention needs to be given to meet the needs of boys. However gender concerns have not just been through the lens of gender equality and non-discrimination. The annual reports and field reports are rich in details regarding the gender division of labour within households and in the community as well as preferences, needs and ideas by boys, girls and adolescents – observed and recorded by the RC teams. However issues of gender inequalities and how they might affect access to education and health are not a point of analysis.

The annual report clarifies that the aim of the RC is to suggest issues from the findings that may have potentially useful policy implications. Five potential issues[106] are brought up, one issue related to health and four issues related to education but none of them reflect anything about what was observed in the villages in terms of gender.

In the fourth year report the Foreword[107] by the Ambassador announces: "It is our responsibility to digest this information and reflect on its possible use for our policy decisions. This is the 4th year of the Reality Check study in Bangladesh, and for this report the researchers were asked to provide concrete recommendations that could be fed into the preparations for the new sector programmes in health and education[108]".The ten policy recommendations included are all *gender neutral*, with exception of the TBA issue.

In the fifth and final year of the Reality Check studies, the concept gender is mentioned only once, and only as a general remark, thus not in connection with any findings in the villages. As in the earlier reports from year 3 onwards, the report is full of narratives of the different realities and challenges that girls and boys face, including adolescents[109] - but none of the specific findings on boys, girls or adolescent are mentioned in the summary or in the conclusion chapter.

[106] Bangladesh Reality Check 2009, p. 111 (check).

[107] Signed by the Ambassador, Embassy of Sweden.

[108] Reality Check Bangladesh 2010. Listening to Poor People's Realities about Primary Healthcare and Primary Education – Year 4 (published 2011).

[109] Reality Check Bangladesh 2011. Listening to Poor People's Realities about Primary Healthcare and Primary Education – Year 5 (published 2012).

Findings on the approach to gender issues

Gender is one of the elements of Sida´s rights perspective intended to be one of the guiding perspectives for the RC study. However the RC reports are remarkably silent about gender issues during the first two years of reporting. From the third year onward, however, the annual reports are rich with gender related observations and reflections, showing that the teams are well aware that gender identity is relevant as it cuts across much of the social fabric and realities of the people they are studying (although the term gender is hardly used) and the perspectives. It is also likely that they were aware that people's perspectives were influenced by the gender of the informant and/or member of the households who participated in the RCA study.

However the evaluation team has not been able to find any discussion in the annual reports pointing to the fact that gender issues constituted an essential factor in the overall inquiries of the RCA study. It was not defined in relation to any methodology and strategy for the study, nor analysed specifically or brought up in any summaries or conclusions.

Annex 8 – Summary of findings from field visits in the three RC regions

The evaluation field team (here referred to as EFT) consisted of two national consultants who spent 13 days **in the same three districts that the Reality Check (RC) study teams had undertaken their qualitative field research each year during a five years period (2007-2011).** In the Northern part, the team made interviews only in the peri-urban area; in the Central part they managed to carry out interviews in all three RC locations; and in the Southern part they undertook interviews only in the rural area. Between September 5-14th 2013, they interviewed all in all 42 persons (see table 1 below).

1. First contacts were made with former RC field study team members. Six former RC members were interviewed (two were RC team leaders and four had been RC team members).
2. Service providers in the areas of health and education were also interviewed, some of who had participated in the RC Reflection workshop in 2012. These were medical staff at hospitals/health clinics; NGO staff; pharmacists, traditional birth attendants (TBAs) and volunteers; members of school management committees and school teachers/ head masters (men and women and from both public and private schools).
3. Interviews were held in the study areas with members of the same households who had hosted the RCA researchers (referred to as HHH) - some of who were female-headed households (FHH). The evaluation team were assisted by some RC team members who approached the people to find out their interest in participating in interviews. If agreed, the purpose of the interviews was explained, confidentiality was ensured (identity would not be revealed) and they could discontinue the interview at any time. With a few exceptions most of the persons approached agreed to participate. Six members from three RC study teams were first interviewed, followed by the HHH households and the service providers[110].

Talking with RC field team study members

What was your role and responsibilities? They team members explained that their main role were to observe, collect and record data while staying with a household in

[110] In a few cases this order could not be followed for practical reasons. In some places a HHH took the lead to take/introduce the EFT to other respondents (North and Central Rural), while in some locations, service providers (South and Central Urban) brought the evaluation team to others.

the field. This meant that they observed activities in the households particularly when related to primary education and health. They "cross checked" the information they received through gathering information also from others in the communities. They wrote individual reports and team reports and participated in briefing sessions in preparation for the annual report and made contributions to this report.

Based on their observations in households and at the selected locations, they took part in briefing sessions in the preparation of the draft report and shared their findings with other team members. The RC team leaders in each of the study areas were responsible for coordination of the activities in "their region" and for preparing a report. Each year they approached the same family household and gathered information about the same issues and the changes/development that had occurred. In the final year each team organised reflection workshops at district level with the participation of health and education officials/workers/staff (representatives of service providers). In this workshop, they shared their observations and validated the information collected from the five years with their recommendations for development.

What supervision/training had they received to undertake the RC in the field? Was this different in any way from other supervision/training received earlier? If so in what way was it different? The RC team members had not participated in any formal training to prepare them for the studies in the field. The first RC piloting (pre-testing) in Saturia, Manikgonj, served as sort of hands-on training. Most of them were experienced in Participatory Rural Appraisal (PRA) approaches and methods, which they viewed as beneficial as everybody in the team shared their experiences from the field with each other and developed their plan on the basis of such discussions.

How did they observe and interact with the household members during the day and evening and how did this vary? To what extent were they able to listen to all members of the households? How did this vary between different households? The times of the day or evenings that information was sought from the people in the households varied from case to case. Only RC study member said he was able to know the opinions of a husband and wife at midnight when they interacted and shared their views and concerns and that this was more intense in the evening compared to talking with them in the daytime. Another team member said that she had been able to discuss with a woman in a house after 11 pm when she had finished her chores for the day. Another RC member used the opportunity to gather information from a woman at the time she prepared food.

How did they document observations and information they gathered? How did decide what to document and what not to document? They had pre-visit briefings where they discussed the focus of the year of the overall RC and of particular location. They observed "all" activities, movements and behaviour of host family members on issues related to health and education. Notes were mostly taken in the evenings, when family members did not notice. In evenings the study team members shared the observations made and decided what should be emphasized of what was observed, what not to include and what needed further exploration. "New findings"

were discussed and re-checked. They also shared findings with other study team members - in other regions - through telephone conversations in order for them to be observant on the issues in their respective areas. Between visits in different locations they took one day to share the observations and findings in the team. They prepared the location/regional reports based on the individual notes. The overall RC team leader made the final decisions on what to include in the overall report.

Were there important observations/findings that should have been selected for reflecting the regional reports that were *not included*? The RC study members interviewed stated that all the important findings were documented (after validation/rechecking) and that no important observation was excluded from the final reports.

What were the challenges faced in when staying in the households/the locality and was there any change over the years? Among the major challenges was developing trust in the community and in particular with the members of the host households. However, *this improved in the second year's visits*. Another challenge was the feeling of insecurity and living in a thatched house. Non-cooperation of government officers was another challenge and it was difficult to collect information from them and take photos of government offices – partly because they had no official letter of introduction or to explain the purpose of their contacts with the Government. Non-cooperation of local elites was also a challenge (Northern Region especially). It was explained that the reason for this was that they did not see eye to eye with the RC team members being in direct contact and living with families "bypassing them". Finally, the assignment to collect a wide variety of information in a short time without any structured format was reported as a challenge.

How did they experience living in the household/village and the information they gathered? How did it help them to reach a more in-depth understanding and knowledge of the realities of people who live in poverty? The experience of staying with families for 4-5 days in remote/rural villages gathering information was a new experience and very interesting. The experience of closely observing their way of life helped them to understand the reality of their struggle most of which they did not really know earlier. They have learnt about their food habits and how many times per day they eat, how they cope with crisis, to where they send their children, why children stop going to school, what their preferences are.

What were the observations on gender related issues (women, men, girls and boys) within the visited households (chores as well as perceptions, behaviour, attitudes, voice)? Did they collect, document and/or analyse disaggregated data? Did this change over time? The RC members interviewed stated that they documented information of all activities/developments without any particular emphasis on women/gender issues, i.e. no particular emphasis on collecting and documenting gender related data as such. However, they did observe who made, and who dominated decision-making in the families and who participated in particular

events and activities. They also tried to inquire about the reasons behind certain "who did what" through talking with men, women, girls and boys.

What did they know about how the results from their fieldwork were used and/or promoted? Did they think the purpose of the RCA (as method to help raise the voices of people living in poverty) was reached? If so, how effective did they think this had been and did they have any evidence of this? Only one of the RC study members could mention an example of a specific result; namely that scholarship for students from poor families was believed to be the result for RC (this is not the case according to this evaluation).

What did they know about how the findings from the study have been communicated to the Swedish Embassy and policy makers? How effective do you think the communication on the findings has been to Sida/Embassy, decision-makers/policy-makers? The RC members felt that the RC study findings had been communicated effectively to the Swedish Embassy however not effectively at policy and decision-making level – about which almost all of the interviewed expressed frustration. Some expressed that the RC studies had been a waste of resources as they could not see any serious efforts or follow-up regarding the use of the information they had gathered and the efforts made.

If they were to repeat a study of this nature, would they make any changes to what they would cover? What would those changes be and why would they make them? One interviewed RC member suggested that instead of three regions/locations there should be twenty areas or more included, to make the study results more "representative". Focus group discussions should follow local RC studies and be organised with a cross section of people to triangulate and validate RC findings/observations (in local study areas and neighbouring areas, as well as in other areas. Another member suggested that the number of visits over a year should be more than what RC had done, in order to capture how different seasons may impact on the lives of people living in poverty.

Talking with service provides in the health and education sectors

Most of those who were approached could not recall having encountered the RC study members or knew what the RC study was about. Some did recall how they met the RC team and could mention the people from the households they had visited, or their children. When a foreign person had been part of the study team this had attracted their attention and curiosity. Some could recall that the study team members had explained the reason why they had come and that they had asked for information that related to education and health in the locality.

However, through the discussions with some of **the providers of health services** it transpired that awareness had increased on health and hygiene, and the demands for healthcare services has increased. The existence of equipment and medical appliances has increased over the years but much of it is either unused/underused. The reinstatement of the Community Health Clinics has given poor women and children

better access to preliminary consultations and medicines. The discussions also conveyed that doctors generally do not stay at their duty stations and that although a visit and treatment at the government clinics officially is free, patients have to pay tips to the attendants.

From talking with the service providers of **primary education**, it transpired that overall they felt that there had been improvements over the last decade. People living in poverty had become more aware about the importance of educating their children. Access to stipends had increased, and so had the enrolment rate and continuation of education (fewer dropping out from school). They also claimed that most schools now get books at the beginning of academic year. Further, the physical environment had improved such as having more, and separate, toilets for girls and boys and the practice of corporal punishment occurred less often. It also transpired that the quality of education in government schools where the majority of the students are from poor families is still not up to the mark – good quality education is found among.

They also informed the evaluation field team that there exists no effective monitoring system (in any of the two sectors). In primary education only monthly reports are prepared and submitted on the day of *Upazila* level meeting from (on average) 100 schools. These reports mainly cover the number of enrolled students (boys and girls), attendance and drop out rates. Sometimes the *Upazila* level officials visit the schools - but they mainly give instructions and talk about punishments for instance there have been problems/shortfalls. Some schools have their own monitoring system to follow up on performance and progress to maintain quality. Almost all respondents mentioned that a "monitoring such as RC" would have been better. The information received also revealed that many of the children, mostly boys, who had studied in primary schools or higher levels during the RC study period - now had jobs. Few girls had continued their education and some girls had gotten married.

Participation in the RC Reflection Workshop: The service providers were asked about their opinions about this workshop[111], and what they had learnt either from this event or from having met the RC study team members. Only a few of those met had participated in the RC workshop and of this who had, few could recall the contents/discussions in this workshop. Some opined that workshops of this kind should

[111] This workshop organised in year five (2012) was part of the reflection process. It was mentioned in the original terms of reference for the RCA study. The four objectives that were agreed between the team and the Embassy of Sweden were (i) to gather and present information on the use and usefulness of the RCA; (ii) to receive feedback from families and service providers on the approach; (iii) to provide feedback to families and service providers on what has been presented to policy makers, and (iv) to show appreciation and gratitude to the households and communities involved (Reflection report, David Lewis, p. 35).

be held at local levels, even at Union levels, more frequently as it is good to listen the problems of the poor and share these with others - including government officials.

Understanding the purpose of the RC: They were asked what they understood about the information the RC teams gathered and how they have done it. Some were close relatives to the HHs and other community members and some stated they could understand that the RC wanted to know about the HHs´ income and expenditures, views about primary education, health, through staying with and observing them or staying nearby. They also understood that the study team had checked information received from government and non-government organisations. Some recalled that they had taken photographs and one person compared them to journalists or 'secret agents.

Interaction with people – was there any change over the years? The service providers were also asked about whether there had been any changes in the way of RC study members had interacted with the people they studies over the years. They recalled that the RC team had been introduced as researchers. They had explained what they are doing in the locality and the purpose of research being focused on education and health status and services to the poor. The team interacted with more or less the same people each time and in almost all areas. In the Southern area the RC members had to change the HHH mainly because of Cyclone Cedor.
What were advantages and disadvantages of the way the RC team gathered information? Most of the respondents appreciated the way RC study members had gathered information and the way they wished to raise the voices of the poor. A few said that one effect of the RC method (the monitoring and observing) could be that the performance of some service providers would improve the quality of their services.

What are the benefits of the RC "capturing the voices" of people who live in poverty? The benefits lie in the sharing of information of people's realities such as in the RC Reflection Workshop the last year. The workshop had participants from all categories of service providers (government, NGOs and private actors) and some suggested that such workshops should be held also at Union level.
Influence of RC study at national or local policies or practices (health/education)?

The service providers were asked if they thought the RC had had any influence on national or local policies or practices. None believed that any such effect had occurred. Two respondents (on in the South and one in central) suggested that a study of this kind should have had more HHs in the study, or that a village (villages) should have been studied more in-depth with the information used to lobby at policy level.

Talking with households members who had participated in the RC study

The household members were asked what they thought when they first were approached and asked if they wanted to participate in the RC study. What were they told about the purpose of the study and what made them agree to participate in it? What expectations did they have?

The RC study team had been introduced by local persons some whom were persons of influence in the area. They explained the purpose of the RC team's visit. The household members who were asked to host a study team member were surprised to be approached by the "outsiders" and even more surprised when the RC team members asked to stay in their homes. Many of them could not understand the purpose, and could not believe that the outsiders would stay in their homes for four or five nights but in most cases they had agreed although reluctantly. Many said that they had hoped that a project would be brought to the village/community following the study.

Did they know why they had been selected as a household for the study? They knew that the reason they had been selected to participate in the study was because "they are poor" and that the RC team members would "observe the poor".

Did their views about the purpose of the study change over time and if so in what ways and why did they change? The RC members when leaving after the first year's visit to their homes said that they would come back the next year - but most did not believe that this would happen. After the first year's visit, the study team followed up on developments and any changes since their last visit and why and how the changes took place.

What experience did they get from the study and how did it change over time? Almost all households expressed that it was a good experience to host the RC members. Although they are poor, they tried their best to make their stay in their homes pleasant for instance through providing their guests with better food, or a better bed, albeit the RC members had repeatedly said that that no extra arrangements should be done for them.

Did the fact that they were part of a study, change their lives in any way and if so in what ways and with what affect? Some said that their poverty has deepened and others that they are better off now (mainly as a result of their children being employed and earning money) while others said there was no change. Many claimed however that now are more aware of the importance of providing education to their children, and the importance of health, hygiene, livelihood and other social aspects. Some women mentioned that they now are able talk to unknown persons without any hesitation which they were not earlier and that they believed that this had happened as a result of the RC visits.

What did they see as the advantages and disadvantages of the study? Did they personally get any benefits from it? When rapport had been built between the HHH and the visitor from the second year in particular, most had enjoyed their company. They did not receive any personal benefit except a package containing rice, biscuits and salt at the end of the annual visits. They were pleased that they were able to share their happiness and sorrow with someone outside their communities.

If they were approached again to be part of a similar study would they agree to be part of it? All HH members said that they are ready to welcome RCs or similar

teams again. Some said that the RC members were like relatives and some kept in contact over phone.

Table 1: Number of informants by region, location (urban, peri-urban and rural) and category (host households, focal households and service providers)

	Host Households	**Focal Households**	**Service Providers**
North			
Urban			
Peri urban	2	4	9
Rural			
Central			
Urban	1	1	4
Peri urban	1		2
Rural	2		3
South			
Urban			
Peri urban			
Rural	4?	3	6
Total	10	8	24

Annex 9 – How has Sida reported on the RC study?

The evaluation has reviewed, drawing on Sida's annual reports (2007-2012) how Sida Stockholm has presented the RC the study in Bangladesh and as a method.

The RC study is first mentioned in a Sida Annual report in 2010. The report refers to Sida´s attempt to identify innovative ways to follow-up on the results of development assistance and to understand the reality of people living in poverty – with the purpose to adapt the interventions to the existing needs. The RC in Bangladesh is cited as one example of this effort, described as a "listening kind of study of development". It refers to increased knowledge – but does not specify for whom - about poor people's needs and how service provision in health and education works at local level. It mentions that the study has proved to be important "as it is able to grasp results and actual changes at local level", and that it will the use of the information in dialogue with the Bangladeshi Government to try to improve the planning and implementation of the national health and education programmes. Finally, it states that the RC has attracted interest from Sida staff members in several countries (Mozambique, Mali, Bolivia, Zambia and Cambodia are given as examples)[112].

In Sida´s AR 2011 it is mentioned that Sida has raised the level of ambition in terms of planning and follow-up and reporting on the results of its development assistance. Sida is also continuing the development of qualitative methods for follow-up, among them is "the qualitative and participatory RCA method" used in two countries (the countries are not mentioned)[113].

The 2012 AR states that Sida´s two basic perspectives regarding global development (the rights perspective and the poverty perspective) have continued to influence its development assistance. The RCA is said to be one of several tangible methods for addressing poverty and rights issues in order for these perspectives to be reflected and applied in Sida´s processes, as well as having an impact.

[112] Sidas Årsredovisning 2010, p. 44 (Annual Report, Sida, 2010).
[113] Sidas Årsredovisning 2011, p. 66 (Annual Report, Sida, 2011).

"Through the RCs, qualitative information is collected and compiled - about how the people themselves living in poverty (those who will benefit from the interventions/activities) perceive their situation. This information is later related to data in official statistics and in planning documents and progress reports. The method is built on participant observation and contributes to improved understanding of the many dimensions of poverty, and to more informed assessments of which aid interventions are most relevant in a given context[114]."

Only Sida´s RC implementation in Mozambique in 2012 is mentioned, where families from three districts in Niassa province have been followed during a five-year period. The results of the Mozambique study, it says, will "contribute to an increased understanding for how development cooperation/aid will benefit the poorest people (poorest of the poor) and provide a basis for the public debate about poverty reduction[115]".

[114] Sidas Årsredovisning 2012, p. 140 (Annual Report, Sida, 2012).
[115] Ibid.

Annex 10 – Comparative table of RC studies or studies that draw inspiration from the approach

'The RCA is a powerful tool for improving the connection between pro-poor policies, their implementation and the people that such policies are supposed to serve. Through both retrospective and longitudinal 'Listening studies' RCA offers donors and governments an opportunity to shed light on whether policies and interventions carried out in the name of the poor, translate into tangible improvements in the lives of targeted individuals' (www.reality-check-approach.com)

	Years	Country	Funder	Who?	Title	Approach and Focus	Numbers
1	2007 - 2011	Bangladesh	Sida	GRM	Bangladesh Health and Education Reality Check Approach	Aims to provide policy makers with a clearer sense of people's experiences and views over 5 years about how well the country's health and education sector wide approach reform programmes are working	27 host families in 3 regions, and in urban, peri-urban and rural locations within each region. Additionally focal households
2	2010	Indonesia	AusAid	GRM	Listening to Poor People's realities abut Basic Education, Indonesia	One year study on how activities under a basic education programme have been translated into the experienced reality of people living in poverty	29 host families in 10 villages in 3 locations
3	2012	Nepal	Dfid	GRM	Research into the Long Term Impact of Development Interventions in the Koshi Hills of Nepal	One time Retrospective assessment of how people have perceived and experienced change over 30 years of development interventions as part of a larger study	27 host families in 9 villages in 4 districts

						assessing impact	
4	2010 -2011	Mozambique	EU	GRM	Strengthening Livelihood Options for Vulnerable Rural Households in Gaza Province	2 year Study to provide information on how an investment in Newcastle disease prevention is being translated into the experienced reality of people living in poverty in project areas.	19 host families in 6 villages in 4 districts
5	2011-2016	Mozambigue	Sida	Orgut	Reality Checks in Mozambique: building better understanding of the dynamics of poverty and well-being	Aims to inform public discussion among key development actors on poverty reductiion in target province; contribute to better understanding of qualitative poverty monitoring methods in Mozambique and provide Sweden with relevatn qualitative data on development and results. Integrated qualitative- quantitative methods	Quantiative data from 360 households in 3 sites; 20 focus households to be interviewed in depth each year
6	2013-2014	Nicaragua Pakistan Uganda	Sida	SIPU IDS IOD-PARC	A two year results-oriented evaluation of Sida's support to civil society actors in developing countries via Swedish CSOs – based on the realities of people living in povery and marginalisation	The evaluation aims to find out if, how and why/ why not the support to Civil Society actors in developing countries in developing countries via Swedish CSOs has contributerd to the overall objectives of the support by creating conditions to enable poor and discriminated people to improve their living conditions and quality of life. The study draws on RC methods combined with meso level analysis	Three reality check sites per country but number of households and whether specific households are returned to in the second year not clearly specified in country reports.
7	2012-2016	Ten countries	UK Aid, Irish Aid, Oxfam and	IDS & Oxfam	Life in a time of food price volatility	Four year study in 10 countries in 23 research locations. Multilevel with national food security and FPV data collection, , 23 qualitative community case studies and	Multiple

			BRAC Development Institute			integrated qualitative-quantitative analysis	
8	2008 - 2011	Eight country case study		IDS and the World Bank	Living Through Crises: How the Food and Fuel and Financial Shocks affect the poor	A multi country study on how people have lived through severe economic crises	Multiple

Evaluation of the Reality Check Approach in Bangladesh

This report presents the findings of an evaluation commissioned to assess the five year Reality Check (RC) study (2007-2011) commissioned by the Embassy of Sweden (EoS) in Dhaka to support its engagement in primary education and health service delivery in Bangladesh. The evaluation found that RC study had produced plausible, credible and valuable understanding of the experience of people living in poverty and the challenges that they face in accessing health and education public services. The study has been highly relevant. Its effectiveness and impact have been more mixed, although there are some very positive outcomes. However the lack of systematic documentation of primary data and other information both within the RC study and by the embassy in relation to policy influencing activities points to the absence of a robust information management system for the study. The evaluation found that the RC study suffered from design flaws that were not addressed and the evaluation also found weaknesses in the RC reporting. The lack of attention to gender and the failure to design a monitoring system in relation to policy influencing were significant gaps. The evaluation has faced major challenges in attributing actions by the EoS staff to results and findings from the RC study. There is strong evidence of EoS staff commitment to Sweden's human rights principles, but the RC is unlikely to generated this. The RC had an important constituency of support beyond the embassy with many donor staff speaking extremely positively about what the RC had contributed to their understanding. The RC study as an approach has also provided inspiration to other international studies investigating people in poverty's experience of shocks.

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