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Reality Check Bangladesh 2008

Listening to Poor People's Realities

about Primary Healthcare and Primary Education

Sida

Foreword

Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen. ~Winston Churchill

It is my sincere belief that the needs and challenges of people living in poverty can best be identified by those who are experiencing them on a daily basis. By giving these experiences a voice, development assistance can be effectively channelled to reduce poverty.

Sweden and the world at large have been much impressed by the progress made by Bangladesh towards many of the Millennium Development Goals. At the same time many challenges remain.

This year the Governments of Sweden and Bangladesh signed a 5-Year agreement on Development Cooperation between the two countries. The largest share of the cooperation will be channelled to primary health care and primary level education in support of the vision to ensure equitable and qualitative health care and education for all. This reflects our strong commitment to support the efforts of present and future Governments of Bangladesh, civil society and individuals to reduce poverty.

The funds now made available will be used to help create conditions and opportunities for poor women, men and children to improve their lives. And in order to create these conditions and opportunities we need to understand what their challenges and needs are. And to understand, we must listen.

This Reality Check study is a means of listening to these voices. By listening, we can learn. From learning, it is our hope that we will make better informed decisions and contribute to policy improvements to enable change to take place.

Britt Hagström
Ambassador
Head of Mission
Embassy of Sweden

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Summary

The Reality Check initiative was initiated by the Embassy of Sweden in Bangladesh in 2007 as an important contribution to their Country Strategy for Cooperation with Bangladesh (2008-12). This Strategy emphasises the value of supporting platforms for dialogue 'from below', i.e. interacting with people living in poverty as well as with those directly providing services to the poor. The Reality Check focuses on primary healthcare and primary education. These two sectors are supported by Sector Wide Approaches (SWAps) to which Sweden contributes and are known as the Health, Nutrition and Population Sector Programme (HNPSP) and the Primary Education Development Programme (PEDP II).

This is the second Reality Check study, in a series of five annual studies (covering the period 2007–2011) which are to be conducted in the same locations with the same families and at the same time each year. The study takes place in three locations (urban, peri-urban and rural) in three different districts (North, Central and South) of Bangladesh amounting to a total of nine locations. Three study teams comprising of three members each work independently (one in each district). Whenever possible, each member of the team stays for a minimum of four nights and five days with each of the three families in each location. This second study was carried out in October and November, 2008.

The Reality Check study uses a 'listening study' approach where research teams stay in the homes of families living in poverty and conduct many conversations with different family members, their neighbours as well as different local service providers. It is thus not a conventional evaluation but an appreciation of the day-to-day reality as experienced by people living in poverty, where they, rather than the research team, take the lead in directing conversations.

The second Reality Check built on the achievements of the first conducted in October/November 2007 both in terms of developing the relationships and trust with our host families so that they opened up to us and delving further into their experiences. The main focus of our conversations was on change and our families' experience of change.

Situation in 2008

A number of important macro-environmental influences impacted on our families during 2008 as the following summarises.

The repercussions of the global increase in oil prices and food shortages hit Bangladesh, a net importer of food, with resulting massive increase in food prices. Many staple foods, such as rice and oil, doubled in price. In addition to the increase in food prices, conditions, particularly for people living in poverty, were further worsened this year by damage caused by two floods (July and September) and the devastation

2008 Situation Changes ...

- Increase in food prices
- Reduced food intake

Have affected the three study areas differently with the North study area worst hit, but economic repercussions for our families include;

- Children taken out of school to save money and/or contribute economically (North study area)
- Cut back on household expenditures
- Cut back on private tuition
- Increase in women's employment
- Increase in indebtedness to NGO credit organisations (new loans for post- flood/cyclone rehabilitation)

brought by Cyclone Sidr, which hit the shores of Bangladesh on November 15, 2007. At the time of the study the two year term of the interim Caretaker Government was due to come to a close with a National Election planned for December 2008. Whilst 'our families' had appreciated the steps taken by the Caretaker Government to combat crime and corruption, most were upset that they had failed to control food prices.

The increase in food prices was spontaneously raised as an issue in all three study areas, but the nature, impact and coping strategies were very different in each. The worst hit is the North study area, where the price of rice reached a high of Tk52 per kg (nearly three times the 2007 price). The area has also suffered because of cutbacks in the construction industry which, we were told, resulted from developers' concerns about tax and fraud investigations instigated by the Caretaker Government, which has led to high unemployment among construction and construction related workers. Some families have reverted to only eating one meal a day or have cut down on quantities consumed and some children have been taken out of school to both assist with income generation and to save money. In the South study area, the price of rice reached Tk40 per kg in the summer and this had some affect on household coping strategies although not as far-reaching as in the North. Whereas our families in the urban and peri-urban areas mostly cut back on household expenditures, more members (particularly women) of rural families have sought employment in order to maintain the same level of expenditure. By contrast, the Central area seems very little affected by the food prices which stayed relatively low compared to the other areas (rice Tk20-35 per kg). Their incomes had mostly kept pace and it was not mentioned as a problem at all in the rural area where many of the households are largely self-sufficient in rice and this year provided a bumper crop. The floods this year had severely affected the rural North study area with many farmers losing their only rice crop. The South locations had all experienced some effect of Cyclone Sidr where houses had been damaged, livestock and fish lost and one year's crop lost. These losses have resulted in increased indebtedness to NGO loan schemes.

Main Findings in Health

With the exception of the North study area, cleanliness, management and provision of free medicines had improved in Government health facilities and this was attributed to the monitoring of the Caretaker Government. However, Upazila Health Complexes remained poorly maintained and short-staffed. Despite some early indications that some of our families were considering trying these facilities once more (at district level rather than upazila level), most prefer the convenience of 'one stop' private providers and, since large sums of money are needed for serious ailments even in Government facilities, people living in poverty prefer to pay where they perceive they are getting the best value for money. There is a continuing trend towards self-referral to private Diagnostic Centres where people feel confident that they are paying for modern technology and are pleased to be able to have tangible proof of the services they have paid for. There is some evidence of the emergence of philanthropic (rather than 'for profit' and often family owned) health provision.

Although some free medicines continue to be available in government health facilities and supply seems a little better than last year, they are mainly basic medicines which are readily and cheaply available in the market and people are still required to purchase most medicines outside the government health facilities. High dose anti-biotics are being prescribed routinely. Patients are finding these make them feel unwell particularly as they cannot afford the 'good food' recommended to accompany the course of treatment and also doubt its efficacy in the absence of 'good food'. As noted last year, there is no subsidized treatment for the poor for high blood pressure, cancers, diabetes, stress and other ailments which are often regarded by the medical profession as diseases of the 'better-off'.

The commercialisation of health services brings some problems. The study revealed examples of skilled birth attendants (SBAs) offering services beyond their competence, pharmacists prescribing high dose antibiotics, a 'doctor' offering surgical procedures from his home with fatal consequences and poor adherence to basic safety precautions in Diagnostic Centres. Traditional healers, polli doctors and traditional birth attendants, on the other hand, charge very little, if anything, for their services and the quality of their service is confirmed by results.

Women prefer the oral contraceptive pill readily available from the market as the Government supplied pill is high dose with unwanted side effects and the benefit of free distribution is lost by high transport and time costs to collect. More information about alternative family planning methods, particularly long term methods and harmonising adoption of family planning with religious teachings was felt to be needed by women but also men, particularly in the privacy of their own homes.

The availability of outreach services varied considerably between study areas. In the North study area there was a scarcity of any kind of health extension services but in other study areas, health workers felt there was duplication of effort at a community level and many of the issues that they are required to focus on are no longer needed (e.g. awareness raising on immunization, nutrition programmes).

People concurred with the view that other issues needed attention such as local advice in interpreting prescriptions and diagnostic tests, focus on 'at risk' pregnant mothers and provision of advice to men and adolescents. We observed a higher incidence of TB among our families and their neighbours compared with last year, particularly in the Central

study area. The administration of testing and direct observation treatment (DOTS) is not being experienced by patients in the way prescribed by the Government's TB programme.

Despite an increase in notices provided in Government health facilities and the efforts of the Caretaker Government to monitor facilities and suppress dalal (broker) activities, people are still vulnerable to dalals who help them to navigate the confusing facility environment but take a cut from costs incurred. People continue to be unwilling to raise complaints about all aspects of health service provision, fearing it might jeopardise treatment.

Main Health Findings

Government Facilities

- Increased cleanliness, management and information provision in Government health facilities, particularly in large District Hospitals. Supply of free medicines improved. Reduction in dalal activity. All improvements attributed to the vigilance of the Caretaker Government, which has encouraged some of our families to contemplate trying out Government facilities despite their former preference for private services. But there is deterioration in the facilities in the North study area since monitoring relaxed towards the end of the year.
- Further deterioration of diagnostic and operating facilities as well as increasing staff shortages in Upazila Health Complexes. In-patient numbers tending to decrease as these facilities are used primarily for casualties, very local patients and patients (elderly) needing 'bed rest'. The expansion of these facilities where use is declining is questioned.
- Patients do not feel able to complain about health service provision, fearing it may jeopardise their treatment.

Medicines

- Free medicines available are mostly basic and are cheaply available in the market, so people prefer to purchase these to save time and transport costs. Similarly preferred alternatives to the Government free-supplied contraceptive pill are readily and cheaply available in the market.
- People note the problem that there are no free/subsidised medicines for non-communicable diseases.
- Increase in formal and informal prescription of high dose antibiotics. Inability to consume supplementary 'good food' while taking these leads to patients feeling unwell and doubting the efficacy of the treatment.
- Incidence of TB increasing in some areas and Direct Observation Treatment (DOTS) for TB patients is not being carried out as per the Government guidelines.

Private Services

- People prefer 'one stop' private health services to Government health services as they feel they are getting the best value for money.
- Increase in self referral to private Diagnostic Centres.
- Emergence of philanthropic (rather than 'for profit' motive) providers.
- Increased connectedness between home birth services and polli doctors, pharmacies and private clinics.
- Although there is evidence of market forces exposing incompetent providers, we came across examples where patients are vulnerable to unregulated commercialisation

Outreach Services

- Duplication of effort by Government health workers at community level and perceived redundancy of some programmes (e.g. nutrition, immunisation awareness) was noted in some areas while new priorities are emerging but not being addressed e.g. provision of family planning and health advice for men and adolescents, more information on long term methods of contraception and advice on interpretation of prescriptions and diagnostic tests.
- In the North study area, there is a serious lack of health extension services

Main Findings in Education

As noted last year, education is considered very important and families are making careful decisions to ensure the best possible education for their children. This includes keeping family size small (except the North study area), transferring children between schools, promoting children in the family with potential and transferring resources from those who do not display potential and supplementing schooling with commercial or family provided coaching.

However, the problem with attracting and retaining boys in school seems to be getting worse in all the study areas. Parents complain about how difficult it is to control their boys and despite their wishes for them to be educated, boys themselves opt out. In areas where job prospects are limited (particularly rural areas) or where relatively well-paid jobs are available which do not require education (e.g. construction work in large cities and overseas, some factory work, transport industry) boys do not see the value of education. The 'street life' comprising of hanging around with friends, playing, loitering, picking up casual work to fund their own recreational activities (TV/videos/cinema, smoking) and fishing is very attractive.

Furthermore, boys' experience of school is often poor; they feel outshone by girls (the positive discrimination implemented by pre-schools which promotes enrolment of twice as many girls as boys and female stipend programme at secondary level coupled with the fact that girls are developmentally more advanced than boys exacerbates this).

There is no reliable means to determine school drop-out rates. So called 'drop-outs' are usually explained by transfers to other schools as parents adopt careful strategies to avail the best education and most incentives. Double enrolment is prevalent in urban schools where children are enrolled in formal schools and NGO schools for working children. The latter, which are supposed to cater to out-of-school children, provide double-enrolled children with various incentives, are thought, by parents to negate the need for private coaching and keep boys 'out of mischief' after school. Girls from other schools swell numbers in Class 5 in Government schools so that they can sit the public exam which leads to allocation of secondary school stipends.

Although families are highly motivated towards education (with the possible exception of our North rural study area) the environment supporting education may not always be conducive. Parents worry that they cannot support their children's learning as they themselves are uneducated and some recognise that they sometimes take them out of school unnecessarily. TV attracts some children to stay at home after tiffin break and distracts them from homework and may lead to sleep deprivation as it stays on late into the evening in the one roomed homes.

Private coaching is still considered essential for children to be able to pass Government school examinations and, with rising prices, parents have regretted having to drop coaching. Most private coaches are high school or college students who charge Tk100 per month, which is exactly the same amount as the stipend and we found that the greatest use of stipend money is to pay for coaching. Some efforts are being made to reduce the coaching cost burden such as BRAC primary schools where student study circles meet after school to support each other at no cost and NGO schools which provide free coaching.

There is evidence, particularly in the Central study area, of the emergence of philanthropic educational institutions. These may be

Children drawing what they like and dislike about school.

Children fishing to supplement their families' meals (North area).

home-based or private family–run schools and are particularly good at supporting slow learners and children with disabilities. Under PEDP II, school facilities have been extended and improved, school level implementation plans (SLIP) implemented and resource materials provided. Despite some concerns about the lack of local consultation and delays in construction, these initiatives have been appreciated. The focus on local decision making and local implementation of SLIP is particularly appreciated.

There is huge variation in quality of Government schools even with exactly the same physical resources. Enhanced quality, defined as motivated and caring teachers, and active use of teaching resources, is largely attributed to the leadership of the Head Teacher of the school as well as supportive Upazila Education Offices and interested and motivated School Management Committees. As noted in 2007, NGO schools tend to be preferred over Government schools because classes are smaller, teachers are more caring and there is greater use of games and songs in teaching. Stipends are better organised than last year although there is still concern about unfair allocation, inadequacy of coverage and the fact that the requirements to ensure payment (regular school attendance and performance) are the most difficult for the poorest students to meet.

There has been no direct experience of school-based feeding programmes but teachers, parents and children welcome this idea. Compulsory Certificate in Education training for all primary school teachers has left schools with temporary staff shortages and, according to teachers is too long and theoretical and fails to provide practical suggestions for dealing with the kinds of problems they face e.g. overcrowded classrooms, covering for absent teachers and short class periods. Young teachers find it difficult to implement changes in the classroom without the endorsement of older teachers and complain that short lesson periods and moving between classes prohibits the use of interactive resource materials.

Children often prefer the young teachers and ones who show affection and help them to understand. The interactive techniques using song, dance and games used by BRAC, some other NGO schools and some private schools are regarded as the best way to learn by children and guardians alike. BRAC primary school teachers receive only seven days training per year but, unlike their Government counterparts, work exclusively with one class of children for four consecutive years.

There is little interaction between schools and parents, although many parents and students appreciate teachers who do make home visits. Parents who are often uneducated themselves feel awkward about con-

tacting the school and raising complaints, and, like raising complaints at health services, fear it might negatively affect their children's progress. There are many committees at schools (e.g. school management committee, guardian committee, SLIP committee) but the membership and role of these may not be well known. Where they are active their impact on school quality is noticeable.

Many improvements in primary school service provision are attributed to PEDP II whereas improvements (other than construction) in the health sector tend to be attributed to the Caretaker Government.

Main Education Findings

Drop out and School Refusers

- Boys are themselves opting 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.
- Some children (in North study area) taken out of school for economic reasons this year.
- Many children are out of school (exceeding reported numbers). Most reported drop outs from schools are actually 'transfers' to other schools as parents adopt careful strategies to avail the best education and incentives for their children
- Programmes for drop outs and out-of-school children are attracting children already enrolled in other schools, and double enrolling children already enrolled in other schools.

Quality

- Interactive teaching emphasising games, play, songs and sports in small classes is preferred by students and their parents and results in better learning outcomes which means that BRAC primary and pre-schools which emphasise these are preferred.
- Physical facilities are regarded as less important than the quality of relationship between teacher and student. Schools with similar resources may be very different in terms of quality and better schools are attributed to good leadership, good Upazila Education Office support and supportive and committed school management committees.
- Private coaching is considered essential to pass public examinations and most use the stipend money to pay for college students to provide coaching. BRAC primary schools have introduced study circles and others are providing free coaching to relieve the burden for poor parents.
- Emergence of philanthropic education institutions which are particularly good at supporting slow learners and children with disabilities.

Government Provisions

- Stipends are better organised than last year but the criteria for award are regarded as least achievable by the poor.
- School text books supplied in time and in planned quantities this year. But daily carrying of books to and from school and only 50% hand replacement each year means text books are often in poor condition.
- No direct experience of school-based feeding programmes in our study areas but these would be welcomed.
- SLIP operation varies but local decision making and inclusion in committees appreciated.
- Option for flexible school timing not being taken up.

Teacher Training

- Compulsory Certificate in Education training for all primary school teachers has left schools short of teachers. Teachers find it difficult to implement changes because of negative attitudes of other teachers, short teaching periods, overcrowded classes, covering for absent teachers and having to work with different classes throughout the school day.
- NGO and private school teachers often considered better than their Government counterparts and may have little (days) or no teacher training.

Acknowledgements

The Reality Check has been made possible by the commitment, enthusiasm and teamwork of many. We would like to express our gratitude and to give credit to those who have been directly involved in developing the Reality Check and making it successful.

The Reality Check is an initiative of the Swedish Embassy in Bangladesh and Sida (Swedish International Development Agency) and was launched in 2007.

GRM International is the implementer on behalf of the Swedish Embassy and Sida.

The Reality Check study is being carried out by an international team comprising Dr. Dee Jupp, Dr. Malin Arvidson, Enamul Huda, Dr. Syed Rukanuddin, Dr. Nasrin Jahan, Dil Afroz, Amir Hussain, Ghulam Kibria, Nurjahan Begum and Rabiul Hasan. Dr. Hans Hedlund and Dr. David Lewis are Advisors and Jessica Rothman is the Project Manager.

The approach and methodology used in the study has been developed by the team together with Helena Thorfinn and Esse Nilsson from Sida's Policy and Methodology Department.

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The Reality Check study is only possible thanks to the many families living in poverty in Bangladesh who opened their doors to the study team. We thank these families in all nine locations for contributing their valuable time and allowing the team members to live with them and share their day to day experiences.

Rural household (South).

Introduction

Background to the 5 year Reality Check Initiative

The Reality Check initiative was established by the Embassy of Sweden in Bangladesh in 2007 as an important contribution to their Country Strategy for Cooperation with Bangladesh (2008-12). This Strategy emphasises the value of supporting platforms for dialogue *'from below'*, i.e. interacting with people living in poverty as well as with those providing services to the poor. This principle is drawn from Sweden's Policy for Global Development adopted by the Swedish Parliament in 2003, which highlights two underlying perspectives which are to permeate all of Swedish development co-operation. These are the *rights perspective and poor people's perspectives on development.* They remind us that *'poor people should not be viewed as a homogenous group; that poor women, men and children must be seen as individuals'* and, in order to ensure that *'the problems, needs and interests of poor people are given a genuine and undistorted impact on development cooperation..... the possibilities poor people have to express their needs and advance their interests'* (ref 1) must be improved.

The Reality Check is a *listening study* which has the purpose of *'listening to, trying to understand and convey poor people's reality'*. Listening studies differ from other forms of study in that they give agency to participants, thus offering an opportunity for citizens' voices to be directly linked to policy makers. Efforts are made in the report therefore to present these voices and experiences as accurately as possible.

The Reality Check focuses particularly on primary healthcare and primary education in Bangladesh. These two sectors are supported by large programmes (known as Sector Wide Approaches or SWAps) to which Sweden contributes.

SWAp	Period	Number of consortium partners	Total budget
Primary Education Development Programme (PEDP II)	2004–2010	11	US$ 1.8 billion
Health, Nutrition and Population Sector Programme (HNPSP)	2003–2010	18	US$ 3.5 billion

The Reality Check is intended to provide information on how these large-scale investments in policy change and improved programmes are being translated into the experienced reality of people living in poverty. The Reality Check is a five year longitudinal study (2007–2011) where the research team members interact with the same communities and households at the same time every year in order to identify changes, and to build an in-depth understanding of lived realities.

The study is undertaken in three locations (rural, peri-urban and urban) which each relate to the same municipal towns in three different districts in Bangladesh (one in the North, one Central and one in the South – a total of nine study locations) during October and November each year. Wherever possible each team member spends a minimum of four nights and five days staying in the homes of three families living in poverty. This immersion by the research team members enables the best possible conditions for building trust and interacting with all members of the host family and their neighbours, for building on conversations over several days and for complementing conversations with direct observation and experience.

The study both *complements* and s*upplements* other forms of studies undertaken within the SWAps, but has its own special characteristics (see Box 2). The findings from the Reality Check may confirm those already indicated by other forms of study and thus confer on these another dimension of credibility since they are revealed as a result of in-depth qualitative conversations. The study may also be expected to supplement other forms of study by highlighting information less readily obtained through conventional studies and providing nuanced interpretations of quantitative data.

Impact of the 2007 Reality Check

Following the publication of the Reality Check Annual Report 2007, the Swedish Embassy and Sida sought opportunities to bring the perspectives of people living in poverty highlighted in the study to policy discussions and public debate in Bangladesh.

The Draft Report was shared with the international Consultancy Team contracted to carry out the annual review of the Health Sector programme in April 2008.

The final Report was launched at Sida Head Office in Stockholm in April, 2008 at a meeting attended by over 50 staff of Sida and the Ministry of Foreign Affairs and presided over by the Director of Policy. A brief illustrated bulletin was produced and circulated to increase visibility of this approach. Concurrently, the Annual Report was shared with the Local Consultative Groups for Poverty and Governance in Dhaka where it generated a great deal of interest and support.

In the run up to the Accra High Level Meeting in September,2008, to discuss progress on the Paris Declaration (2005) which led to the Accra Agenda for Action, Sida Head Office devoted one of its web pages

Box 1: What people said about the 2007 Reality Check Report

'I think it's excellent, and I disagree with your colleagues who think it has all been covered in the FMRP reports. It has not. I think the very clear (to my mind) value-added of this work is what it highlights as critical factors for access among the poor: These are issues that can only be brought to life, I feel, with user-ended work of this kind. I don't think many other reports have done this'.
Dr Naomi Hossain, Team leader, FMRP

'It was enlightening and fun to read. I am sure this is valuable and much needed 'insights' - as time moves on I remain more astonished at the lack of the kind of grassroots detail we have. Worrying. So well done on bringing the most important focus back in. Methodologically, this is exciting work and I enjoyed the use of pictures etc. Visuals work well to convince. The writing also conveys the idea that much care has gone into the methods. **Dr Joe Devine, Centre for Development Studies, University of Bath**

I am so impressed and enthusiastic about the Reality Check programme. I want to express my admiration for what you have all together set up and what is being achieved. I hope this wakes up, provokes, shames even, other donors and has the impact on policy and practice that it promises. How can I get lots of copies of the report? Also I do hope you will be able to distribute it widely among other agencies, together with some device – can't think of anything off the top of my head – which will make

to the Reality Check entitled *'Reaching Results through Reality Checks'* in the resource pack prepared for the meeting.

Another outcome of the first report was that the Swedish Embassy in Dhaka supported an Immersion Programme for Development Partners to *'help create ownership of the Reality Check'* in June 2008. During the programme, Development Partners spent one night and two days staying with families living in poverty to experience the Reality Check approach, gather their own insights and develop respect and interest in people's voices and lives. Thirteen participants representing four of the SWAp donor consortia took part. Sida's report noted *'Development Partners were very enthusiastic, indicating that before they had never interacted with poor men and women whose lives they are supposed to improve'*. The participants' own comments included, '*We had opportunities for conversations not just asking questions'*. *'It became obvious during the immersion that many of my previous visits to the field only glanced over the surface of what poor people in Bangladesh are experiencing'* and *'Participating in the immersion provides a signal to external partners of the importance to engage with and, with open senses and respect, listen to what poor people have to say'*.

As a result of the Immersion and Reality Check experiences, Development Partners involved in the sector programmes are requesting the relevant Government departments to organise less-structured field visits to enable them to have more informal interaction and conversations with programme participants. For example, recently Development Partners asked for a list of schools in the area they would be visiting and in small groups dropped in on these at random. The informality led to a different relationship with programme participants and insights emerged which would not have been possible in more formal circumstances. Others have commented that the Reality Check approach has helped to enhance interest and question 'received wisdom'.

Inspired by the Reality Check, an Exhibition on the Right to Health was jointly organised by GTZ and the Ministry of Health and Family Welfare held in Dhaka in October, 2008. It presented photos and life stories from the 2007 Reality Check as well as cartoons and paintings solicited through a nation-wide competition (this inspired the Reality Check to commission cartoons for this report). This Exhibition was attended by over 3,500 people and there are plans to take the Exhibition on tour to provincial cities. Significant news media coverage was generated around the Exhibition in both English and Bangla language newspapers.

them open it and read at least parts and not just bin or put in that pile of good-to-read-but-wont-read. Congratulations all of you, and do keep up the good work!'

Prof Robert Chambers, Institute of Development Studies, University of Sussex, UK

'I want to say that you have a very interesting project on the way and I think it is very important to find ways of producing knowledge about poor people's perspectives and life conditions that can be useful to policy makers. When (people) say that the information produced in the report is already known to policy makers and development officials, looking through the report, I don't believe (them). My experience of many development workers and policy makers at higher levels is that they don't know and do not always want to know how things work for poor people, how they look upon things and what strategies or tactics they employ in order to pursue their life goals. The logic of some of the "poor people's" actions are not evident (as you show in the case of children drop-outs). But, it is demanding to learn about the practical and structural obstacles that poor people face.

Dr Charlotta Widmark, PhD, Department of Cultural Anthropology and Ethnology, Uppsala University, Sweden

The 2007 Report also led to contributions to some leading practitioner documents, PLA Notes, *Reality Checks: First Reflections*, *Immersions: Learning about Poverty Face-to-Face*. It shares notes made by research team members in the field and endorses the importance of adopting the immersion approach in this study (ref 13 – see references on page 98)

A presentation was made at UK's Department for International Development (DfID) in London in November 2008, entitled *'Bangladesh Reality Checks and Supporting Immersions'*. This emphasised the importance of combining Reality Checks with professional immersions by donors so that they can better relate to and endorse the Reality Check approach.

A presentation entitled *'Privileging Citizens Voice over Noise; Reality Checks and its implication in Bangladesh'* was made at INTRAC's *'Whatever Happened to Civil Society?'* international conference in the Netherlands in December 2008. At the conference, which was attended by 140 participants from over 40 countries examples of civil society activity and hosted debates on the nature and future of civil society. The paper presented made the case for Reality Check initiatives as a means to ensure that voices can be directly linked to policy makers without being politicised (ref 14)

Introduction to the 2008 Reality Check Report

This report presents the findings from the second year of the 5 year Reality Check Initiative. These findings have emerged from field work carried out in October – November, 2008 and from subsequent inter-team dialogue and analysis. The findings are presented in a similar form to the 2007 Report to help the reader compare the material. The Reality Check is designed to create a longitudinal study, presented systematically through a coherently organised series of annual reports.

The next section is a brief methodology discussion which explains what makes the study different from others and the small refinements and innovations were made this year within the basic approach.

This year's report includes an expanded discussion of context at both national and district levels, given the volatility of the political and economic situations. The main findings are presented under the headings of Health and Primary Education under the same sub-headings introduced in the 2007 report. The only change is the addition of family planning to the maternal health section. This year, several key themes emerged. These are drawn together in the concluding section (where Sida's PNTA [participation, non-discrimination, transparency and accountability] framework as an analytical tool is used). In this section we also present some tentative policy implications from the findings.

Box 2: What Makes the Reality Check Approach Different from other Studies?

The Reality Check both complements and supplements other studies but has its own characteristics as follows;

a) It is longitudinal; tracking change over five years,
b) It is qualitative (seeks answers to how? and why? rather than what?, when? and how many?) and deliberately explores a range of experiences,
c) It uses informal conversations, not interviews, to put participants at ease and enable greater openness,
d) It includes participants whose voices are less often heard (elderly, infirm, young, persons with disabilities) because it focuses on the whole household and not on forums such as focus group discussions
e) It uses immersion (staying with families living in poverty) so that the researchers can better understand the context in which conversations are held,

Methodology in Brief

A full description of the methodology can be found in the 2007 Annual Report, and is summarised in Annex 5.

The 2008 study is the second in a series of five annual studies covered by the Reality Check longitudinal study. What is essentially a *'listening study'* approach was adopted where research teams stayed with families living in poverty and conducted conversations with different family members, their neighbours and different local service providers.

The nine locations for the study were the same as those selected in 2007 and comprise an urban, peri-urban and rural community in each of the three selected districts (in the North, Central and South of the country). The three communities in each District all relate to the same municipal town with the peri-urban location approximately 8–11km and the rural location at least 32km distant from the town.

Each team member stayed with their own host households for a period of at least four nights and five days in each location. This means that a total of 24 host households are included in the study as 'HHH'. The only exception being the urban locations in the Central and South districts where overcrowding precluded living with the host family. In these situations, the team members spent long days (from early morning until evening) with the family instead. Details of these host households are provided in Annex 1. In addition the study includes neighbours as focal households and thus the study includes at least a further 70 households.

The team was able to build on the trust created in the first year to forge deeper relationships which led to more open and candid conversations. We took the photographs which had been taken in 2007 with us, and used these to open discussions on what had changed over the year for the family. Most families had not believed that we would really return, despite our promises, and we were warmly welcomed back and were able to engage much more quickly than the first year. Conversations were more relaxed, and we were able to be more participants than observers compared to the first year.

A number of new interactive possibilities emerged from the more relaxed relationship we experienced this year. For example, people were prepared to debate and argue with each other as we listened, we chatted more with different members of the family (e.g. by accompanying children to and from school), we were able to explore issues in depth by asking people to explain further and talk about how they felt about certain situations, choices and decisions and we asked people to role play what they were describing (e.g. children demonstrating how teacher's behave). We were more integrated into the household and could watch parent-child interaction as well as the relationships between sibling and

f) It involves shadowing members of the family as they interact with formal and informal service providers or following up on their comments about service providers by having informal chats with them which enables these voices to also be heard.

In sum, the Reality Check approach, where the team stays with the community for several days, allows researchers to be particularly attentive in recording different perspectives and other perspectives, relating these to actual life conditions (immersion and observation) and to following up earlier conversations (rarely possible in other forms of study).

"This is my village!" By Hamim, 12 years. He has a special artistic talent so his parents send him to art school to encourage his talent and interest.

friends. Our higher level of acceptance meant that we were able to observe inter-household conflict and private relational dynamics to a higher degree than had been possible last year. More use was made of drawings, particularly by children. This had several purposes beyond inclusion; as a way to distract children while conversations were being held with other members of the family and to calm them down in a way they really enjoyed.

One team used a tape recorder to record some conversations, which helped their understanding of people's stories. Although we took a video camera with us, rainy weather, difficulty managing the public interest it caused, and several missed opportunities precluded any useful footage being recorded this year. Several photo stories are being compiled following, for example, children growing up, and changes (positive and negative) to physical facilities (schools and health facilities).

Based on feedback received from the Reference Group in Dhaka on the 2007 study, the team made efforts to highlight more clearly whose voices were being listened to, and tried to ensure a better balance of age and gender. As a result, the sources of direct quotes and stories used in this year's report are acknowledged, and the teams reflected in more depth on the gender implications of the perspectives they gathered. This year, we also spent more time with some of the local service providers, both formal and informal, to try to learn more of their distinctive perspectives on health and education issues (see Annex 3).

This year a Reference Group was established in Dhaka comprising senior Government officials in the Health and Education Sectors and international development partners from the consortia which support the Sectors. The aim of the group is to provide advice to the Realty Check team before the field work highlighting issues that should have a special focus. They attended a de-briefing following the field work and helped to identify the key themes emerging from this year's work. They reviewed the draft Annual Report before publication and are regarded as agents of change who bring up issues that have emerged from the Reality Checks in relevant forums. The overall value of the Reference Group is to ensure the Reality Check is *relevant* to the needs of those concerned with the sector programmes and to ensure that there is optimal *dissemination* of, *reflection* on and use of the findings. Nevertheless, we were careful to ensure that the spirit of the Reality Check is not diluted and the Reference Group were encouraged to endorse the fact that the impetus for the study comes from people living in poverty; it is *their* priorities, *their* perspectives and *their* experiences that we are trying to capture and understand.

During 2008 the Swedish Embassy has continued its efforts to build interest in the Reality Check approach among Government officials and development partners. As well as hosting a number of presentations, meetings and facilitating the Reference Group, it has also encouraged development professionals to undertake 'mini immersions' to experience the value of the approach for themselves. These are important measures to encourage recognition of the validity of the approach and to promote informed deliberation around the policy implications of the findings from the Reality Check.

The Reality Check is not a conventional evaluation where achievements are assessed against a set of normative programme intentions. Rather it is an appreciation of the day to day reality as experienced by people living in poverty and the Reality Check Team is acutely aware that to be able to do this well, they must suspend judgment and reduce the influence of external bias on their conversations. There is thus a need to let the study participants take the lead in directing conversations while the team needs to maintain this ideal with a careful balance of external expectations.

Context

National Context

The second round of the Reality Check Study took place in October–November 2008, just as the two year term of the interim Caretaker Government was due to come to a close. We encountered uncertainty during the fieldwork about whether and when deferred national elections would take place. But elections were finally held on December 29th 2008 and returned an Awami League Government to power with a large turnout.

The Caretaker Government had assumed power after a state of emergency had been imposed in January 2007. The Caretaker Government brought the growing levels of street violence to an end, raised hopes that corruption and instability would be tackled, and attracted support from many of the international donors. In many local areas, there were reports of reductions in political and criminal interference in activities such as the allocation of relief resources and in the tendering process for market licenses and local construction projects.

These aims were initially greeted with cautious enthusiasm locally and internationally, but concerns soon began to surface about deteriorating human rights and democracy as the Caretaker Government banned political party activities and restricted freedom of association under its Emergency Power Rules. In 2008 the Caretaker Government's focus increasingly turned to gearing up for free and fair National Elections which they had pledged would take place before the end of the year. The Election Commission successfully issued voter identity cards to all eligible voters and it was reported that 11 million false names were removed from the Electoral Register. On August 4, 2008, municipal elections were held under tight government control. These were widely regarded as fair, and resulted in a decisive victory for the Awami League.

During 2008, the repercussions of the global increase in oil and food prices hit Bangladesh, a net importer of food. Many staple foods such as rice and oil doubled in price. In April 2008, protesting garment workers defied the State of Emergency to demand wage increases to cover the rising cost of food. By September 2008, the monthly inflation rate was reported to be around 10%. In October 2008, The World Bank agreed on a US$130 million soft IDA loan to assist government responses to the growing food crisis. A World Bank report calculated that the increase in food prices during 2008 had forced four million households back into poverty - a 3% increase in poverty which would adversely affect Bangladesh's otherwise good progress in relation to the Millennium Development Goals. The report also found that many poor households were reducing their food intake, and that 8% were withdrawing children from

school so that they could help with their family's economic activities. A range of new or upgraded social protection measures were thus planned by the Government in its 2008–9 budget, which allocated US$800m to try to address the food crisis, including increasing rice subsidies and a new 100 day per year employment guarantee scheme which began in September 2008.

Conditions, particularly for people living in poverty, were further worsened in 2008 by the devastation brought by Cyclone Sidr which hit the shores of Bangladesh on November 15, 2007 (just after our first year field work). The cyclone, the worst since 1991, affected 17 Districts and claimed a reported 3000 lives. The cyclone also caused extensive damage to property, livestock, and crops with an estimated cost of US$1.7–2 billion. Damage caused by two floods (July and September 2008) were estimated to have caused further losses of US$1 billion.

In early 2008, avian flu was reported to have affected 50 out of the 64 Districts in Bangladesh, leading to the slaughter of a million birds. The poultry industry claimed that the outbreak resulted in the closure of 40% of the nation's poultry farms. The disease appeared to be brought under control for several months, but new outbreaks in October and December 2008 again caused concern.

District Context

There was a noticeable shift in the way people talked about the Caretaker Government compared with last year. People we spoke to appreciated efforts to reduce crime and corruption, but were upset that the Government had failed to control food prices. In the North study area, we found that the stricter implementation of tax collection had led some wealthy people to limit their visible business activities (such as construction) for fear of being investigated by anti-corruption officials. The result was that many of the labourers and small traders who depend on the construction industry found themselves out of work. We encountered some who were trying to eke out a living as hawkers.

People from all three of our study Districts told us that they were disillusioned with national politics (though less so with local elections), although all had got their voter identity cards and indicated an intention to vote. However, during our field work, there had been no information about candidates and no canvassing, and people were sceptical about whether elections would take place. There was widespread fear that a return to elected democratic government would herald a return to *'business as usual'* with a resumption of patronage and corruption. But it was also widely felt that a political Government (particularly if the Awami League was elected) would bring down rice prices by providing subsidies.

Economic Climate

While everyone we spoke to was concerned with rising food prices, the impacts and people's coping strategies were very different in each study area. The worst hit was the North, where the price of rice reached a peak of Tk52 per kg (although at the time of the field work it had come down to Tk47 per kg). This was a threefold increase from the previous year. One explanation given to us was that shopkeepers were hoarding food, only allowing people to purchase small quantities on credit and repay in instalments. In the urban slum, the combination of cutbacks in the construction industry and the food price increases has resulted in more

women and children working compared with last year, in low-paid jobs such as domestic maids. Children were working to sort vegetables in the market, collecting fallen vegetables from market trucks, or fishing in order to supplement reduced meals. Some families have reduced the number of meals per day to just one, taken in the late afternoon.

A medicine salesman told us that the sale of drugs has dropped sharply as people are doing without because they have no money. There has been an increase in loan-taking and on-lending, as well as increased food purchase made on credit. Families have cut out snacks (e.g. school children's tiffin) and snack hawkers have consequently suffered. In the peri-urban area, people have reduced the amount of food taken at meal times, as well as the number of meals taken. More water is added to the rice when cooking to make a porridge which is more filling than conventional cooked rice. As in the urban area, more women have to work as domestic maids. The tight economic climate has resulted in less use of rickshaws and has adversely affected rickshaw drivers' incomes.

The floods severely affected the rural community with many farmers losing their only rice crop. One outcome is that children are working more, such that boys may graze cows, catch fish and work in the stone quarries, while girls look after younger siblings, collect fuel and rear poultry. In the rural area, there are fewer opportunities for women who are expected to remain close to home. Fortunately, there is still plenty of fish in the khas water bodies, and fishing was observed as a major preoccupation for many family members at all times of the day. Despite the establishment by Government of 'fair price' facilities for basic foodstuffs, these are all located in the city, and few of our families could afford the transport costs needed to make use of them.

In the South, the price of rice had reached Tk40 per kg in the summer, double the 2007 price, although it was decreasing by the time of our visit. This had some effect on household coping strategies, but these were not as far-reaching as in the North. Incomes have dropped as market prices have stagnated or fallen as illustrated by the following:

I work as a scrap-collector: I go from house to house collecting plastic and metal. First, I take a loan from the middle man, and I use this money to pay the households that provide me with scrap. I then give the scrap to the middle man as payment, and he will sell it further to a recycling place. But now suddenly the price for metal has gone down. This time I cannot manage to get enough scrap to pay off the loan and I am in debt. I work from early morning until evening and still I may only earn Tk40–50 per day. Then, if I pay Tk40 for one kilo of rice, there is nothing left! How can we survive on this? (Urban HHH father, South)

Box 3: Coping with the Impact of Cyclone Sidr

Pannu's house was completely leveled during Sidr. The family had just taken shelter in a relatives' house when a big tree fell on the house. Luckily, no one was hurt, but the tree destroyed not only the house but also the few pieces of furniture and assets they had inside. Pannu approached a UP member to get support to rebuild his house, but without success. Along with many others they received relief in the form of food for four months (4 kg rice, ½ litre of oil and 1 kg dhal per month).

One year after Sidr, Pannu's family is still living in a make-shift house. He has recently taken two NGO loans amounting to Tk13,000 in order to rebuild his house. All the material is piled up in his homestead and he is waiting for the builder to come and make plans. Sidr also destroyed the family's crops. They used to grow vegetables for their own needs, and pan for selling on the market. Since the cyclone they have not been able to take up farming again; it is too costly to reinvest at the moment with all resources and effort going into re-building their house. The family needs the extra income the cultivation could bring though, but they have no spare money after repaying the loan every week, so

This narrow passage, which also serves as storage and kitchen, leads to a row of small one-room homes that many slum dwellers live in. (South slum).

Women working for an NGO craft enterprise to supplement family income (South).

If you go to the market you will have to pay Tk200 per kg for beef, and only two years ago it was Tk90. And for selling the leather from the cow, that price has been the same for over five years! So the price of things we need to consume is going up, but for our own production, that price is going down or staying the same. The poor people living here, they eat less food now. (Urban Community leader, South)

Peri-urban farmers complained that they had been unable to afford fertilisers this year, significantly reducing paddy production. In the rural areas, at the time of our visit the price of rice had fallen to Tk32 per kg, but during the summer it was reportedly as high as Tk40 per kg. The household coping strategy here is different from the urban and peri-urban areas. Instead of cutting expenditure, families are trying to find additional means of increasing their income. For many, this means that more women work outside the home. Some are involved in NGO income-generating activities, and others have established new working relationships with farmers. This is occasional work, accessed on a day to day basis, depending on household needs. *'We prefer to work,'* one woman told us, *'and still eat three times a day, instead of not working, and only taking food*

cannot invest in this income-generating activity. Pannu is worried and hopes the coming year will pass without problems, such as sickness, which will hamper the income he receives from van pulling.

Pannu's house was destroyed during Cyclone Sidr. Through taking loans with two NGOs he has purchased material to build a new house.

Mothers work long hours in garment factories...but get to make the financial decisions in the family.

Sohel, 14 years old, has dropped out of school to look after the family's cow. 'I cannot allow that our cow dies in front of me, so even if I have the intention to go to school I can't. This is what I must do now' he says.

twice a day'. Asking how they feel about having to work they responded, *'We feel sad, because we know it is because we are poor, and our husbands income cannot support us. And we know we will have to do this for a long time, so we feel sad. If I see a neighbour that does not have to go out, I feel sad, thinking they are lucky, they don't have to work, but I do'.*

By contrast, the Central area was relatively little affected by the increase in food prices and there was very little evidence of any new coping strategies. Urban rice prices were about Tk20-25 per kg, and the highest prices noted were in rural areas where it was Tk30-35 per kg. Although people mentioned the high price of food in the Central area, it was not regarded as a big problem as their incomes had mostly kept pace. It was not mentioned as a problem at all in the rural area, where many of the households are largely self-sufficient in rice, and where this year had provided a bumper crop as a result of ideal and timely rain. In fact, many rural households benefited this year from higher rice prices, because they were in a position to sell their surplus. In urban and peri-urban areas, others seemed to cope with the price increases: vegetable sellers seem to have been doing quite well with an increase in quantity of vegetables sold (replacing meat in the diet) with little or no increase in prices, rickshaw drivers were able to increase their fares (25% in peri-urban area), basket weaving (the main income for one of the peri-urban communities) has increased in terms of volume and selling price, and most garment factory workers have secured wage increases this year.

Despite the differentential impacts of food price increases, all our families have gradually changed over the last few years from eating meat fairly regularly to eating it at special occasions only. Vegetable consumption has increased, and in rural areas and some peri-urban areas, also a greater reliance on catching fish.

Numbers of home-owned chickens are down because, fearing a further avian flu outbreak following the one at the start of 2008, households have sold their remaining chickens. This means that egg consump-

tion is also down. However, the households see this as a temporary problem and new chicks are already being reared. Some commercial poultry farms and poultry belonging to adjacent neighbours were destroyed by the army following the outbreak, and it seems that the commercial farms are not yet interested in rebuilding. There was no apparent impact in the North and South study areas.

The Southern locations had all felt the impact of Cyclone Sidr. Only a few houses had been damaged in the slum, but the peri-urban had been more seriously affected. Some of this impact was immediate (the destruction of houses, livestock and fish) and some may be longer lasting, such as the lack of fodder for livestock which has taken a long time to grow back, and fish ponds infiltrated with salt water. The rural area was less affected by Cyclone Sidr, where only a few houses were badly damaged. The village received relief goods immediately after the storm in the form of food, medicines and tin roofing sheets. One year's crop has been lost in both the peri-urban and rural locations and the communities are slowly recovering. Box 3 tells one family's story regarding recovery from Cyclone Sidr.

NGO Activity

Another major contextual difference in the three study districts is the prevalence of NGO activity. There are comparatively very few NGOs in the North study areas. Activities are mainly restricted to micro-credit, with a few also involved in informal education and health awareness work. The remoteness and inaccessibility of the Northern rural area has resulted in virtually no NGO or Government outreach services. Very few of our households use NGO micro-credit services.

By contrast, many NGOs work in the South study area, particularly in peri-urban and rural locations, with more arriving following Cyclone Sidr. In the rural study area, people claim there are as many as 64 different NGOs operating. While most are engaged in micro-credit, some have built up long-term relationships with communities supporting them with health, sanitation and education. There is one INGO that runs a child sponsorship programme, and another operating a clinic which provides family planning services and primary health care.

Many of the people we spoke to were critical of NGO credit practices. The high level of NGO micro-credit has led to high levels of debt in the South, with some people juggling as many as four concurrent loans. People told us they feel under pressure to repay these loans. We were told that few formalities are required to secure an NGO loan, and that further loans from the same NGO can easily be organised when only half an existing loan has been paid off.

There is comparatively little NGO activity in the Central location. BRAC operates schools and supports community health workers, and there is one NGO involved in the national nutrition programme, and a handful of other NGOs providing micro-credit. There is very little loan activity in the slum, and compared to the South, quite modest levels of borrowing in the peri-urban and rural areas.

Of our three study areas, the North is the least 'developed', perhaps comparable to how other parts of the country were two decades ago. It has low levels of education and women's mobility and is comparatively neglected by Government and NGO service providers. The South has a history of NGO activity, with positive impacts in sanitation and education. The Central location, on the other hand, has very little NGO activity but has

Highlights Heard

District Context

- Food price increase, unemployment due to cutback in the construction industry and floods which destroyed one full crop have had a big impact on families in the North study area; women and children have taken up paid work and families have cut back on consumption
- Families in the South took a knock from Cyclone Sidr losing livestock, crops and some housing. Many suffered also from food price increases but are gradually recovering
- Incomes for families in the Central study area have mostly just kept pace with the food price increases (which were less anyway than in the North and South)
- There is huge variation in the nature of extension and outreach services for our communities with those in the North being the least well serviced

Construction of good drains has improved the disposal of wastewater (North).

A family analysed its weekly expenditure by distributing pencils between different items of expenditure. From left to right: rice, vegetables, school, bamboo, school books and NGO loan. Before doing this exersice, the father tried to hide the fact that the headmaster of the private school let his boys attend for free and that he had a very large NGO loan.

considerable private sector investment in garment factories, transport, overseas labour and servicing the Dhaka construction industry with high female employment. The implications of these contextual differences on the experiences of and perspectives on health and education service provision are important in understanding the findings which are presented in the two following sections.

Range of our Host Household Incomes

The following income ranges are given for our host households. However, it must be recognised that these are estimated averages which are subject to seasonal fluctuations, may occasionally be supplemented by sales of assets and are not adjusted for expenditure. Many of our host households had considerable loans to pay off which mean that their disposable income is very much less than stated here.

Location	Urban	Peri urban	Rural
North	Tk340-Tk1100/wk (Tk120-275/wk/adult)	Tk400-890/week (Tk222-400/wk/adult)	Tk550-1000/week (Tk225-550/wk/adult)
Central	Tk500-1775/wk (Tk170-300/wk/adult)	Tk500-Tk1040/week (Tk170-350/wk/adult)	Tk670-1910/week (Tk225-382/wk/adult)
South	Tk1260-1400/wk (Tk315-325/wk/adult)	Tk1080/week (Tk540/wk/adult)	Tk600-1200/week (Tk300-600/wk/adult)

Main Findings in Health

This section provides the main findings in relation to people's perspectives and experiences of health provision. It builds on the 2007 report and attempts to emphasise changes since then as well as highlighting issues omitted or overlooked last year.

Health Providers

As reported last year, families living in urban areas continue to have the greatest choice in service provision, comprising a mix of formal and informal, government, non-government and private health providers. There continues to be both Sadar and District Government hospitals in all three districts, as well as NGO clinics, which provide maternal and child services in addition to limited primary healthcare. Large numbers of private pharmacies and Diagnostic Centres continue to exist, although the numbers of these in the urban South area are declining apparently due to inability to meet regulatory requirements and as a result of patients choosing only to use Diagnostic Centres that also provide doctors. In the North and Central urban areas of the study, the numbers of new pharmacies and Diagnostic Centres are continuing to increase. A brand new clinic has opened in the North urban area under the Urban Primary Health Care Project, run by a local NGO. Although it provides primary healthcare for the whole family, our families perceived this clinic as being a Family Planning centre only.

Peri-urban families also have a relatively wide choice, but this tends to be constrained by consideration of transport costs to make use of government or private facilities in the municipal town. This means that they are more likely to rely on the local polli doctor and local pharmacies. The following comment is typical, *'We never go to the hospital – only when we cannot move out of bed… then we consider going to the hospital'*. (woman, peri-urban South).

With the exception of the Central study area, it is our rural families who have the least choice. In the North location, the District Hospital is 40km away and transport costs are high. They use the Upazila Health Complex (UHC) and its doctors who also practice privately, but more often depend on medicine sellers and quacks. In the rural South they use a local polli doctor, pharmacies and various informal service providers. In the Central rural area, they too also rely on the elderly polli doctor who runs a medicine shop in the market. In both the Central and South study areas, if the problem is more serious, most use their extensive network of family connections to advise them and facilitate treatment in the municipal towns or Dhaka, thus extending their accessibility to a range of providers. They rarely use Government facilities as it seems that having made the investment in transport they want to be sure of getting

One of the many well stocked pharmacies open long hours.

Women and children queuing outside a doctor's chambers at the district hospital.

The district hospital is noticeably cleaner compared to last year (South).

speedy and good treatment as summed up by the polli doctor in the rural Central, explaining this behaviour, *'Government is government… at a private clinic they know there will be doctors at all times and that they will be caring'.*

Both the District Hospital and the Sadar Hospital in the South were found by us to be neat and clean, well-organised and with increased patient numbers compared to last year. The nearly empty wards at the Sadar Hospital seen last year are now overcrowded (130 patients in a 100-bedded facility), and patients were found lying on mattresses on the floor in the District hospital. Nevertheless, we found it more clean and orderly than last year. The out-patients attending the District Hospital have increased to 900-1000 per day. Staff at these hospitals attribute these changes to the vigilance of the Caretaker Government which has instigated regular monitoring visits. We heard rumours about doctors from the District Hospital being humiliated in public for poor behaviour. According to these accounts, one doctor was dragged outside by army personnel and had his ears pulled, another was hung upside down in view of the passing public.

By contrast, in the North location the situation in both the District Hospital and the Sadar Hospital has deteriorated markedly. People told us that the state of cleanliness and orderliness has reverted to how it was before the Caretaker Government instituted close monitoring. This monitoring, undertaken by the army in 2007, ceased this year in these hospitals. The condition of the Sadar Hospital is considered so bad and there are so many staff shortages, that we were told *'nobody bothers to go there now'*. Furthermore, people told us that the remaining doctors are only interested in furthering their own private practice, and increasing the commissions they receive from referring patients to private diagnostic centres. As the District Hospital is so near, patients prefer to go there.

The Central District Hospital appears to be more used than it was last year, and some of our families had first hand experience of its services. This seems to be because of the perception that the monitoring efforts of the Caretaker Government has made it more efficient. Staff at the District Hospital told us that the out-patients numbers are increasing because of improved road communication, better medicine supply and because it offers more space than the Sadar Hospital. Some staff at the local UHCs said people have to go to the District Hospital because there are no staff or facilities at the UHCs. People agreed with this view, and indicated that their preference was also because the best doctors are found at the District Hospital. Like the District Hospital in the South, the wards are overcrowded.

Despite overcrowding in District Hospitals there are empty beds.

Highlights Heard

Health Providers

- As found in 2007, there is a greater choice of health providers in urban and peri-urban areas than rural
- Since costs for serious ailments are always going to be high, people prefer private health providers because they are more efficient, more caring and transparent about potential costs than Government services
- Cleaner and more organised district hospitals have attracted back some of our families who had previously given up using them. But UHCs in urban and peri-urban areas are avoided as they are poorly resourced and maintained
- Even more evidence of self-referral to private Diagnostic Centres as this saves time and represents good value for money and effort spent

Although the District Hospital is preferred over the Sadar Hospital, we did meet people in the slum who had 'gone back' to using the Government *'old hospital.'* For example, one woman told us that she had received free medicines (worth around Tk75). She voiced surprise that the doctor actually spent time to examine her sick child, and used a stethoscope. She felt this was contrary to what neighbours had been telling her about the hospital before. She was used to hearing that 'the doctors were no good' and that 'nothing was free', but now she believes things have changed and people should go and experience this change for themselves. However, most people still remained sceptical, as typified by these comments about the District Hospital: *'Nothing has really changed for the poor'* (small business man, slum Central) and '*So what if there are more medicines at the hospital? If I have no food in my stomach why would I need antacids?'* (elderly woman, urban Central)

Three UHCs in the study areas are currently being expanded from 30 to 50 bed facilities (Central rural and peri-urban and South peri–urban). Very few of our families use these facilities, preferring, if they have serious health problems, to go directly to the District Hospitals if they have decided to use Government services. All three UHCs appear to be deteriorating compared to last year although cleanliness was observed to be better in two of them. Two were suffering from severe staff shortages; (five doctor vacancies in South and three in Central) and in the third, six doctors had transferred over the year leaving periodic shortages (although, recently, all had been replaced). UHC medical staff refer all but the most straightforward cases to the respective District Hospitals, and wards in all three hospitals were only 50–60% occupied.

Those patients we talked to were all either from the immediate vicinity (making it easy for their families to care for them) and were mostly elderly (on *'bed rest'*) or casualties who were brought to the UHC by third parties. All these UHCs were poorly maintained. We met one young mother at a UHC (South) whose newborn baby had problems with bleeding from the umbilical cord and respiratory problems. Despite advice to seek treatment from the District Hospital, the mother told us they cannot afford to go there. Reluctantly the doctors allowed her to stay, *'Let's hope we can treat them here'*. About 300 patients per day are seen at the two Central UHCs, the same or less than last year. Only basic diagnostic tests continue to be conducted at the UHCs (blood, urine, stool) and X-ray facilities were not available. There is ambivalence about seeking services from these UHCs

as typified by comments such as *'The UHC is our hospital –we should support and use it'* (woman, rural Central, who felt they should use the facilities but don't) and *'It is like a cow shed'* (woman, peri-urban, Central).

By contrast, the UHCs serving the North and South rural communities were overcrowded. In the North location, the lack of choice of alternative service providers means that *'people are bound to use the UHC'*. In both locations the doctors see patients outside hospital hours and in the North, people prefer to see the doctor first and then push for admittance to the UHC. In the South, the registration cards remind patients that *'private practice during office hours is against the law'* and this rule seems to be observed. However, patients try to avoid seeing the doctors in the hospital, because, as several told us, *'They will give you very little time; not more than a few minutes'*. Generally, people feel that the service at the UHCs is not good. In the North there is no facility for pathological tests and consultations lack privacy and are brief. A father in the South who lost his son to diabetes told us, *'If we could have a good hospital here, that is what I wish for.'* He spent large sums of money getting treatment from Dhaka, *'If there had been a good hospital here I could have spent that money on treatment not on transport and my son would have been able to live longer'*. Perverse-

Box 4: Let Down by the NGO Clinic

Pushba recently gave birth to her fifth child. Late in her pregnancy she started to feel unwell. She went to see the health worker at the NGO clinic. She was given a list of tests she should take. She was advised to come back the next day since there was no lab technician or health worker to help out with the test. She was not pleased about this but there was nothing she could do. The next morning she gave birth. She was not mentally prepared for this, and called for the TBA, living nearby. The TBA arrived, with only her hands and advice to guide her through the labour.

The health workers at the clinic did not, according to Pushba, provide any information regarding what to do when it was time for delivery. Despite the fact that they have health workers moving around in the community she had not been in touch with anyone during her pregnancy until the day she walked to the centre herself. And despite the fact that they claim to provide all pregnant women with information regarding the free of cost ambulance service and delivery centre nearby Pushba did not know anything about this.

The TBA gave her account of what happened: She was called for in the night. Before she started to assist Pushba she asked for her permission to do so, *'Are you sure you want me here? Do you not want to go to the clinic? You know that at the clinic there will be only men, and maybe they will laugh at you. Are you sure you want me to be here?'* upon which Pushba answered *'If it is my fate to die then be it. I want you to stay and help me!'* The TBA then ordered for a glass of water with molasses to be collected from a nearby huzur, who had blessed the water. Pushba drank from the water three times. Just after this contractions started. She assessed the position of the baby and helped deliver it. Then again Pushba had to drink of the blessed water, and the placenta came out. During the procedure the TBA told us how she had assessed her own skills and told the by-standers about how doctors in hospital would have assisted, that it would have been a much prolonged delivery procedure, and that the placenta would not have come out so easily.

The TBA that assisted Pusbha's birth and came out in the middle of the night.

Pushba gave birth to her fifth child at home.

Midwife (rural area) working for an NGO, educating children about health and hygiene, and assisting pregnant women with check-ups and delivery.

ly, neither of these overcrowded hospitals are being expanded, whereas those which are being used progressively less are undergoing expansion. There is a continuing trend for people to self-refer to private Diagnostic Centres. This was very apparent in the Central peri-urban location where many showed us their test results (X-rays, USGs, test certificates – always in english). They feel confident that they are paying for modern technology and are pleased to be able to have tangible proof of the services they have paid for, which they can keep and show to others for confirmation of diagnosis and follow up treatment locally. A neighbour of our host family, diagnosed with gallstones, was typical. He self-referred to a Diagnostic Centre near the District Hospital on the advice of a neighbour and he was pleased with the result, *'Because the centre takes a lot of money, they are more serious than the Government. It is much better than free services'.*

A new Diagnostic Centre is being built in the Central rural area. This is the first example of this sort of private initiative in a rural area in our study. The owner is a retired local businessman who told us that he wanted to *'Do something for the community… and I know that they have to travel such a long way for these services'.* His motivation is a mixture of profit and philanthropy.

Box 5: Two Different Views on Upcoming SBA Training

The HA and FWA are included on the list of upcoming SBA training. But they have different views and apprehensions regarding this training.

The HA says, "After getting the training my workload will become double with existing and new tasks. I won't be able to take care of my family and my children. I won't get any rest and relaxation. I will have to spend nights without sleep to deliver babies and the following morning I have to perform the usual duties as before."

She is thus not motivated to become a SBA. She says, "Earning more money is important but if I can't take care of my children, especially when they are very young and school-going and need my full support and guidance, it's not worth it!" By contrast, the FWA is very happy and eager to get the training to become a SBA. She thinks her status will be elevated in the community with increased income. As she has seen that other SBAs have such a good income, they will be able to have a good private tutor for the children, buy different types of assets as well as having savings. She said, "Somehow I will be able to cope both the tasks together!"

Box 6: SBAs Face Lots of Criticism in the Community

M. delivered her first baby when she was 13 years. She had prolonged labour pain (2 days) for which two TBAs were called. Finally the SBA was called in and baby was delivered with the help of an episiotomy. She prescribed antibiotics (500mg 8 hourly for 7 days; each costs Tk13) to prevent any infection. But the family did not buy these and managed to get 3 days free of cost from FWC. The SBA got handsome money as fees. Few days later the SBA learned that M. complained of stool coming from the birth canal (recto-vaginal fistula - RVF). The family blamed the SBA for this complication accusing her of making this opening with her scissors while doing episiotomy. As the SBA failed to explain that it's not her fault, she took M to the gynecologist at the District Hospital. There the family understood that prolonged labour had caused the fistula/opening. Finally the fistula was repaired at the hospital and M is now fine.

G. of the same village visited the MCWC for three antenatal checkups as it was her first pregnancy. The doctor there advised her to deliver at hospital but her mother preferred home delivery with the help of the SBA. The labour lasted more than 36 hours and the mother and neighbours became anxious. They wanted to take G to the hospital anticipating complication but the SBA resisted saying, 'No need to go to hospital, it will be a normal delivery- I am confident'. Finding an opportunity (as the SBA took a break for lunch) the mother and neighbours hurriedly transferred G to the Sadar hospital where a dead baby was born after an episiotomy. The whole community was annoyed with the sad event as it was the third similar bad case handled by the SBA in two weeks.

Only in the urban Central area had people heard of the new Grameen mobile phone based 'Health line' initiative. They had seen it advertised on TV *'but can't really believe it'* and therefore have not tried it. People seem to think it is an advertisement for the Grameen business rather than a genuine social service. Many also felt that they would rather see a doctor face-to-face although, they said, they might use such a service to confirm a diagnosis by phone. This was despite the wide spread use of mobile phones across the country.

Maternal Health and Family Planning

In all areas, most babies are born with the help of *dais* at home. As explained in the 2007 Report (p 32), there is an active and strong preference for this not just on the basis of cost. Dais are known to the family, live close by and are available 24 hours a day, monitor the pregnancy, are kind and considerate and provide help before and after the birth. Home delivery provides a familiar and supportive environment. We spoke at greater length this year to a dai in our rural Central area who had brought over 100 babies into the world without any problems. Only one of 'her mothers' had to have a caesarean but, in her opinion this was not

Box 7: Family Planning, Men said…

'I use condoms but I don't know if I am doing something wrong against Allah!'

'I don't know anything about what men can do to prevent pregnancy. I think I should know but don't know where to go to ask.'

'I have heard a vasectomy makes you weak so you cannot work!'

'Ask my wife, I don't know!'

Box 8: Family Planning Decisions (Central)

This young family is typical of current thinking among their neighbours wanting to limit their families in the rural Central area. L. is twenty six and mother of a little girl who is now four. She and her husband make all their plans together and have ambitions for their daughter. Neither parents studied beyond class 5 so they want their daughter to have a better education. They are considering moving to the town so she can go to a better (private) school. L. takes the pill (Femicon) because she and her husband are very adamant that they do not want another child yet. Her husband works away from home quite a lot but makes sure L. always has an adequate supply of pills. L. tells us that her daughter is a big expense and that another child would not be a good idea now. They will wait until their daughter is at full-time school. Then they will only

Box 9: Family Planning Dilemmas (North)

'My husband is a driver and earns about Tk3000 per month. We are facing many problems to manage on such a small income. I have an 11 year old daughter, and sons of 6 and 4 years old. I had a still birth last year but am 8 months pregnant again. I know it will be a burden to rear four children with a small income but I have nothing to do. My husband has no knowledge to keep the family small. I heard from an NGO worker that a small family is a happy family but I have no scope to keep my family small. I have never had an opportunity to meet any family planning worker to discuss this because every morning I collect firewood and come home late. No family planning workers ever come to the village. My husband does not want to use contraceptives and he feels shy to purchase from local medicine shops as most of the sellers know him as he is a driver. We don't know much about contraceptives and don't discuss with others… also our small income is a problem to buy contraceptives. If we could get it free at our doorstep then we could use. (Woman, 32, peri-urban North)

'I gave birth to five daughters and one son but only the son and two daughters are alive. All died soon after birth from the same problem which included frequent changes of colour. My mother and mother-in-law suggested I get help from the kobiraj because it was a kind of kobiraj disease. I am now pregnant again and hope for a son, as I am worried that my son will not survive. So we need more sons. I have been to the UHC for check-ups but I did not share my previous problems with the doctor because it is not his subject and he did not ask about my history. He just checked my weight and examined me and gave advice about my daily activities. I never saw a family planning worker. My sister-in-law uses pills which her husband collects from the medicine shop. She always tells me about it but neither I nor my husband is convinced to try it. (Woman, 26, rural North)

Polli doctor sells contraceptives to all, including unmarrieds, and has a pregnancy testing kit for sale.

necessary but instead was forced on the mother by her mother-in-law. She chatted at length about the deliveries she has observed in hospital, but feels the process is embarrassing. She criticised the position that they adopt to give birth, saying *'Women cannot push on their backs, squatting is much better'*. She confirmed that she will give *'saline'* if the labour is long and requests the elderly polli doctor from the market to administer this. He told us he used to work as a male dai before (he has over 70 years of experience). He administers pertoxin (also known as oxytocin) and salts separately to help give energy and increase contractions.

TBAs may adopt some folk practices, but those who do not perform well are soon put out of business as illustrated by two examples; in the urban slum in the North, the elderly TBA who has become deaf is no longer used and in the rural Central area another who had forced a delivery which resulted in the fatal deformation of the baby's skull was never used again.

Hindus are required to give birth in a room separate from the home which poses a particular problem in urban slums where there is little space (North location).

have one more, no matter what sex the next one turns out to be. *'It is Allah's wish so we will be happy'*. The dai who helped bring L's little girl into the world says, *'Everyone wants smaller families these days. But sometimes accidents do happen.'*

This young (peri-urban) couple are very keen to prevent having any more children as they only want two The husband knew very little about family planning but his wife knew about the injectibles from her neighbours at her parents home. A polli doctor administered the injection confirming to them that it *'Was safe and not complicated'*. She paid Tk100 for the first one but subsequent ones were free. However, she got pregnant even though they were careful about the dates for the injection. They don't trust the injections now and will use the pill.

'Women from the outside have no voice in the family or in the community.' (urban, North)

Polli doctor provides treatment and advice.

Box 10: Family Planning Dilemmas (South)

'I am 35 years old and a few months ago I gave birth to my fifth child. My husband does not like family planning because he believes it is the Almighty who decides when we have children and that He will take care. So I took the pill without informing him. But my husband found out and prevented me from continuing to take it saying 'everything depends on God'. So it is impossible for me to continue. Also, the pill does not suit me. When I took it I felt ill and weak so I gave up and now I have five children. I suffer because I cannot support my family. I suffer from illness and my children starve often. There is another option, sterilisation but I will never do this because my husband says it is a great sin. So I am ready to die but I am not ready for an operation like that. And keeping my husband out of it… that would send me to Hell when he will go to Heaven. Now, in the name of Allah I have taken herbal medicine which will work as contraception. My neighbour did it and she got results.' (Woman, peri-urban)

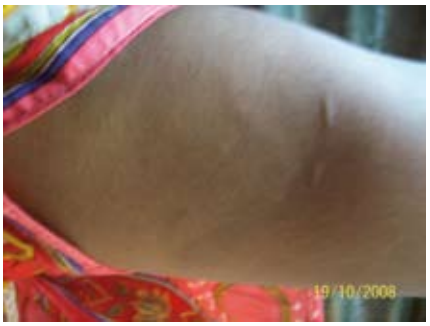
Susanna has four children but she only intended to have two. She is suffering from hypertension and heart problems which require regular medication. She tried to take the pill but her doctor told her to stop because of the other medication. That is why the first two children came along and she has found no other family planning method. (Urban)

Pushba's story (box 4) describes even when a mother was seeking advice and support from the NGO clinic, what she got from them fell short of her expectations. A dai was called in to help because she was available in the middle of the night when the labour started unexpectedly. Another woman in the same area complained that she visited the same NGO clinic where they told her she would not give birth for 2 months, but gave birth to a still born baby soon after.

Others tell of good experiences of NGO clinics. An INGO operates in the South peri-urban area and one of their outreach workers is very well respected. She covers 250 families and has been working in the community for 4 years. She includes family members during her regular monthly home visits to pregnant mothers so that the advice she imparts will be easier to follow. She provides food (wheat, pulses and palm oil) to the mothers on these visits and after the baby is born. She makes sure that the mother has the phone number of the local dai, whom she has trained, and advises her to seek help from the hospital if labour is prolonged. Men are very aware of this worker's activities and believe that through her, women's awareness of pregnancy and delivery had improved.

Although Skilled Birth Attendant (SBA) training is supposed to be taking place in all three study areas now, it is only in the Central area that we have come across them. In the rural area, we met with a HA and FWA who are due to go for training soon. They have very different views on this prospect (Box 5). In anticipation of a more commercial role, the FWA has personally purchased a digital blood pressure machine and, as mentioned below, is going to extra-ordinary lengths to subsidise services at the moment probably to impress her future client base.

The two sisters we met last year in the Central peri-urban area are still operating as SBAs, but are now more organised and have more influence than last year. They maintain a list of pregnant women in the area, provide them with mobile phone numbers to call in case of need, and make house-to-house visits, maintaining a better network for referral. The SBA's approach is becoming much more commercialised and profit oriented. Even last year people said of them *'Now they have a big bag and training, they expect more money'* and *'They run after money'* (2007 Report p 26).



A woman shows off her Norplant implant.

Box 11: No Free Help for these Ailments

An urban slum (North) woman has experienced hardships throughout her life. Her mother took her with her when she split from her father and then fostered her out following a quarrel. She was abused by her foster mother and was married off to a much older man when she was only 13. Her husband stayed with her very little, perhaps a night or two per month and provided very little money for her and her children. The constant stress has resulted in her suffering high blood pressure. *'But I cannot provide food for my family two times a day. How can I buy medicines? I could control this if the government hospital would provide me free medicine… my family can do nothing for me except to watch me die'.* (North)

Another man (60 years) from the same slum is unemployed because of his medical condition and has to maintain a family of nine. He suffers from painful piles but the medicines prescribed were too costly so he did not take regularly. Having suffered for more than 5 years, the condition has become serious and an operation has been recommended but he was told it will cost Tk20,000 at the District Hospital. He has thus resorted to homeopathy which relieves the symptoms. His younger brother had the same condition but the Tk25,000 needed for a private operation was provided by his employer. (slum North)

Tk500-2,500 is needed every month to pay for medication for asthma for one young daughter of one of our FHH in the peri-urban community. (North)

A woman from the rural South had to sell a cow to raise Tk4000 for an emergency operation for a tumour on her leg.

This young girl is pregnant and intends to have a USG to check the position of her baby but has not bothered to have any other check ups during her pregnancy.

They charge a flat rate of Tk800 for a normal delivery and Tk1500 for stitches. As a result of their activities, they say that 'at risk' mothers are better identified, but experience shared by families using their services suggests that they intervene unnecessarily and beyond their competence because of the profit motive. This leads to delayed referral and increased risk. The profit incentive has also meant that they now operate beyond their designated service areas (this has been made possible because of their use of mobile phones). The sisters regularly provide injections (oxytocin) to increase labour contractions (at least 3/10 are said to need this) but, contrary to SBA training guidelines, no records are being made of this. The sisters are defensive about their work. *'TBAs and village doctors are jealous of my income and are spreading bad rumours around'*, one tells us (see Box 6).

We met two traditional healers in the rural Central area this year that assist with maternal health problems. One works with his wife. She examines patients at their homes and her husband, whose father was a renowned homeopath, gives the treatment. They help with problems such as prolapse, white discharge, excessive bleeding, irregular and painful menstruation providing homeopathic and herbal remedies and inserting rings for prolapse. The treatment given is on a cost basis (e.g. Tk10 for prolapse rings) and the consultation is mostly free, although grateful patients will give gifts if the treatment is successful. The man's main source of income is a business and he does this work as a social service to the community, *'Because women are shy or afraid of hospital and young girls feel they cannot talk to any of their family'*. However they are not registered and are therefore concerned that their practice is *'not legal'*– but then they say *'We are not doing this to make money, only as a social service'*. The community regard them as really helping the community and the couple told us, *'If we were not good, people would not come to us'*. The other, a women healer, provides similar services and, among other things prescribes herbal medicine for frequent abortion in humans and cows! She is also consulted to assist with infertility. In both cases, the community bestows social status on these health providers.

Our study areas revealed very different views on family planning and its use. In the Central area, there is a clear preference for small and spaced families. *'Before we had no information about family planning, but now*

Box 12: Two Boys with Injured Arms

Aslam (peri-urban South) hurt his arm and the UHC sent him outside for an X-ray and some medication. Back in hospital it was decided that he needed a plaster cast which would cost Tk400. His mother protested, *'Because I said I had already paid for treatment and it is supposed to be free in hospital. I told the doctor I don't want to pay and don't have the money. The doctor refused. I then said I only have Tk200 here. Still the doctor refused and told me to go and arrange the money and only come back when I could pay the Tk400. But my son was in pain. So I left Aslam with one of the nurses and quickly went to my father's house to borrow Tk200. I came back to the hospital, paid the Tk400 and they put the plaster on right away'*. The doctor advised that they should comeback after 4 weeks to have the plaster removed but after only one week Aslam was greatly troubled by the plaster. His mother found that ants had entered the plaster. After discussion with her husband and realisation that if they went back to the hospital they would be charged more money, they decided to cut the plaster off themselves.

Ali (peri-urban Central) fell out of a tree and dislocated his arm. His father decided not to take him to the hospital as he did not want the bother or expense of having an X-ray and hospital treatment. Instead he took him to the local kobiraj who manipulated the arm and provided massage oils. The arm is better but Ali still has some slight deformity.

there is strong social pressure to keep families small' (Woman waiting at the District Hospital, Central). Another added *'This means we can give our children better health and education and there is more space in the house'*. Box 8 describes L's position which is typical of this area. Nevertheless, there is pressure to have the first child quickly after marriage to prove fertility and women worry that the contraceptive pill might affect fertility (e.g. we were told *'Nari/jorau pure jai'* –meaning, 'the uterus is burnt with the use of the pill'). In the more conservative North, family planning is still a taboo subject, few adopt its methods and families tend to be large (5–7 children).

Women mostly use the oral pill, Femcon which is readily available (Tk20 per month and includes 7 days of iron tablets) from pharmacies and is preferred to the Government supplied pill, Sukhi, as transport costs to collect it counter any benefits from it being free. Also, people say that Femcon has fewer side effects; women complain of headaches, dizziness, interim bleeding and feeling weak using Sukhi. Norplant is becoming popular for those who have completed their family. In the rural area, we were told the FWA bears the transport cost to the FWC some 5km away in order to keep numbers of users high because oral pill use and injection numbers are decreasing. Oral pill user numbers recorded at the FWC have dropped because alternatives are available elsewhere. Injection user numbers have declined in some areas, because women told us they do not like the fact that menstrual bleeding stops, their lower abdomen feels heavy and some also worry about the feeling of loss of femininity (because bleeding stops) and possible infertility. In other areas (urban Central), injections seem more popular. Norplant is preferred to Copper T because *'We can see it and know it is working'*. But users are not always happy. They worry that the *'Sticks' might disappear into the body'* and like injectibles, since bleeding stops they fear a loss of femininity.

Many told us the problems with Norplant and injectibles resulted in them reverting to using the Pill. Although it can be inserted by a FWV at satellite clinics rather than involving a trip to the FWC, Copper T is associated with more bleeding and fear that it might be lost. However, one user told us that the Copper T is preferred because it is less of a bother than the pill. One FWA has a Copper T fitted herself but her son's hand has broken since and she is linking these two events and is now advising clients not to use a Copper T. She also refers and accompanies clients to an NGO Clinic in Dhaka for swift legation operations. She only gets Tk35 for lunch for this and no transport cost is provided. It seems she goes to extraordinary lengths for no clear material reward, but she says, *'One satisfied client will bring more'*.

There is little house-to-house family planning counselling available from Government or non-government sources as there has been in the past and women told us that they get most of their information from neighbours who have experienced different methods.

We talked with several men about family planning and they complained that there was no information programme designed specifically for them. Those in the Central area would like to know more about different family planning methods, and their associated side effects, but only get limited information from their wives. Little is known about vasectomy. People think the man will be too weak to work properly following a vasectomy. Men were nervous about the procedure and said it was better for women to take measures and urban slum women told us they were unhappy with the idea as *'Onno meyer shatte takbe karon baccha*

Highlights Heard

Maternal Health and Family Planning

- As found in 2007, there is always a preference for home births with a traditional dai who is known to them, caring, and available 24 hours before and after birth
- Polli doctors and private clinics are better networked with their patients than before largely due to mobile phones
- SBAs want to make money and so people believe they intervene beyond their competence and delay referrals
- Local informal health providers are liked because they can give confidential and discrete advice and follow-up on reproductive health issues even to unmarried girls
- Strong preference in the Central study area for small and spaced families (two children considered ideal)
- The low dose oral contraceptive readily available in the market is preferred over that provided free by the Government which is high dose with attendant side effects and incurs transport costs and opportunity costs to collect
- Women do not like long term methods of female contraceptives which result in loss of bleeding which leads to women feeling a loss of femininity. There is not enough counselling about different methods
- Men feel excluded from information about family planning. Many rely on their wives for information but they would like to know more about options, their side effects and how to rationalise use with religious teachings


District Hospital.

hobe na' (he will stay with another woman because there is no fear of more children). One man in the Central slum who has had a vasectomy recently told us that he is very satisfied, but has not told his wife due to fear of social stigma. Men in the North were *'not interested'* in family planning, although some purchase the oral pill for their wives. They are not willing to use condoms and expressed concern about the tension between Allah's will and their wives' interest in using family planning. Even in this conservative area, however, both men and women told us that they thought there should be more home visits to provide advice and support in family planning decisions.

In the Central area, there is wide knowledge of menstrual regulation services and so unsafe abortions are rare. The price charged for this varies depending on the length of the pregnancy and unmarried girls are expected to pay more. There is also wide knowledge of the 'morning after pill' which is readily available in local pharmacies and from SBAs. Pregnancy testing strips are also available in some pharmacies (Tk20).

Special Measures for Inclusion

According to patients, our families and hospital staff, this year medicine supplies to Government hospitals have improved slightly in terms of quantity and regularity - but not variety. This more regular supply is attributed to the Caretaker Government. The same, mostly generic, medicines as last year are available for free (a little less than half the ones which hospital monitoring boards suggest should be available free) and people in all locations complained that they still have to buy most medicines outside.

A dispenser at the peri-urban UHC told us that even though supply is better it is not enough, *'I ask for 60,000 tablets and get 5,000… how can I make that last? We give out medicines for free without any discrimination until the medicine runs out. Then we have to wait for the next delivery, which may take as much as two months'.* In the Central UHC, doctors said that out-patient numbers are swollen by people who are not really ill. They drop by the hospital while doing their marketing or because, according to the doctors, women whose husbands are working abroad *'Come for recreation'* and *'Complain of weakness so they can get prescription vitamins for free'.* Another doctor added, *'Some women get cross that I want to ask them for their medical history as it wastes their time. They just want me to write a prescription so they can get their medicines for free and quickly'.* The doctors doubt that these patients are the most needy.

It is well known that the only medicines available free from Government hospitals are the cheaper generic ones. For families in rural Central this means that it is not worthwhile to avail these because transport costs are so high and they are readily available in the market.

We came across three examples of doctors providing treatment from their homes for free. One, referred to as the *'Bideshi doctor'* as he has a foreign degree, is a Government doctor but when he returns to his family residence at weekends, provides informal advice and prescriptions to known families in the Central slum. He also provides special care and support for one of our HHH TB patients for whom DOTS treatment was denied earlier. Another qualified paramedic runs a daily clinic in a nearby pharmacy. He is referred to using the informal word 'tumi' for 'you', which implies a close and good relationship. He is said to 'never charge' for his advice and readily refers patients to the government hospitals. Another paramedic, this time in the rural South area, who

works in a UHC some distance away, offers services from his own home. He is well trusted and people both consult him directly and seek second opinions on diagnoses they have received from the UHC. He does not charge anything. Our families said that he argues that since he already has a salary from his government job he is willing and happy to provide services for free.

A few of the private doctors in urban North study area charge the poor minimal consultation fees of Tk50. Government doctors sometimes exercise their own judgement about peoples' ability to pay and waive these unofficial fees. They may prescribe only what is available in the hospital dispensary or write notes to pharmacists and Diagnostic Centres indicating that the patient should not pay the full amount. A couple from the peri-urban South told us how their hospital fees were waived because the doctors at the government hospital often used the services of the husband, a rickshaw driver, to transport their wives or carry goods from the market for free.

The new Urban Primary Health Care Project (UPHC) in urban North runs a Clinic, which provides poor patients with free medicines and maintains a wider variety than the Government hospital. However, very few people seemed to know about this facility. The Clinic distributes red cards to poor families (based on a household survey), so that they can avail these free services. However, better-off families (who would any way get medicines at a subsidised price from the Clinic) seem to be provided with these cards too. The Clinic runs satellite clinics in the slum twice a week but people feel this should be six days per week. Because the medicines are free, some people collect prescriptions from other clinics, notably the nearby NGO clinic, and get them filled at the UPHC Clinic. Another UPHC operates in the urban South and is situated right in the middle of the slum. A relatively less poor family managed to get one of these red cards entitling them to free services this year by simply asking the Clinic for one. Yet, a young widow with a small son (6 months) and no means of support tried to get help when he suffered repeatedly from fever and diarrhoea and the Clinic refused since she could not pay. Other NGO clinics in other locations, although very close to our communities, are also not fulfilling their intentions to provide services for the poor. As noted in last year's report, their free services for the poor are limited and not always well targeted. Furthermore, people don't know about them. A Missionary Clinic operates in the municipal town in the North where people are supposed to get treatment for a minimal fee of Tk5 and free medicines are provided but none of the slum families know about this facility.
Many told us about the changing nature of disease currently affecting the poor. A polli doctor in the rural South said that previously people

Reality Check in action. A boy having a discussion with one of our team members about school, and describing a drawing he has just made.

Box 13: Escalating Costs in Government Hospital

Saddam got his leg trapped unloading trees off a boat. He came to the District Hospital because he thought it was for poor people. But he has already spent Tk30,000. The major operation he needed was delayed because the hospital did not have the materials needed. The doctors wrote out a list of requirements which necessitated collecting some from Dhaka, including metal plates and screws. He thinks he will have to stay in the hospital another six months and fears the total cost will reach Tk50,000. *'How can I manage this? I can't beg, borrow or get any more money now. I don't know what to do'*. But despite the financial crisis he faces he still says the doctors and other medical staff are doing a good job. (urban South)

Highlights Heard

Special measures for inclusion

- Although free medicine supplies in Government facilities have improved (attributed to the Caretaker Government), the ones now in stock tend to be the basic medicines which are readily available and cheap anyway.
- Noted more strongly than last year was the fact that there is no free or subsidised treatment for conditions such as heart problems, diabetes, cancer and stress which are prevalent among people living in poverty
- Doctors say that many of those coming for free medicine are not ill but just want painkillers and vitamins
- Some doctors provide services for free in their leisure time, or arrange waiver of their commission on referrals to Diagnostic Centres or reduce their fees for those they know are living in poverty
- Clinics with special programmes for the poor are not well known or accessed by the genuine poor
- The national nutrition programme is needed in some areas (e.g. North) but is not operating there and is redundant in others where it still operates
- People living in poverty are particularly vulnerable to malpractice and exploitation

had suffered mainly from diarrhoea, dysentery and cholera but that the prevalent problems now are cancer and heart disease. His explanation is that while sanitation has improved, the increased use of chemical fertilisers and insecticides has exposed people to new risks. The health stories in Box 11 illustrate how ailments suffered by the poor are not adequately addressed with free or subsidised medications. Last year we highlighted this problem as follows; 'Some H/FHHs complained that there are no free medicines for diabetes and heart disease and doctors have told them that these are *'diseases of the rich'* contrary to the comment heard frequently, particularly in urban locations, that *'the poor suffer from these too'* (2007 Report p 25).

There are many programmes in Bangladesh offering free eye treatment, particularly cataract operations, but two of our FHH had failed to find out about these. A mother and her fourteen year old daughter in the Central rural area and a man in the rural North all suffer from cataracts. He says, *'I heard that many organisations provide free treatment to the poor, but I have no such information and I do not know where I will get free treatment'.*

Polli doctors in the peri-urban South and rural Central areas give free consultations but sell medicine, sometimes allowing deferred payments. Pharmacies in the urban North may sell medicines at lower prices, based on patients' ability to pay. Pharmacies may also keep their prices down for the poor; *'If we see a poor person…we can tell from the way they are dressed… then we can cut the price. This is what we can do if the poor person comes directly without using a dalal'* (pharmacist, urban South). In some Diagnostic Centres in the South there is a provision for the poor to pay less if the patient comes from a known doctor and the prescription has 'should not pay' written across it. However, this practice is also extended to doctor's relatives. Something similar is implied in the Central area too. Diagnostic Centres are requested by doctors to reduce their charges by 20% if the patient is poor (or a relative). This is the equivalent of the doctor's 'cut', which they forego.

The nutrition programme has recently re-started in the rural Central area, although the volunteers are reluctant to prepare and supply the 'pushti' packets despite an increase in the price paid for these (increase from Tk10–Tk12, giving them Tk1 profit per packet). They say that there is little need for this programme here. The three community health workers (Health Assistant, Family Welfare Assistant and Community Nutrition Provider) who work together from the Community Nutrition Centre once per month told us that they think all mothers are aware of nutrition now, and that the programme is redundant. However, they no longer make house-to-house visits, and our observations from living in the community suggest that there are a few vulnerable malnourished mothers and a few with oedema (swelling) who fail to meet the BMI criteria, which

Box 14: Forced to Use a Private Clinic and Still Paying for it

M self referred to a private clinic having suffered high fever and abdominal pain for over one month. Her mother-in-law insisted she went there after phoning a doctor and explaining the symptoms. A USG revealed an incomplete abortion. So with Tk5000 she had a DNC. The family was very happy with the behaviour of the doctors and the treatment but thought it was worth about Tk1000. M and her husband know people who have used the district hospital and believe that the doctors there are better (more specialists) and the price low but they had no choice as they were pressured by the husband's mother. The husband has taken out an expensive loan to pay for this - with interest to pay it will end up costing Tk6300 rather than Tk5000. They said they would go straight to the District Hospital in the future and not ask anyone's advice. (peri-urban Central)

entitles them to nutrition supplements. There is no nutrition programme operating in our communities in the North and yet here there is perhaps the most malnutrition and poverty of any of our study areas.

A new programme started in August, 2008 in the Central rural location which was referred to by people as a *'three month VGD card'* enabled holders to receive 15kg rice three times which they collect from the UP Chairman. The recipients are different from those who usually get VGD cards. Several people we spoke to felt that these had been distributed politically and not necessarily to the poor.

Costs

'I have spent so much money for treating my wife beyond what I can afford. It seems it is better to get a new wife rather than treating a sick wife' (man, urban Central).

There has been no increase in standard displayed charges (for registration, admissions, diagnostic tests) made in the Government hospitals this year except for the admission fee for in-patients at the North District hospital (increased to Tk20 from Tk15). However, these tell little about the real costs of hospital treatment, both for out-patients and in-patients

People in the urban North area say that there is always a small (additional informal) charge made by Government doctors for their out-patient consultations. This is implied to be the case in other areas too: *'Doctors do not care or look at a patient without money. Tk50 was paid in the past but due to the fear of the Caretaker Government doctors have a higher risk. They have thus doubled their fees, they now take Tk100 at the hospital, same as they do in their private chamber in the afternoon'* (woman, rural Central) and *'After standing in the queue we pay Tk3 for registration that gives us access to the general practitioner. This doctor will write a prescription for general medicines and if they are available we can get them from the hospital dispensary. All this is included in the Tk3 but if they choose to see a specialist they have to pay Tk50'* (woman, peri-urban South).

As we reported last year, Government hospitals are regarded as expensive as so much has to be bought from outside. A peri-urban woman (South) told us, *'I cannot feed my (sick) husband, so how can I buy him medicine? The doctor was always writing a slip about what medicine to take and we have to buy it from outside, but when we go there we cannot manage to pay for it. If*

"My dreams are lost because I cannot get better" (Boy, 13 years old)

Box 15: A Boy's 'Lost Dream' Because Medical Treatment is too Costly

'I am a boy of 13 years. My father is van puller and mother collects firewood for maintaining our family of four. I have completed successfully three year's course at BRAC school I am eager to study more but now I am not able to attend school due to my knee problem. In late 2005, I felt pain in my knee and went to pharmacy to receive treatment and that treatment continued for about six months. But that treatment did not cure, rather pain was increasing day by day. Then my father went to the District Hospital for better treatment. The Doctor examined me and gave a medical test (X-ray of knee). The X-ray was without cost but when my father gave the X-ray plate to the doctor, he then further advised my father to go to a specific diagnostic centre for blood tests as he found nothing in the X-ray. Then my father took me to that diagnostic centre and paid Tk2200 for the tests. My father could not collect the report by the same day as it required time for blood tests and we needed to spend another day at the District town. My father looked very gloomy and he became depressed, as he lost another day to earn.

He asked me how he could collect such a big amount of money and then we came back and went to pharmacy and shared everything with the

This woman is uncomfortable and in pain but her husband says he has already spent a lot of money on her health, 'It is better to have a new wife than spend more money on a sick wife'.

the doctor gave us a clue of the price of the medicine this would help us to make sure the pharmacist does not exploit us. As it is now, we have no idea if the cost should be Tk5 or Tk30. So we are completely in the hands of the pharmacist'. Many told us of expensive operations at Government hospitals (see Box 13). This comment from a patient in the District Hospital in the North is typical, *'Everything we have to buy from outside, only food is free'.*

We were told that doctors at the District Hospital in the North discourage patients from having diagnostic tests carried out in the hospital. One patient told us *'The doctor told me to undergo a number of tests at the Diagnostic centre. When I requested him to allow me to go to the District Hospital where he was a doctor, I was stunned at his reply as he told me if I would go there he would not support me as he could not rely on other places. Rather he could rely only on the Diagnostic Centre he recommended for the result'.*

Often the X- ray machine is not working, but doctors exploit this even when it is working. One patient told us that when he asked for an X -ray he was told that the hospital *'doesn't have equipment'* and was told exactly where to go for an X-ray. It is believed that doctors take a 20–50% commission on such referrals. Staff of a Diagnostic Centre told us how a doctor was surprised to receive Tk5000 from them as referral fees at the end of the month, but it was explained to him that that was normal practice. This doctor is now referring patients to this particular Diagnostic Centre on a regular basis. In the Central area, people assume that the doctor's fee is included in the test fee from the Diagnostic Centre. In the rural South, non-medical staff at the UHC told us that doctors have links with Diagnostic Centres and patients may have to pay *'up to ten times more for a test compared to the cost in the hospital'.* These are doubtless exaggerated claims, but illustrate the fact that it is usually hard for a patient to compare costs. In this particular hospital the only pricelist available was completely obscured behind another poster, and private Diagnostic Centres do not always display their charges either. Our families confirmed that it was usual practice to be referred to these Diagnostic Centres.

Last year, we noted that patients seemed to be asked to complete a range of unrelated diagnostic tests by doctors. The prevalence of this seems worse this year and, of course, leads to unnecessary costs for the patient. We found X-rays being recommended as first line of investiga-

Box 16: Continuing Problem of Dalals

paramedics. Then the paramedics prescribed only one tablet named Dichlophen, a sort of pain killer with an antacid and still I am taking those tablets. But it is not the right solution for me. This pain stopped my study. Always I have to stay in my house and I feel so bored. I can't run like others. I like to play cricket and sometimes I join with the children and they give me opportunity for batting and wicket keeping. I don't know what will happen in future'.

Babul, a pharmacist told us there are less dalals now since the military took action against them, but the real problem is that they are linked to people high up in the hospital administration so the military cannot deal with this on their own. Everyone profits from their business and it is hard for pharmacists who do not want to cooperate since musclemen are involved.

With his help we met a few dalals hanging around the emergency department of the hospital. Some were in bad health themselves and we were told they were drug addicts. A dalal told us, *'Patients are confused even after buying a registration ticket, they don't know where to go for treatment, they can't find their way inside the hospital'.* Sometimes these dalals are asked to run errands for hospital staff. (urban South)

tion for possible TB even when sputum tests are free. Frequent referrals for USG often as first line tests for reported *'stomach pain'* or *'chest pain'* and many tests being done at once rather than sequentially as one would expect from an algorithmically-driven diagnosis. It has become normal for pregnant women to have USG, which are often self-referrals. This is often demanded by the mother's mother or mother-in-law to check the position of the baby and sometimes to check its sex. Some increases in costs for tests have been made in some Diagnostic Centres.

However, as more people seem to self-refer to Diagnostic Centres and in these cases less unrelated tests seem to be carried out, costs can be contained compared to going through a medical practitioner. As mentioned above, people seem very pleased with getting tangible results from these private Diagnostic Centres and feel they are getting value for money. Last year we noted the common practice of seeking help from a variety of health providers simultaneously or sequentially, which incurs high cost and creates a frustration that many tests had to be repeated because records are not passed on (2007 Report p 27). Clearly, holding one's own record in the form of test results from Diagnostic Centres helps to reduce such costs.

Urban pharmacies in the South study area say that since medicine prices have increased *'Profit is less for us now'* and that they cannot pass on the increase to their customers. In the North, medicine sellers told us that sales have dropped since the economic crisis has hit and many construction workers were put out of work. People said that they are more likely not to complete a whole course of treatment now, because they cannot afford to even though they understand that they should. One of our FHH (rural South) walked half an hour to return two capsules of medicine she no longer needed for her husband and got Tk20 from the pharmacist.

Pharmaceutical representatives were banned from visiting doctors during clinic hours by the Caretaker Government, and were found to be having to adopt different tactics to sell their products. In the District Hospital in the South, they hang around in the corridors hoping to be able to hand over their business card to a doctor saying that *'a smile and handshake will make an impression'* and maybe lead to an appointment later. We were told that many doctors have connections with these representatives and receive Tk10,000 if they prescribe a drug from their company over 20 days (Tk20,000 if they agree to prescribe three drugs). The same practice is rumoured at the UHC too.

Dalal (broker) activity has increased in the North study area and they are operating openly once again in all the government hospitals. Among the dalals which promote private diagnostic centres there are also pharmaceutical representatives (*'in suit and tie'*) who persuade patients to buy certain medicines. This all happens despite sign boards exhorting patients: *'don't talk to dalals and report to the authority if there is any sort of harassment by dalals'*. By contrast in both the Central and South areas, dalal activity has been greatly reduced but not eliminated (see Box 16). Dalal activity has reduced considerably in the Central MCWC although there was some concern that it still happens at night when there are few staff on duty. At one of the Central UHCs a hospital worker said, *'Dalals would not dare to operate here now – they are afraid of getting caught'*. In the South Diagnostic Centre staff told us they try to prevent dalal activity by beating them up.

Highlights Heard

Costs

- Since serious health conditions will incur high costs anyway regardless of health provider, the private services are preferred
- If the patient wants more than a cursory consultation (minutes) and a prescription, they will have to pay something in a Government facility
- Many Government doctors take 20–50% commission on referrals to private Diagnostic Centres and discourage the use of Government diagnostic services
- Self-referral to Diagnostic Centres reduces costs because they are 'one stop' and reduce the number of unnecessary tests being done
- Fewer dalals (brokers) are operating in Government health facilities as they fear getting caught by the Caretaker Government's initiated army monitoring
- High dose medicines are routinely prescribed and patients told to counter the side effects and boost their efficacy by eating well. But people living in poverty cannot afford good food and stop taking tablets early because they make them feel unwell and this rather than the illness prevents them resuming work

An Upazial Hospital frequented by the rural villagers.

A new information centre at the district hospital.

Health Facility Functioning

Hospital quality and efficiency

In the South study area, remarkable positive differences in Government hospitals have been noted by staff and patients we talked to this year. Some positive changes are also apparent in the Central area. But all the positive trends observed in 2007 in the North study area have eroded. In all cases, the positive changes (this year and last year) are attributed to the Caretaker Government's initiatives to monitor the facilities regularly.

At the District Hospital in the South, there is a new information booth provided for patients at the entrance. All the corridors were clean and tidy, with cleaners constantly wet-wiping the floors and waste bins placed in every corner. Last year the corridors had been littered with old mattresses and furniture and the toilets were not clean. The registration counter now opens promptly at 8am. There are guards outside each ward who check visitors. A new system of visitor cards has been introduced. A patient's family has to purchase a laminated card (Tk60) to enable them to visit the patient at any time, including outside visiting hours. On return of the card a refund of Tk50 is made. The card notes that the *'Remaining Tk10 will be kept for the betterment of the patients and the ward'*. These cards do not seem to have a time limit and we met a family using the same card for two months. Nobody at the hospital complained about the introduction of the card or its cost although some doubted how the Tk10 was used, *'If they really use this for the patients it is really good. But we have no way of knowing. But this is a way for the Government to keep discipline in the hospital…it is working and we also like this order'*.

A local leader in the slum was spreading rumours about this, *'Since the Caretaker Government things are not going well. They have introduced a new system at the hospital. You have to pay Tk120 to get in to support your family. You get Tk100 when you leave. Six months ago it was Tk60, now it is suddenly Tk120. Soon it will double again to Tk240'*. Fathers were outside the maternity ward when we visited, prevented from entering while the doctors conducted their rounds but there was no complaint. They explained they were waiting for prescriptions so they could go and get the medicines their wives needed. The Sadar Hospital, too, was much improved compared to last year. Staff told us that people are using this facility again because

2007 – sink without plumbing in the outpatiens department at the Upazila Health complex...

2008: still in the same condition as it was the year before.

Outpatients at the Upazila Health Center closed before official closing time.

there is 'no mismanagement now', and this was borne out by the over-flowing wards which were nearly empty last year.

In the Central District Hospital, there were no observable changes, although some vacancies have now been filled by doctors transferred from local UHCs (leaving vacancies there). However, there is a severe shortage of nurses and of the 27 presently on staff seven are on maternity leave or training. There was none of the discipline observed in the South, and people wandered freely throughout the hospital. The only guard we saw was tending a patient one day, and re-bandaging a patient's hand on another day! Like the South, mattresses were provided on the floor for the extra patients (beyond its 100 bed capacity). Wards were not better maintained than last year and were rather dirty, despite the new Interdepartmental Services Monitoring Board displayed in the corridor which lists 15 indicators which are to be assessed daily. The chalk check marks did not look fresh. The toilets observed last year are just as dirty and in the same state

There has been however, an increase in public notice boards painted on the walls of the hospital. Although opening hours are clearly displayed, unlike the South, this District Hospital did not open until 9.30am; one and a half hours after the official time. Patients told us, *'We know the official time is 8am but it never opens before 9am.'* Although three operating theatres were planned for this hospital after five years only one is functioning. This means that an operation may be interrupted if an emergency comes in. It also means that obstetrics/gynaecology can only use the Operating Theatre three times per week whereas one Operating Theatre was intended to be dedicated to this.

The Sadar Hospital seemed to have instigated some improvements; there were more doctors on emergency call and the wards seemed to be more organised. The MCWC in the same grounds had improved enormously. It was much cleaner and wards were full and more orderly. The numbers of patients have increased gradually each month since the new Medical Officer took charge. He is a man who exudes energy, *'Everyone knows me and we have a good team here now'.* This was the only health facility where the Citizens Charter is displayed. The staff also told us that since the Caretaker Government, *'We feel free now. We do not suffer from political pressure and the facility is working much better now'.* This Facility was awarded 'A' quality by the Ministry of Health in June 2008.

Hospital wards are cleaner and neater than in 2007.

But there are still some hygiene issues. This used surgical glove was left in a public corridor for several hours.

In the North District Hospital, functioning has deteriorated. Staff feel more relaxed as the brief period of army monitoring of activities has now ceased. The registration procedures have broken down once more. No new equipment has been installed, and the X-ray facility is often not functioning. The hospital displays a sign saying it is now a *'Youth Friendly Hospital'* but there is no indication of what this means. Medicine supply is still poor in terms of variety available. Doctors routinely attend out-patients clinics late. The state of the District Hospital is summed up by these comments from a woman patient, *'I know there are boro doctors in the Hospital, but they have little time for us, even they don't listen to us properly. The Hospital environment is noisy and the nurses and ayahs behave rudely to patients. Moreover, we are forced to go to Diagnostic centres for tests and are prescribed costly medicines'.*

In contrast to the District and Sadar Hospitals, all the UHCs remain poorly maintained and little has changed since last year. Nurses who had worked for more than 15 years in one of the Central UHCs told us that this was the worst year for maintenance and non-medical supplies. They even have to ask patients to bring in paper so that patient notes can be written up and they showed us patient notes they had made on a notepad provided by pharmaceutical companies to emphasise their point. There is no money for light bulbs, brooms and other consumables and so the medical staff purchase these themselves. One matron told us, *'There is no budget for maintenance, so we do it ourselves'.* Despite this, the wards and other public areas were cleaner than last year. The sheets, although only changed for each patient, were neatly folded and straightened and, unlike last year, there was no garbage or food stuff on the floors. However, the cat we observed last year continues to wander through the wards undisturbed! In the other Central UHC, livestock graze in the compound despite signs and efforts to stop this practice and the wards and corridors are not clean. The Storeman told us that *'The cleaners think they are doctors and don't think they should clean… their supervisor is never there'.*

There is some mismatch between staffing and resources. The anaesthetist and surgeon are grossly under-utilised at one of the Central UHCs, as the new operating theatre has not opened yet. In one of the South UHCs, the X-ray machine has been out of order for fifteen years but the technician has been coming to work every day even though he has nothing to do.

The notice on the tree outside the hospital says "Grazing of Animals is Prohibited", but animals roam freely on the hospital grounds.

Government staff behaviour

Poor staff behaviour is still regarded as a major reason why people do not choose Government facilities. Private clinics are always staffed and the staff are regarded as pleasant and caring. One of our HHH mothers in the South told us about how her son was treated roughly by nurses in the UHC. They forced a saline drip into his arm and blood gushed out. She complained to a nurse, whom she knew, and she was advised to pay the first nurse Tk20 to get better treatment. Our mother did so and, indeed, got better treatment. It was also noted in the North study area that the behaviour of staff seems to *'suddenly improve'* if they are provided with a bribe. A mother who was admitted to the South District hospital with high fever following a still-birth was ignored after admission to the ward. The doctors demanded she arrange three bags of blood before they would do anything for her. She managed this but then a further three

Box 17: TB – a Worrying Trend

Last year, members of two of our host and focal families in the Central urban location had suffered with TB. This year, the number has risen to members of seven families. Not only has the incidence increased but the recurrence rate is high with most of the patients indicating that they had thought they were better and then succumbed again.

C's story is typical. She started coughing last November and when pain started she went to the Sadar Hospital. She was told she would need an X-ray but there are no facilities at the hospital so she would have to get it done at a private diagnostic centre. She did not have any money for this and the Chairman who had helped her in the past refused to give her the Tk200 she needed. So she did not go back. The pain worsened and she went to the hospital again. This time, they sent her for a free sputum test and prescribed some medicines which had to be bought outside of the hospital. She went for the test but did not buy the medicines. The test confirmed she had TB and she was referred to the DOT centre in April. She says she was given two months of tablets. When she first started to take them she felt more ill, *'They made me feel dizzy and weak. I said please Allah take me, it is better than this'*. She persevered with the tablets for seven weeks but the headaches and dizziness remained. *'The doctor told me I should eat more protein. Since I cannot afford to do this I know the tablets will not work properly'.*

She had been told to attend the DOT centre after 8 weeks. When she went there with her DOT card, the shebika ticked all the boxes at one time, thus affirming daily doses had been taken. By this, the card implied that C had taken the

Emergency waiting room at Goverment Hospital.

Soneka and her son Aslam's experience at the Upazila hospital was unpleasant until they bribed a nurse upon the suggestion of another nurse.

bags were demanded and it took her family another day and half to organise three new donors.

Construction

A number of the Government facilities are undergoing expansion at the moment. In all cases construction has been delayed. The partial third floor construction which started in 2007 at the Central MCWC is still unfinished. The Medical Officer says it is currently in *'slow motion'* due to a dispute between LGED and the contractor. One of the Central UHCs which was in an advanced state of construction in 2007 is still not ready. This delay is because the budget had to be re-approved to include a boundary wall and no construction has taken place in the last three months. The new construction promised in 2007 at the other Central UHC has not materialised. Building materials are still piled up in the compound. At a UHC serving the peri-urban South, building material are also piled up outside the hospital awaiting construction of expanded wards and doctors quarters.

medicine even though there had been no direct observation (and C's neighbour told us that C had thrown away some of the tablets because they made her feel sick). This time the sputum test was negative. C started working again. But in September this year, the coughing and pain returned. *'I did not want to take the medicine again as it makes me sick. If I take it I cannot earn. Anyway, I cannot go up to the hospital again and again as it costs Tk20 on the rickshaw and all the tests take so much time'.*

C's son-in-law also has TB (confirmed by the Mantoux test) but, according to him, since *'he is not coughing blood'*, he is not entitled to free medicines. He therefore buys Ethionamide from a doctor at Tk300 every 15 days. The medicine makes him feel very bad but he has to keep going to work at the garment factory. *'Without this, how can I feed my family?'* he says. But just two days before we chat with him he was so ill that his family thought he was going to die.

Both C and her son-in-law do not think they will still be alive next year when we visit.

Another woman, E, had completed her full course of DOTS for pulmonaryTB but she said, *'No BRAC Shebika or Government staff ever followed-up at home for DOTS'.* The same symptoms have re-appeared a year later. Following tests, she has been told it is not TB and has not been provided any treatment but she is sure that it is just as before, including coughing blood. She cannot afford the full cost of private treatment and so she takes medication irregularly.

Hospital food

Despite the policy to enhance hospital food, the patients at the Central District Hospital still get only two meals which do not seem to be improved since last year. The food provision in the North District Hospital is regarded as inadequate so, although it is free, *'The quantity and quality of food is not enough'* (Patient). People from the peri-urban community complained that it is difficult to collect food from outside the Hospital and it is expensive. Food provision in both of the Central UHCs has improved; in one, all patients get three meals per day comprising banana and ruti for breakfast and either fish or beef and rice at lunch and dinner and patients we spoke to seemed very happy with this food provision; an adolescent from our rural FHH who had been admitted to the other UHC because of profuse bleeding from a cut, told us that the *'Food was good, we had egg and fish and got three meals every day'*.

This man is suffering from TB but is not getting free treatment.

Health extension work

Home visits by health workers seem to have more or less ceased in all areas or have never happened (urban slums and rural North). A FWA in rural Central says that combining running outreach clinics and house to house visits is a *'miserable life'*. She rarely makes house visits now, only to motivate people for Norplant camps and ligation. Her colleagues (the HA and CNP) feel that they should all sit together at a community clinic rather than these small outreach centres and there would be no need to make household visits. They say that the peer pressure among adolescent girls and general awareness of immunisation makes house visits under the EPI programme redundant.

Community health workers also told us that they feel there is much overlap in their roles; for example they are all involved in motivating people under the EPI but not only do they think that people already are well motivated and this activity is unnecessary but if they do it, it is duplication of effort. They felt that there needs to be clearer demarcation of roles and efforts which are complementary rather than duplication.

TB treatment

TB seems to be a growing health problem, particularly in our Central study areas. In the urban area we met more than 10 people in our F/HHH with diagnosed TB and more with symptoms. This shocked us compared to last year. The Regional Medical Officer (RMO) told us that the incidence of TB is indeed increasing dramatically in this district. He thinks this is because of the increase in factory-based employment. The private diagnostic centres we visited unanimously indicated that they currently do more tests for TB than anything else. The stories told in Box 17 are typical. The patient puts up with the cough until the pain gets really bad and they cannot work any longer. It seems that they do not automatically get sent for the free TB testing (offered under the Government's TB programme) but X-rays are recommended. These cost money and patients will therefore avoid this if possible. Once a sputum test (which is free) has confirmed TB, the Direct Observation Treatment (DOTS) programme implemented by BRAC operates and does provide free medication. The DOTS is supposed to involve direct observation of patients to ensure that they take their medication. The RMO confirms that free DOTS treatment is only given to those with positive sputum tests and that medicine is given for two months, but that BRAC shebikas do not make home visits any more. Doctors elsewhere in the district tell

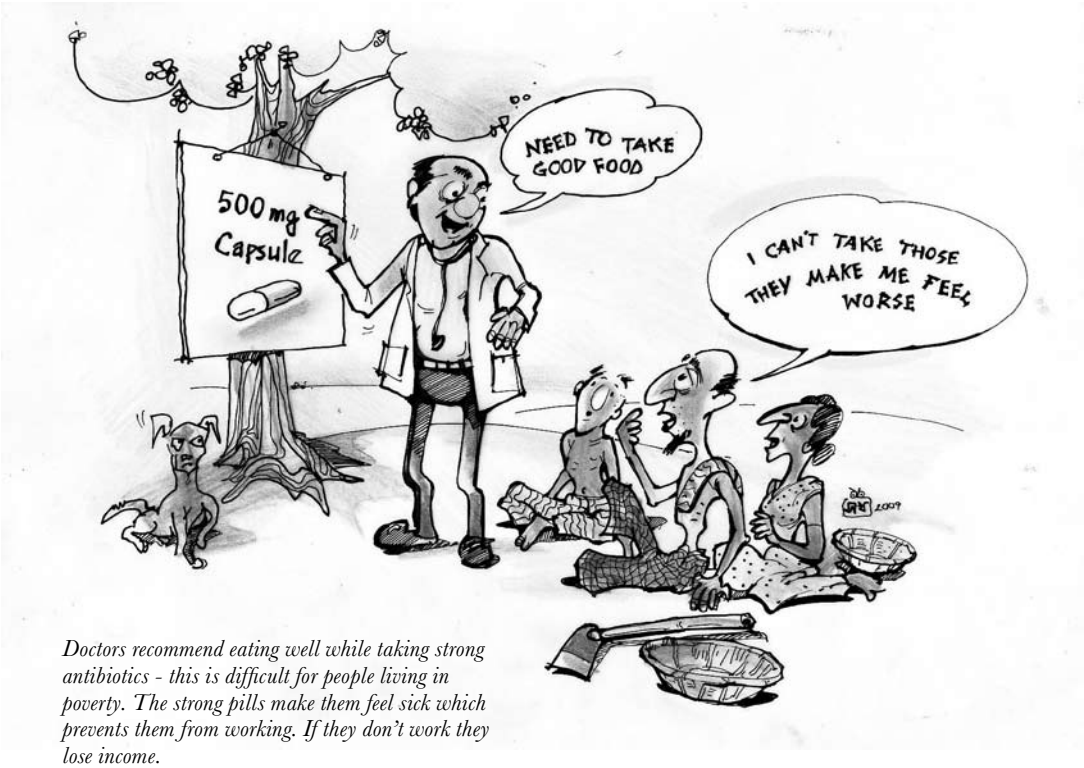
This girl has TB... again. She is very depressed that even having completed treatment she is again suffering from TB.

us that 15 days worth of tablets are given at one time and there is no direct observation.

A BRAC shebika at the district hospital also noted that the incidence of TB has risen sharply this last year. She told us that no home visits are ever made now, and since patients cannot afford to come daily to the centre they get given at least 15 days of tablets at one go with the expectation that members of the family are supposed to check if the medicine is taken. A patient in the rural area seems to have a recurrence and doctors have told him to continue to take medication from BRAC, but they have refused saying they are only able to treat patients for six months and no longer. His DOTS card has been ticked at one time, but he explains that the shebika (a relative) allowed them to take medicines monthly which they collected from her house. The family had no expectation that the shebika should come to their house and were just grateful that they only had to go to her house once per month to collect the medicines rather than going into town to the UHC. There is a problem with this system because patients find the medicine makes them feel very unwell and therefore take it only intermittently. They also feel that since they are told to eat well, the medicine's efficacy is lost because they cannot afford to do this. As all our TB patients live in houses in close proximity to at least five others, so the risk of contagion is very high.

Regulation of private providers

The lack of regularisation and monitoring among private health service providers was illustrated this year by a particularly striking example of malpractice (in the rural South), the growing problem of use of high dose antibiotics, cases of skilled birth attendants offering services beyond their competence, and the lack of health and safety considerations at private Diagnostic Centres.



Doctors recommend eating well while taking strong antibiotics - this is difficult for people living in poverty. The strong pills make them feel sick which prevents them from working. If they don't work they lose income.

A doctor who failed the Civil Service examinations and is therefore unable to practice in a Government hospital has opened his own private practice in our rural South location. He is undertaking surgical procedures and over the past few months three patients have died. He has provided Tk100,000 compensation for one family over an admitted mistake during an operation to remove an appendix. Despite his fatal mistakes he continues with his private practice.

Several patients at the District Hospital and among our F/HHH in the Central area shared their prescriptions with us. Where antibiotics were prescribed, they were always at doses of 500mg. A conversation with a pharmaceutical representative visiting one of the many pharmacies in his patch (more than 100 pharmacies and 120 doctors) told us, *'This is the case only in Bangladesh. There is no regulation so people buy medicines outside. This leads to resistance. When they go to hospital the doctor asks if they have taken antibiotics from outside and if they have he automatically prescribes high dose'.*

Our conversations with patients indicated that people felt these high dose antibiotics made them feel sick and it was difficult to afford and take them. Their doctors had told them to eat well *'But how can we do that when we have to pay high prices for these tablets and cannot work because we feel sick?'* (Urban slum woman). The pharmaceutical representative confirmed that high dose tablets/capsules do make people feel unwell but they need to be supplemented by good food. When we tried to buy antibiotics from the pharmacies outside the District Hospital, only high dose tablets were available – no pharmacists could even find the 250mg Amoxycilin for example. Following the practice which has been prevalent for many years, pharmacies were prepared to sell single antibiotic tablets rather than complete doses. We also did observe some signs of a change in behaviour whereby some patients are purchasing complete courses of tablets at one time. Although difficult to do, there is a growing recognition of the importance of taking a complete course and not irregularly.

Highlights Heard

Functioning

- New information booth and visitor card system in a district hospital (South) has helped to create a more organised environment
- Government health staff still regarded as rude and brusque (and need bribes for improved care) compared to private providers
- Very little home visits carried out by health workers in most areas. Duplication of effort on issues which need less focus nowadays (e.g. general immunization and nutrition awareness) to the neglect of vulnerable and at risk cases
- TB incidence has increased this year among our families and DOTS is not properly administered

Highlights Heard

Voice and complaint

- People do not know to whom to complain and are fearful of negative consequences if they do complain, which might jeopardise the care of the patient
- Medical staff have no means to raise their issues, concerns, make suggestions or influence programming

While we were visiting a Diagnostic Centre outside the UHC (peri-urban South), a woman came in for an X-ray of her leg. Her husband and son accompanied her into the X-ray room and nobody showed any concern regarding safety. This was obviously normal practice.

Voice and Complaints

"Nobody listens to the poor, even the Almighty Allah". (Slum-dwelling woman, North)

As indicated last year, people do not know to whom they should complain, and are fearful of negative repercussions if they do complain; *'We just shout within us when doctors keep us waiting. We do not complain because we think it will have bad consequences for us'* (Mother of a child suffering with diarrhoea, rural North). During a conversation with a man at a tea stall (South peri-urban), he told us: *'It is right that the hospital does not receive the medicines it needs, but out of 5000 tablets they take 4000 and only 1000 remain for the poor. I know this because I have seen it happen, how some get free and others do not. But if I complain or mobilise a group of people to complain what will happen is that all my actions will be made into something political… some will say you have your interest, you belong to that party and then they will focus on that, on oppositional politics and not the issue. … The Government should introduce another system. I should be able to post a complaint in writing to a neutral party. If I send a complaint to the hospital the way things work now nothing will happen. It needs to be seen and dealt with by an outside body'.*

There was a new sign in the Central District Hospital requesting patients to report complaints, but no suggestions as to whom or where these complaints should be directed. A patient read this notice out for us, and then laughed at its absurdity. This provoked a little discussion with others passing by who had never taken notice of the sign until we pointed it out to them, and they too noted the pointlessness of the notice. The Central MCWC had a new wooden Suggestion Box in the entrance hall, but nobody had noticed it – it was written in English.

However there are examples of cases of successful 'issue raising' by patients and their families e.g. in the peri-urban UHC patients requested to be put on the veranda beside the ward where *'It is light and they get fresh air'* (nurse), and the mother who could not afford to be referred to the district hospital and negotiated to stay at the UHC.

In the rural South study area, there is a local 'anti-corruption' group operating. The local trained homeopath is a member of the group, and told us that they have been able to intervene successfully in forcing an unregistered pharmacy to close. However, he did not think that the group should intervene regarding the misconduct of government doctors (although he was highly critical of them) or in the case mentioned above where a doctor is undertaking operations at his home and has apparently caused a series of deaths. It seems that the status of doctors is highly respected such that local action is not considered appropriate.

But it isn't just the patients who feel unable to raise their concerns; medical staff also feel frustrated that there are no platforms for them either. Doctors told us in one of the Central UHCs that they don't really have any opportunity to influence policy and programmes. The Joint Secretary of Health visited them six months ago, and they were very open with him; *'He listened and gave us hope….. but three months later he was transferred'*. Similarly, the three health workers in the Central rural village felt there was no opportunity to influence how programmes were run, raise their concerns or make suggestions. They felt amongst other things

The village women complain that there is no emergency service available during pregnancy and delivery at their nearest Upazila Health Complex. When visiting the hospital, we found that the gynecological examination chair had found new use as a laundry rack.

that their roles overlapped, that nutrition programmes were largely unnecessary and that community clinics should be re-established but were frustrated that these issues could not be discussed. The UHFPO in the peri-urban UHC in the South has recently taken up this post and has extensive experience. He shared many innovative ideas he wished to introduce, including one he had experienced working in another UHC where minor surgery capacity was enhanced (under an EU programme), but with elections looming and political interference he feels it will be years before decisions can be made. He says it is particularly difficult because the Upazila Nirbahi Officer, who has ultimate power over decisions, does not understand how health facilities should be managed. He feels frustrated that he has to accept the decisions of *'bureaucratic careerists'*.

One of the many private diagnostic centres.

Quality

There is no change in how people perceive quality of health service provision from last year. The criteria include speed of cure, being given respect and attention, time and clear explanations, being able to see the same medical service provider on subsequent visits and not being asked to make many repeat visits for check up and diagnostic tests, (which cost time and money) except perhaps a stronger rationalisation of using private services because paying *'guarantees good service'*. Above we quoted the polli doctor in the rural Central area who said that, *'At a private clinic there will be doctors and they will be caring'*, and the man who had self-referred to a private Diagnostic Centre because, *'It takes a lot of money and they are more serious than the Government hospital. It is much better than a free service'* (peri-urban Central). Such comments are typical of many people who explain why they chose private rather than state health services. The fact

Highlights Heard

Quality

- As noted also in 2007, quality of service is based on speed of cure, attention and respect, time and clear explanation, continuity of care and not being asked to undertake repeat diagnostic tests. On this basis, private services are judged to be best as payment guarantees good service

that the latter are open and staffed 24 hours and patients are seen quickly is very important to people, once they have made the decision to seek medical assistance outside their community. Once the condition is considered serious, then the family knows that large amounts of money will be required regardless of whether they avail private or state services and, if this is accepted, then they nearly always opt for the more efficient and *'more caring'* private option. There is no need for bribes in the private sector, and people therefore felt it was easier to anticipate costs.

The growing trend for self-referral to private Diagnostic Centres emerges partly because these services are efficient and available. The one-stop service (test and interpretation) and the long opening hours means that people do not need to take time out of income earning or have to make multiple visits (as tends to be the case with state services). With self referral, particular tests can be requested and greater agency exercised over associated costs than submitting to the multiple tests often recommended by doctors. As mentioned above, having copies of test results is also considered an important aspect of quality of service. Whether this in fact leads to improved health at a lower cost is however not at all clear.

Nevertheless, the perception that the Government facilities were better run and more likely to have a ready supply of free medicines (as a result of the Caretaker Government action over the last year – Central and South, but no longer in the North study area) has encouraged greater use of these facilities, although few of our families had experienced this for themselves. Those who had, mostly expressed mild surprise at the greater efficiencies and better facilities than they had expected. However, since people make decisions about health seeking based on their relatives and neighbours direct experiences, it would take time for any positive feedback to percolate. Positive stories about the recent changes in Government services were more likely to come from urban and peri-urban families than rural ones.

Access to Information

In the North study area, information flow tends to be less prevalent than in the other two study areas. People tend to get their health information from neighbours and relatives and from direct experience. Some health messages are gathered from NGO advertising on TV, and school books provide some information on nutrition and sanitation but *'We are too busy to look at the books'* (woman, urban slum North). The Meena cartoon series sponsored by Unicef back in the early 1990s are still enjoyed and its messages known. In the rural area, people listen to radio and were familiar with sanitation messages but our interactions with them indicated that they were not practicing these tips.

In the Central area, TV is an important source of health information and has been the main source of information on HIV/AIDS, nutrition and sanitation. People are relatively well informed about nutrition, particularly about good food and the food needed during pregnancy. Some information is gleaned from the Class 9 Home Economics book as well as other school text books. However, 'knowing' is different from 'doing', and many shared with us the problems of putting this knowledge into action. For example, it is difficult to eat well at the start of pregnancy when feeling sick and considering the unavailability of nutritious but cheap food. Information about where to go for treatment is mostly passed on by neighbours and relatives who are satisfied with services they have directly experienced.

Last year, we noted that there seemed to be little sharing of health provider information in the Central rural village and each cluster of households seemed to have their own experiences and dependence on connections to health services in the district town or more often Dhaka. This situation continues and where emergencies happen (as was the case this year) neighbours are consulted quickly and decisions made to use almost exclusively private service providers.

As discussed above, men told us that they feel marginalized from family planning information. There are almost no health workers (Government or NGO) who continue to make house to house visits. These were opportunities in the past for men to get information. In the conservative North, house visits would help to preserve personal privacy.

The potential impact of quality extension services is obvious when comparing the rural South and the rural North. In the South study area, INGO activity over many years has resulted in all households having their own latrines. These are installed properly and have wooden frames and CI sheet walls, roof and locking doors. We were told that NGO workers used to make 'latrine inspections' to make sure they were kept clean and used properly. In the North, our families have never had any hygiene or sanitation programmes and the incidence of diarrhoea and dysentery is high. The Union Parishad has recently supplied ring and slabs but no technical support so these have been installed incorrectly. Most of the families have only used two or three rings instead of five and the latrines are already filled up and unhygienic. One of our team asked how he should use the latrine at his host household, as it was only partially screened by jute sacking. He was told that they mostly use it at night and in an emergency screen themselves with an umbrella.

The families in the rural North had no information about family planning and never saw any health workers whereas the NGO health workers were very active in parts of the South (see above 'Maternal Health'). In the Central areas, the flow of information is enhanced by the connections with relatives in Dhaka, garment factory based employment, the high level of migrant workers, TV and greater use of mobile phones.

Although there were many new painted signs in Government hospitals, few people seemed to pay much attention to them, requiring us to point them out. In some hospitals signs were in English (lists of attendant doctors, opening times) which could not be read at all by most users. The new information booth in the South District Hospital (with information on doctors, telephone numbers for ambulances, availability of diagnostic tests and costs and details of visiting hours) was much more useful as it was manned throughout official opening hours and people were seen actively using it to navigate their way through the unfamiliar hospital protocol.

The much-touted recently established Citizens Charter was found in one hospital only; the MCWC in the urban Central study area. It was displayed on huge plastic posters along the main wall in the entrance hall.

The lack of information makes room for dalals to operate. They profit from peoples' need for clarification in unfamiliar situations (see 'Costs' above). Lack of information regarding diagnosis or treatment from medical professional's leads to requests for help from non-qualified people and the possible spread of rumours.

Highlights Heard

Access to Information

- Very poor sources of information in the North study area
- TV is an important source of information
- People mainly rely on the experience of neighbours regarding their own health and would like to have access to people who could help interpret diagnoses, read prescriptions and tell them what costs are reasonable to anticipate
- Men want more information on family planning
- Signs put up in hospitals providing information go largely unnoticed

Highlights Heard

Why do some actively opt out?

- In the economic straightened circumstances prevailing in 2008, people were more likely to resort to local and informal health providers

A young mother with her baby arrives with rickshaw van to the upazila hospital.

Why do Some Actively opt out?

With rising economic hardships as a result of increased food prices, recovery from Cyclone Sidr (South) and unemployment because of the downturn in the construction industry (North), more people were opting to use local informal health services to avoid the expense of both travel and the cost of formal health care. As allopathic medicines are readily available in shops or through hawkers at very local level, the use of kobirajs and hujurs seems to be less although they may be part of a strategy for cure if it avoids the patient having to spend time and effort in formal healthcare (see Box 12). However, despite slightly increased local use of a nationally known hujur who resides in the rural Central area, he himself uses a 'boro doctor' for his own and his family medical complaints.

Tabiz are worn by babies 'to stop crying' more or less everywhere and, may have even increased this year compared to last year. But tabiz wearing by others varies from community to community (eg many in South peri-urban and almost none in South rural).

People's perceptions of what makes a good health facility

- Speedy and efficient service, so waiting times are short and return visits minimised.
- Availability of medicines beyond the basic ones so minimising the need to purchase medicines. Advice regarding what they should expect to have to pay for medicines purchased outside.
- MBBS doctors.
- 'One stop' service; in other words, examination, tests, diagnoses and provision of prescriptions can all be done at one time and in one place.
- Respect and attention from medical staff (also referred to as courtesy, kindness and caring) including clear explanations of diagnoses, prognoses and treatment.
- Opening times which facilitate work commitments and long journey times.
- In more conservative areas, female doctors for female patients.
- Affordable ambulance facility at hospitals.
- Less concern about the physical facilities although cleanliness and provision of drinking water essential.
- Clear information on anticipated costs of treatment in hospital and advice on expected costs of medication bought from pharmacies outside so patients are alert to over-charging.

Main Differences in Health between Study Areas

North	Central	South
Deterioration in management and cleanliness in the District hospital this year compared to last (attributed to relaxation in monitoring by the Caretaker Government) but still preferred to Sadar hospital. MCWC is too far from the city so people cannot avail that services.	Improved cleanliness and management at district hospital and MCWC and both more used than last year. In-patients wards full. But no improvement in opening on time or security in the District hospital.	Greatly improved cleanliness, management, provision of information, security in the district hospital compared to last year (attributed to Caretaker Government). In-patients wards full (rather empty last year).
Additional unofficial fees always solicited by Government doctors from out-patients. High level of money making through referral to Diagnostic Centres and private chambers.	Less prevalence of additional fees charged in Government hospitals than in the North study area. Some evidence of referral to Diagnostic Centres for commission but possibly less than in the North and South. Some doctors providing philanthropic care.	Some demands for unofficial fees by Government doctors but less frequent and smaller amounts than in the North study area. However, they earn from referring patients to their own private chambers and Diagnostic Centres. Some doctors providing philanthropic care.
High dependency on UHC in rural area as no alternatives and high transport cost to District hospital. Preference for local pharmacy and private doctors in peri-urban due to high transport cost and long waiting time in Government facilities in peri-urban.	Decreasing use of UHCs, preferring private medical services or District hospital. UHCs only used by casualties, elderly 'bed rest' and very local people.	District hospital preferred to UHC in urban and peri-urban but reliance on UHC in rural area as limited alternatives.
Increased dalal activity at Government facilities.	Greatly reduced dalal activity at Government facilities.	Greatly reduced dalal activity at Government facilities.
No community nutrition programmes but greatly needed.	Community nutrition programme regarded as redundant.	Nutrition programme operating and very important in peri-urban area.
Limited NGO activity. Poor sanitation and hygiene practices.	No NGOs except micro credit, the national nutrition programme and few BRAC schools.	Huge number of NGOs with long tradition over many years. Very good sanitation and hygiene practice.
Family planning information and outreach poor. Large families.	Preference for small families. Relatively good knowledge on family planning although information for men insufficient.	Mixed family size preferences. Access to family planning information better than in the North study area but still regarded as inaccessible by many.
No information on menstrual regulation.	Menstrual regulation well known, particularly in urban area.	Menstrual regulation well known urban area.
Medicine sales down this year because of economic crisis. More people buying part courses of treatment.		People more aware of importance of following full course of e.g. antibiotics, therefore making informed choices, including refraining from taking antibiotics unless they could afford a full course.
	Only study area where Grameen's 'healthline' known but not used. Much health information gathered from TV	

Differences in Health between Urban, Peri-urban and Rural locations

Urban	Peri-urban	Rural
Most choice of service providers; formal and informal, Government, NGO and private hospitals, Diagnostic centres and pharmacies.	Relatively wide choice of service providers but constrained by transport cost considerations. Few private chambers as doctors tend to have these in the district town.	Reliance on polli doctors and medicine sellers because of high transport costs. For more serious cases greater reliance on UHCs (North and South but not Central) because fewer alternatives and high transport costs.
Information (on medical matters) based on experience circulates faster than in the peri-urban and rural areas. More information gleaned from TV.	With the exception of the South study area, information flow better than in rural areas especially if work entails journeys to the district town or factory work. In the South study area , the peri urban community seems quite isolated.	Information flow may be quite poor (particularly in the North study area) and knowledge of services and service providers limited. High reliance on relatives living in major cities or abroad for advice in availing medical services for serious ailments. Bill boards with health messages do not seem to have any impact.
		Rarely use Government services in central and South study areas. As transport costs are high, preference to avail private (efficient) services prevails.
Self procured and installed latrines (many unhygienic) and poorly maintained or rely on insufficient and poorly maintained shared latrines provided by the Municipality.	Most household have latrines.	Except in the South study area where NGOs have been very active on sanitation, although most households have latrines, often poorly installed and maintained.

Comparing Earlier Indications with what People Living in Poverty say:

Health Services

FMRP Report (2007) notes:

- definitions of what constitutes quality of service provision varies considerably among medical professionals
- time loss is a major cost for people who work in the informal economy
- consultations for patients average 4-5 minutes
- payment is normal in Government health facilities for anything more than common ailments

The Reality Check participants say:

- what is important for people living in poverty is overlooked in service provision - mornings are often crucial earning periods yet Government services are open in the morning
- most prefer private providers since they have to pay anyway and feel they are getting better value for money with private providers

Maternal Care

The Stakeholder Consultation Report of the HNPSP (2008) notes:

- 85% of births are at home
- an 'improvement' in numbers of hospital births from 9% to 15% over the period 2004-7
- women are little aware of delivery services available
- dais are untrained and unskilled persons putting the mother at high risk
- people are not aware of maternal health services available for them

The Reality Check participants say:

- Government facilities can be the most risky place to have a baby as it may be unhygienic, under staffed and under-equipped
- they make careful choices about where they give birth and do know about Government and private facilities but actively choose home delivery with a dai because she is available 24 hours per day and helps before and after the birth
- dais are used on the basis of their reputation while poorly performing dais are soon put out of business - dais are linked through mobile phones to doctors and private clinics
- except in the North study area, they are aware of immunization and nutrition during pregnancy and after birth

Family Planning

Government statistics note:

- contraceptive prevalence rate is declining slightly (58.1% (2004) to 55.8% (2007))

The Stakeholder Consultation Report of the HNPSP (2008) notes:

- a desire to keep family size small (from focus group discussions)
- people cannot afford to buy contraceptives from the market

The Stakeholder Consultation report of the HNPSP (2007) notes:

- men complain there are no services for them at FWCs

Reality Check participants say:

- mostly, young parents have a strong desire to keep their family size small
- low dose oral contraceptives are readily available from the market leading to less use of Government supply and some women take without the knowledge of their husbands - cost is not a deterrent to using contraceptives from the market
- men have very little access to family planning information

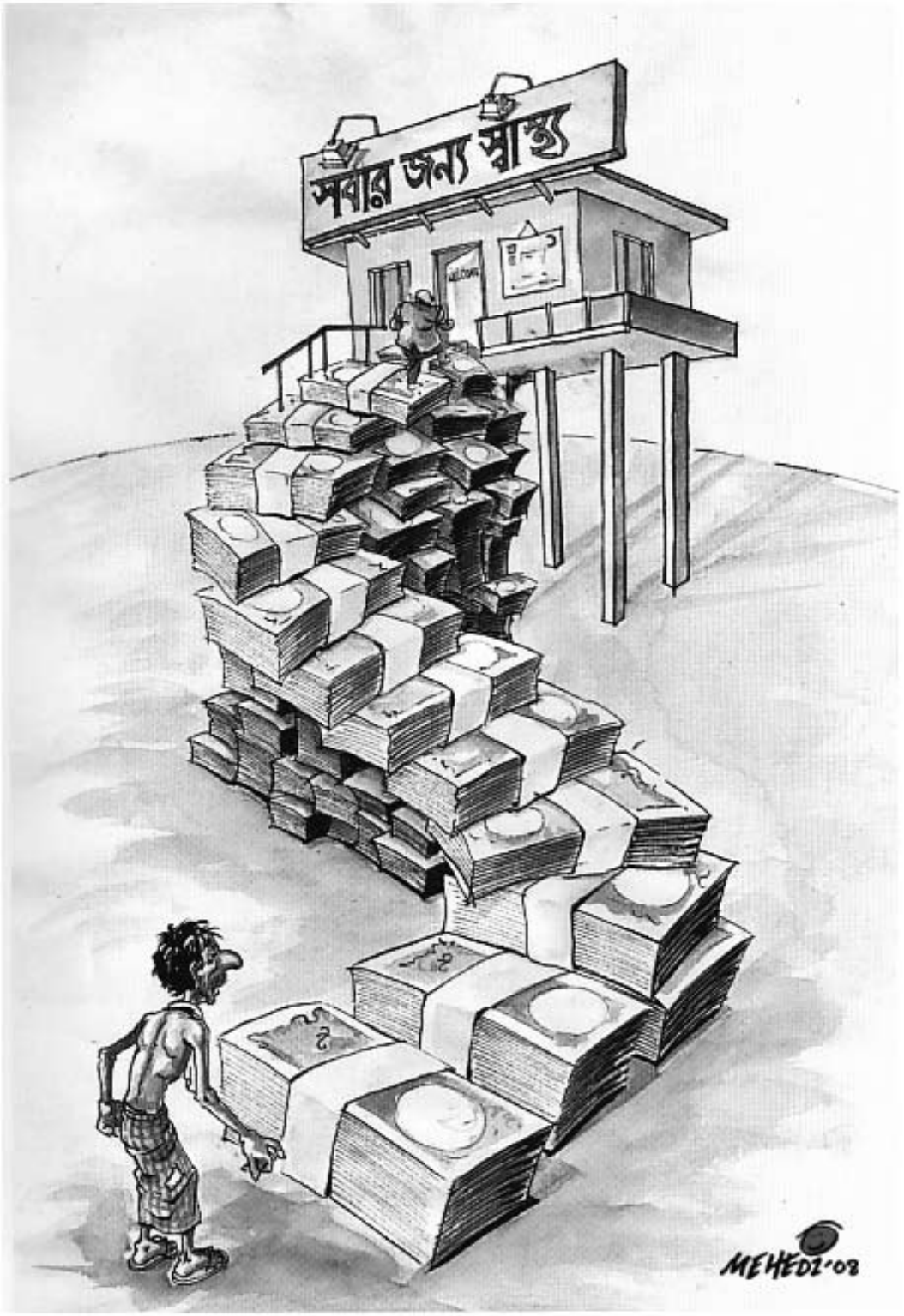
Diagnostic Centres

The Stakeholder Consultation report of the HNPSP (2007) notes:

- private diagnostic centres lack trained manpower and misguide patients

The Reality Check participants say:

- doctors often recommend diagnostic centres partly because of commissions but also sometimes because they are more efficient
- market pressures are selecting out poorly performing diagnostic centres - patients take away their own test results to confirm with others
- many diagnostic centres have MBBS doctors attached to them
- private diagnostic centres are preferred because they provide 'one stop' services



Accessing health services can be seen by people living in poverty as very costly.

Main Findings in Education

This section provides the main findings in relation to people's perspectives and experience of primary education. Like the previous section, it builds on the 2007 report and attempts to emphasise changes since then as well as highlighting issues omitted or overlooked.

Primary Education Providers

There were some changes evident of PEDDII related activity in all the Government schools in our study areas this year. This included School Level Improvement Plans (SLIP) programmes being initiated, teachers receiving Certificate in Education training and recent or ongoing school infrastructure construction work.

However, we found that the retention of students at Government primary schools seems to be a growing problem. Often incorrectly recorded as 'drop out' students, we found that most of these children had, in fact, transferred to other schools. These transfers are the result of parents adopting careful education strategies which balance each of their children's assessed potential, with the costs and quality of different kinds of education providers to ensure that those with potential get the best education possible. One example of this careful planning is given in Box 18, and there are several other stories involving parents transferring their children at critical stages of their schooling.

There were several striking changes from last year in terms of education provision. The first is an increased number of schools for working

Box 18: Getting the Best from Schools

Although very poor, Mokmuna has high ambitions and thoughtful strategies to educate her four children. The only son, started with pre-school Arabic and was admitted to the Government primary school in class 1 and got stipend. He did well there and *'was loved by his teachers'.*

However, one day in Class 2 he was severely beaten with a stick by a male teacher for *'a trivial reason'.* He came home crying and refused to go back to school. Mokmuna and his sisters also cried to see the sores on his back and withdrew him from the school. Attempts by the remorseful teacher to get the boy back to school failed.

Mokmuna sent the boy to the nearby informal madrasha to pass the time to complete the year and then sent him to the Quaomi Madrasha in the adjacent village. She chose this because they give special attention and care to all students, teach all the Government curriculum subjects in addition to Arabic and it is residential and free of cost. Now he is in class 3 and is doing well. He is determined to complete his SSC there.

Mokmuna's two daughters continued to study in class 1 and 2 in the Government primary school but did not get stipends (Mokmuna thinks this is discrimination by the teachers). She could not afford a private coach but every weekend when her son came home he tried to coach his younger sisters. But he told his mother that both of them were very weak in all subjects, especially in math and questioned the point of keeping them in that school. They did not bother to appear in the final exam and dropped from school. Now the mother is waiting to admit them in the new BRAC School near the market, as she knows that quality of education is good there.

Although under 8 years old, the girls manage their mother's small grocery shop attached to their house when their mother goes to market.

Soon to be extension of Government Primary School, a new construction under PEDP II.

Village pre-school.

Children have to carry a large stack of school books to and from school.

children in the urban and peri-urban areas. A new ROSC school has been set up in the Central urban slum and an NGO-run school for working children operates on the outskirts of the slum. The ROSC school caters for 35 'out-of-school' children, but some have transferred from formal primary schools to this one. In the South slum, there are now seven different NGO schools (two new this year) within a 1km radius of each other. These are all intended for working children and several include vocational training in the curriculum (eg. sewing, welding, mobile phone servicing, TV/radio and motorcycle repairs). These schools also have enrolled children from Government schools, either as supplementary schooling (alternative to coaching and, according to parents 'keeps them out of trouble') or substituting completely for the Government school. A single NGO runs three new schools for working children in the North slum, supported by Unicef, and the children attending these are genuine working children who are helpers in the market, work in shops, hotels and as domestic helpers. The teachers are very young and get 21 days basic training and four further short courses (4-5 days). One other NGO runs a pilot programme (also supported by

Box 19: Private Coaching

Mokmuna believes with that girls' confidence will be developed through memorizing prices, learning calculation practically and keeping the petty cash.

The rickshaw-puller husband is little afraid of the strong and straight forward wife but he always gives full support to the decision of Mokmuna regarding education of the children. (Rural Central)

The young university student we met last year is still providing morning coaching (in English and maths) at his parents' home. When we talked to children who are his tutees, they told us that he is better than their teachers (at the Government school) – *'He helps us to understand'*, but explained this was not just because his classes were small but because he teaches well. They say they learn more in one hour with him than at school. *'If he took all classes (not just maths and English) it would be better to not go to school'*. (Rural Central)

"It would be much better if our coach could teach us all the subjects then we wouldn't have to go do school!".

Unicef) where students are paid to teach out of school children. The programme also provides lunch on a pilot basis. And yet another new school for working children (also supported by Unicef) has opened this year in the North peri-urban location.

The second change is the emergence of more private schools apparently driven by a philanthropic motive rather than by profit. In the Central urban area, we found a small school being run by an Open University student in her parents' front room. She provides a caring environment for children with learning disabilities and she told us, *'I am pleased to be able to be busy in my leisure time'*. In the peri-urban Central area, we came across two private schools which were set up by families as a community service rather than a profit motive. For one founder it was a *'long held dream'* based on the belief that the village was *'not an environment for study'* and a desire to provide village children with a formal and disciplined learning experience. Although he himself was only educated to Class 5, he wanted to do something different, *'Not like BRAC or Government primary schools'* but more child-centred. He introduced more games, competitions, songs, poems and sports (he employs a specific games teacher) and purposely keeps class sizes low (less than 25 per class, total 160). Many of the teachers are young graduates or studying for their Masters degrees. Although, there is a constant turnover of staff as they are often looking for other jobs, the Principal finds that they are all very enthusiastic and energetic.

The other private school was started by one man a couple of years ago following a personal tragedy. Like the first school, the founder was only educated to Class 5 but has a strong belief in education. He wants to *'give something back to his community'* and, using family resources, he has established a school which currently caters to 197 pupils. He employs eleven teachers, three of whom are family members who do not take a salary. The Principal says he is rather relaxed about fees, which are anyway low, and if parents have a problem paying, he does not pressure them and he has actively encouraged children with disabilities. Sometimes they will provide needy pupils with uniforms, pencils and books.

The third change is a slight increase in the use of madrasa. Parents will send very young children to the madrasa to ensure *'they are more pious'* (North slum) although in the North, the high cost of this particular madrasa (Tk450 admission and Tk100 per month) has led to the decision by our families to withdraw. Another madrasa in the North (peri-urban)

A new BRAC school.

Box 20: 'I had so much Hope for my Boy'

T. is 7 years old. He went to primary school for 2 days. He tells us it is too far away but happily skips in front of us to show us where it is – getting there in minutes! His father is very upset that he does not go to school. He says he has tried very hard. He had ambitions to educate his children and hoped his son might become a doctor. He has even beaten him (often) over not going to school . Others say T. only wants to play. They call him by a derogatory name to shame him for not going to school. His friend says he spends all day looking for marbles in the drains to sell. Others say he is *'ageri pagri'*. His mother says he doesn't even try. He is supposed to go to a private tutor now but is irregular. His tutor rolls her eyes *'He only wants to play'*. His father worries that *'He will be like me and dependent on others'* and *'Will influence his little sister. He may end up in jail'*. T. himself says he is not sure what he wants to do when he grows up, *'Perhaps a vegetable seller?'*

Box 21: Always in Trouble

M. is about 12 years old and always in trouble. He used to go to the government primary school but he didn't do well and dropped out. His family have given up on him. He spends all day fishing, picking fruit, playing games and loitering. His father nearly cried when he spoke of his son as he says he has tried hard to make him go to school and to behave. But everyone thinks he is *'a menace' 'a good for nothing'*. In despair, his father got him a job in a handloom factory, *'If he won't go to school, it is better he works than*

Highlights Heard

Education Provision

- Highly motivated about educating their children, parents adopt careful strategies to move their children to different schools at different stages to avail the best education and incentives
- Schools for working children have proliferated but many children attending these also attend Government schools
- More private schools and an increase in private schools with a philanthropic rather than purely profit motive. These are good at including children with disabilities and slow learners
- Slight increase in the use of madrasas as girls feel more secure and it is considered more disciplined for boys
- Private coaching is still considered essential and it is mostly provided by college students

particularly caters for the poor, and the students collect rice donations from the neighbourhood to pay for their education. More girls are attending the girls' madrasa in the rural Central location this year, as people claim there is more attention and personal care to students, and moreover there is a Tk30 /month stipend. Girls told us they transfer to this school because they can play in the walled playground, and generally feel more secure as they get bigger. Parents say the education is so good they don't need stipend money to pay for coaching. More local boys attend the Etim Khana (primarily a boy's orphanage) than last year, also in the rural Central area. It provides religious education for the first 3 years and parents regard this as an important foundation. They told us that when the boys get bigger they are less easy to control and so it is good to start with religious education (good basis for developing moral values) then transfer to the Government school later.

Private coaching continues to be regarded as essential for children attending Government schools, and parents and teachers automatically include it as an educational cost (see costs below). It is increasingly being provided by college students who charge Tk100 per month (the exact amount provided by stipends) rather than by teachers. In some places where there are few college opportunities or where employment is more attractive than further education, there are few students interested in providing this coaching (see Box 18). In the rural South study area, the presence of the INGO child-sponsorship programme means that parents feel they need to engage tutors so that they show that their child is making progress. Recognising this burden, the INGO has recently started a free tutoring programme at the school before and after school hours, which is run by young students who get paid Tk500 per month. This tutoring programme is open to all children, not only the sponsored children of the INGO.

The proximity of the school, particularly for small children, is a major factor influencing choice. A young mother in the rural Central area, herself a BRAC school graduate, has always wanted her daughter to go to a BRAC school. One has opened this year about half a kilometre from their home, but the mother says it is too far away for her daughter who she describes as *'naughty and will run off'*. Parents of a boy and girl in the South peri-urban area have sent their girl to the private high school a few kilometres away, but their boy to the nearby Government school. The boy told us, *'My mother does not want me to walk too far to school'* and his friends explain that

hangs about getting into trouble', but M left after a few days. He told us it was too hard.

Talking to him and observing him, we found him bright and active. It took a long time to win his trust - he is used to people complaining about him and lecturing him. He wasn't prepared for just a chat. *'I don't want to go to school because I don't like it'*, he said, *'but I am not naughty or stupid as everyone says'*. He told us that the teachers punished him a lot but this turned out to be an *'acceptable excuse'* rather than the real case. He may have been singled out a bit more than others (as his friends said) but he wasn't beaten regularly or badly. He grinned at us when we queried this further, *'Actually I like to play more than going to school'*. When asked about his future he said he didn't know but, perhaps surprisingly, said he would like to go to school again. (peri-urban Central)

Boys prefer playing to school.

"I don't like the long walk to school and I'm afraid of the road – a boy was killed there last year".

Sattar (age 10) likes science, especially when teachers use pictures, such as this drawing by Sattar himself, to illustrate what they are teaching.

he would be distracted by other boys and get into trouble. The busy and dangerous main roads are a problem for some and constrain choice (in all areas). A mother in the peri-urban North sends her children to the nearby madrasa, because the other schools are too far away.

Special Measures for Inclusion

Boys.... the growing problem of self exclusion

Last year we highlighted the problem of boys refusing to go to school despite their parents' strong motivation for education. *'Boys are very disrespectful nowadays'*, some frustrated parents told us (2007 Report p43). This trend has become more apparent this year in most of our study areas. To explain the large numbers of out-of-school boys in the North slum, parents told us that, *'Boys are difficult to control'*. NGO school teachers here told us that, *'It is easy for children to play truant and parents don't know this. It is easy to play in the hilly areas and nobody can see them or stop them playing all the time'*. We noted that the numbers of boys and girls enrolled in school tend to be rather similar in Classes 1–3, but that the numbers of boys often drops in Class 5. By way of explanation a school Head told us, *'They are reckless these days, and parents cannot control them. They play and fish all day. The only thing to get them to come to school is to provide a tiffin, attract them with sports, like cricket and football'* (urban Central). Another head teacher (urban Central) says that boys are very irregular in their school attendance (50% compared to girls 90%). Many of these boys have fathers who have abandoned the family or are 'drunks' and so the mother expects them to help around the house. But also these abandoned mothers cannot afford the coaching costs regarded as essential and give up on their boys education altogether. A few of the boys, the teachers say, earn but many more 'just loiter'.

Some boys feel ashamed because they have started school late or have had to repeat classes many times and they are *'very big boys sat among very little children'* (Head urban Central). One boy from one of our families in the rural Central location had dropped out because he felt ashamed to be so tall in Class 3. The Headmaster (urban Central) went on to say that there

is no incentive for boys to continue in Class 5 because there is no secondary school stipend, *'There is no doubt that the prospect of getting a stipend pushes the girls to do well'*. Furthermore, schools are not very happy to admit over-age boys to school as they can be very disruptive and may harass the girls. One Head cites an example of a rather academically good boy student who continually teased the girls and whom she had to expel *'as an example to others'*.

Other school going children say that some boys don't come because they get beaten at school, but many think this is the *'acceptable excuse'* for not going to school as mothers feel sorry for their sons and do not force them to go. The real reason they do not go is because they choose not to go as they prefer to play and watch TV. The lure of the street is exemplified by a boy's own admission (urban South) even though he has career ambitions, he admits to being easily distracted by other boys in the street and he goes roaming with them. He likes school particularly the discipline, standing in line, marching and singing and sports. He also likes science, because the teacher uses illustrations which make it easier to understand but he doesn't like the punishments meted out by teachers and felt very upset when he was ridiculed in class by a teacher for a minor misdemeanour.

A mother from the South rural area also worries about the influence of 'the street', and told us that she had sent her elder boy to her father's house because, although the education was good in the village, she was concerned that *'he would get involved with friends who are not interested in school and who just want to play and hang around on the roads. If these boys influence my son all our efforts* (to give him a good education) *would be in vain'*. A sister of another family (urban Central) complained about her brother who irregularly attends school because, *'He loiters around, plays video games, buys and eats snacks and plays and gossips with non-school going friends'*. She is afraid that he may drop school, particularly as she feels her father has no time, her mother is often sick and she is recently married so there may not be any control over the boy. Another worried sister (rural Central) told us she is keen for her brother to be educated (currently in Class 2), but his attendance has become very irregular so his stipend is stopped. She said *'He was doing well as I used to pay for his private teacher, but now I am not working and our parents can't afford it. If I was educated, I could help to coach him at home, I always try to motivate him to go to school every morning but most of the time he ignores me. He is always wants to play with friends'*.

Boys who struggle at school prefer to go to work. BRAC pupils told us that boys don't want to go to school because they can easily become bus conductors or like to drive rickshaws, *'But [that] we are very serious'* (peri-urban Central). School-going children drew pictures of their school day and pictures of children who were not in school. They derided those who were not in school and some said they did not like them because they *'smoked'*, *'hang around'* and *'are naughty and dirty'*. They pick up jobs as mechanics and drive rickshaws. The son of one of our HHH has dropped out of school and is typical (Box 21). In the rural Central study area, boys tell us they have own interest to earn and are not pressured by their family. Others work in ice cream factory/misti shops and their parents told us it is, *'Not our wish, but if the boy will not go to school then it is better he is employed'*. And here we noted that there are many out of school boys between the ages of 12–16 which others described as *'sleeping, going here and there, smoking, gossiping and doing nothing simply badaimmya'* (worthless)' Some of these are waiting for relatives to fix them jobs (mostly construction) overseas. Employment expectations in the North study area are limited

Girls are more likely to attend pre-school (they purposely admit twice as many girls as boys) making them familiar with school when starting Class 1. This is intimidating for boys and makes them reluctant to go to primary school.

and boys, in particular, see little point in continuing education. Boys sometimes outnumber girls in Class 1 in primary schools, because many boys have to repeat a class because they fail the end of year exams. The explanation provided by GPS teachers (peri-urban Central) is that because these boys have not had the chance to go to the BRAC pre-school nearby (where there is a policy of enrolling two thirds girls) they are at a disadvantage when they enter primary school. The comment from the Class 1 teacher reinforces this disadvantage for boys: *'We like taking children from the BRAC school as they already know so much'.*

A BRAC school supervisor we met in the peri-urban Central area, told us that boys don't go to school because, *'There is no follow up at home when the boys are absent, boys are less motivated than girls, girls are more attentive*

Box 22: What are Stipends used for?

Mostly the stipends are used to *'pay for private tutors'* (and it is no coincidence that most private tutors charge Tk100 per month the same as the stipend allowance)

The second most common use is for 'educational materials' and 'uniforms'

Occasionally stipends are used to make NGO loan repayments or contribute to household expenses. One mother (rural South) is saving it for her daughter's dowry.

M's mother used the first stipend payment to buy three chickens with the hope that they will produce more and she will be able to sell them and buy a goat. She used the second payment to buy a school uniform for M. (peri-urban Central)

R's mother is keen to keep the stipend money for her private teacher (Tk100/m) for almost the whole year except 2-3 months after the final exam. With any savings she buys school uniform and other necessary things required for R at school, *'Of course adding more money from her own source'.* (peri-urban Central)

Box 23: Two Neighbours and their Sons

These two families live just a few yards from each other in our Central peri-urban location.

Both families live in single room houses. Father A is a postman and basket maker and has three boys. Father B is a rickshaw driver and has five children but only four still live with him. They are aged 11, 5, 4 and 3. The family income of family B is boosted by the wife who works at a garment factory whereas wife A is a housewife. Father A is always working; he carries on basket weaving throughout our several conversations. Father B is very depressed and feeling weak (his father-in-law says he is 'lazy and does not work hard enough'). He falls back to sleep straight after our chat in the morning. Both fathers want their children to go to school. Father A talks about this

and have no family assets' (so have more to gain from education) and *'Parents insist that boys are involved in income earning activities'* (although this is not borne out by our conversations and interactions). A BRAC teacher explained why girls are given preference at BRAC schools, *'Boys are looked after by their parents, so we are trying to empower girls'*. In the rural Central location, two new BRAC pre-schools have started in the same compound as the Government primary school. Parents found it odd that two schools have been established to feed into the one government school. Potentially this would lead to 66 children of whom 44 are girls being made ready for entry to the Government primary school that has only three teachers for the entire school.

Parents of out-of-school boys in the rural Central area said that they had tried to get them to go to school, even resorting to beating and arguing with them. They don't feel that they can *'indulge them and persuade them affectionately'*, as this will further *'spoil the child'*. Some indicated that mothers/anyone in the family must be educated to be able to help the children to learn and check quality of education.

Stipends

As highlighted last year, there is still resentment that there is not a stipend programme in urban areas. However, the proliferation of schools for working children somewhat mitigates this, particularly as they are often being used as supplementary education (see below 'Drop-outs').

Last year we found many examples of irregular administration of the stipend scheme, but these have now been largely resolved and payments now appear to be made through bank officials. In the rural North area, the bank official refuses to come to the school and so mothers incur high travel costs to collect the stipends from the nearest bank 5km away.

Teachers in several areas say it is the stipend which keeps children at school, as typified by this comment from Government primary school teachers (peri-urban South), *'The stipend is the main reason why parents send their children to school'*. But this does not tally with our interactions where

all the time and says that is why he works so hard. His two older boys (9 and 11) go to a private school but he doesn't have to pay fees as the Headmaster is an old friend of his. The boys are always dressed smartly in their school uniforms. We visit the school where they go and the elder one competently sat among older students in the special coaching class. He wants to write school text books when he grows up. Father A makes sure that homework is done but feels he *'cannot guide properly'*. His boys go every day to school and are never late. He has strong views about what is quality education and feels that government schools are woefully inadequate. He feels the teachers are inattentive as they have permanent safe jobs.

By contrast, Father B wearily explains that he is upset with his elder son (11) who will not go to school. *'He has nothing in his head'* and goes on to tell us about how much he has scolded him for not going to school. But asking about the next child (a girl), he has to ask others where she goes to school. We ask if the next child, a son, goes to school? Father B thinks he is enrolled in the BRAC school but doesn't actually go. *'He is influenced by his naughty older brother… I am frustrated with them both'*. The mother leaves the home early each morning and comes home after 8pm six days per week, leaving Father B and her elderly parents to look after the children.

The father-in-law of Father B thinks that family A is 'very nice' and explains this because they live a little apart from everyone else and other children are not always distracting his boys. He says, *'The father is very hard working… the family is calm and plan everything well'*. He thinks he earns more than his sons-in-law, but in fact he does not. The family income of Family A is less than 80% of Family B's.

Both families see schooling as important but Family B has basically given up on their 'hopeless boys' whereas Family A is ambitious and optimistic and are proud of their boys. They worry that they cannot do more for them.

most families are keen for their children to receive education and so earn and save for this purpose, irrespective of getting a stipend. In some cases, children who have stopped getting their stipends have dropped out of school for a variety of reasons. Reasons include their frustration at not doing well (the reason they have lost their stipend), reaching an age when they think they are ready to work and feeling ashamed rather than the loss of the financial incentive per se.

The attendance and performance criteria to qualify for a stipend are the most hard to meet for poor children, *'I lost my stipend because of my irregular attendance and my parents' inability to provide a tutor. I failed the exam. My father is a rickshaw driver and has to maintain six family members. I lost interest in school and I am embarrassed among my friends that I lost my stipend'* (girl 11, peri-urban North). In the North peri-urban and rural areas, flooding prevents children reaching the schools and they are unable to meet the attendance criteria to qualify for stipends. Even in the non-flood prone Central area, teachers worry about the low attendance in the rainy season and *'fiddle the attendance sheet so children do not lose their stipends'*. One said, *'How can children go to school without umbrella? We don't want to risk them getting sick and their books destroyed - so schools should supply umbrella'*.

Rather than being essential, most parents regard the stipend as an important additional contribution to educational costs, and most use it to fund private coaching (see Box 22). Several parents, and particularly teachers, said the stipend covers too few students. In a school where everyone is considered poor, it is hard for the SMC and teachers to make choices about who should receive the stipend. *'Actually the need (for stipends) is much higher, more like 80% of students. I think they should halve the amount of stipend and give it to 80%'* (head GPS peri-urban South). A head in the North who was doing just this under his own initiative last year has been

The parents of these toddlers are already making plans for their sons' education.

Mother helping her child with his homework while cooking.

Box 24: Different Views of the Value of Education

High expectations...

'I grew up in a very poor family and could not get much education. I started to work as a child helping my father. I used to be an agricultural labourer and now I run a business but we will always be poor but at least I have achieved this. But I want my children to have a better life. I see it as my responsibility to guide my children and also to make them understand the importance of education'. (Father, rural South)

Rahima says that, *"Having two eyes I am 'blind' without education and I need to depend on someone else for many things. Women should study as much as possible, early marriage and child bearing ruined my life".* She believes that through her girls' stipends the Government is supporting her to continue the education for both daughters although if there is no 'stipend' in the future she will never stop their education –*'Even if the family have to half starve'* (Rural Central)

S. is just four years old. She already packs her (pretend) school bag and (pretends to) go off the school with her three year old cousin each morning. Her mother has taught her many rhymes, dances and her letters. She has passed on what she learnt from attending a BRAC school herself. There isn't a BRAC school near enough for S to attend and her mother does not want to send her to the nearby Government primary school because, *'Children who go here are not serious. S will be distracted. There are too many children who only want to play round here'*. S' mother thinks that you can tell when children go to a good school because they wear good uniform, are disciplined and will have teachers who really help the children to understand in a comfortable and good learning environment. S' mother thinks they will move house so that they can find the kind of school they think S should attend, *'Where she can do well, go on to secondary school and eventually get a good job'*. (Rural Central)

Second Government Primary School - a model for others.

Children doing piece work to contribute to their school costs.

reprimanded and is now following the 40% rule. A young teacher said it would be, *'Better to give to all or not at all'* (rural Central).

In the peri-urban Central area, we engaged government primary school teachers in a discussion of alternatives to the stipend and they concluded that the money would be better spent to provide centralised resources (such as pencils and exercise books) for all students to use in school rather than the divisive system of selecting those who were poor. Other teachers in another school said that they feel the stipend money is so little it makes little difference (rural Central). As reported last year, the stipend also seems to have a value beyond money confirming regular attendance and good performance which in turn reflects well on parents.

The father, of son age 2 works as a mason: *"I like my job. I am well regarded and have a good reputation. But this is the last time anyone in my family is involved in this type of job! I will never allow anyone to do this … I will push my sons through education so that they can get a service job, in government or business, anything that gives him a permanent position- some security."* Ali expressed strong feelings about his vision for his sons, who are only two years old. Although they are managing at the moment, Ali sees himself as vulnerable. Should he get ill their income and financial situation would quickly deteriorate. They have a wish to ascend out of this position, and see education as a way to ensure a better future for their children.

Low expectations...

'We don't expect out children to be anything other than rickshaw drivers or van drives or mechanics so schooling is not so important.' (Parents, peri-urban North - These parents are rarely home to supervise their children)

In the rural South, we were told it is easy to get a job if you are uneducated as there are plenty of NGOs with handicraft centres which employ uneducated women. *'For an educated man there is nothing to do here, everyone is planning to move'* a man tells us. Girls with class 10 education are trying to get work in Dhaka in garment factories but competition is fierce and, *'A class 10 pass is no guarantee to get a job in the garments'* .

This girl lived with another family for a year working as a maid. Her parents are very poor, and needed the extra income. This year she has started school and is very happy, although she also said that working as a maid was not bad - the family treated her nicely.

Despite the perception that the stipend programme is now being better administered, there is still a lot of dissatisfaction about how these stipends are awarded. For example, one of our HHH (rural Central) only got one for the first time this year (the boy's final year in primary school), and their neighbour who is clearly needy did not get one at all. Another mother in the same area has two girls and both get the stipend, but people say they are not that poor and point to another with two children who did not get it but deserved to get it. One government primary school claims students have been *'lured'* to another with the promise of stipends but parents say they made this choice themselves because they were unhappy about how stipends were awarded in the first school.

Parents' attitudes

Teachers often still claim that some children do not go to school because poor parents are not motivated. For example, a Government school teacher (peri-urban South) told us that parents are not really interested in their children's education, because, *'They never come to us to discuss it'*. Another Head (South urban) shared his frustrations at the lack of parental involvement, *'They are not engaged, they are not caring and 80% of our students do not want to do their homework. Parents need to get involved'*.

But this *'lack of interest'* is not borne out by our interactions with parents who are mostly highly motivated to ensure their children are educated (as noted in 2007 Report p36). The reasons they do not come to the school are more to do with their own low self esteem and sense of inadequacy, often because they themselves did not receive much education. Akber (urban South) is typical of many we met who wants his child to be educated but recognises he is not as supportive as he could be. He wants his son, who is in Class 2, to study until Class 10, so that he *'Can run a business, maintain a shop and help his own children with study at home', but there are 'three red marks' on his son's report card, 'I think this means that my son has not been promoted to the next class but I am not sure as I cannot read. I am not going to blame the school for this failure. Actually, it is our fault'*. And his wife agrees, *'When we go to relatives' houses for ten days or so we don't tell the school before or check whether it is open or not, we just take the children with us at any time'*.

We asked a slum girl (Central) to record her school day with a disposable camera. Her photos showed that she went off with her mother to visit relatives rather than going to school that day. Both the girl and her mother have ambitions for her to be a doctor, yet taking a day off in this way did not strike them as a problem at all. Another slum parent (South) says, *'As parents we hardly bother to help our children to read at home. We live in one single room and in the evening we watch TV. We don't bother that this is the time for homework for my son and daughter. We just enjoy the TV until we go to bed'*. One team member found that all three of her HHH's (urban, peri-urban and rural) were absorbed with TV late until at least 10pm each night (the peri-urban family watched a neighbours TV). There was clearly a problem for children to study and sleep. In the peri-urban North study area, parents said they feel inadequate that they cannot help with homework and the lack of electricity precludes homework being done at night.

By contrast, another family in the South slum always help their children with their homework and do not make demands for them to do household chores so they are always ready for school. Their children say they sometimes feel pressure because of this close supervision but appreciate being let off chores.

Highlights Heard

Inclusion

- There is a growing problem of boys' self-exclusion from school against their parents' wishes. They prefer to play, loiter, see little value in education, feel outshone by girls and have frequently had poor experience of school
- If families cannot afford coaching and there is no alternative like BRAC study circles of a free coaching (as at some NGO schools), then children may drop out because prospects of passing exams are low
- Stipend administration is better. Stipends are mostly used to finance coaching. People still feel that there is some unfair allocation, inadequacy of coverage and criteria of performance and attendance are the most difficult for the poorest to meet
- Parents are mostly highly motivated about education but feel ashamed to interact with the school because of their own lack of education
- TVs in one room homes create a problem, distracting children from doing their homework and keeping them from sleeping. Parents admit that they sometimes take their children to visit relatives without concern about school
- A school based feeding programme would be widely welcomed

In the rural South, there is exceptionally strong motivation to send children to school even considering the recent economic hardships resulting from the price increase and Cyclone Sidr. Mothers help their children with school work while they do their household chores, and they read to them and try to answer their questions. Our feeling is that over the years, there has developed a strong and positive competition among the schools in this village. There are two Christian NGO schools, one Government primary school and a missionary school. The later has raised the expectations of what quality education is. Furthermore, there is an INGO child-sponsorship programme that emphasises schooling and provides support with educational costs.

Schooling is often regarded as the responsibility of the mother, *'I don't understand about the quality of schools, my wife can tell you about this'*, or *'Taking care of my son as a student? That is totally my wife's role so you will not get much information from me'* (man, urban South). Box 18 also highlights the role of the mother in decision-making about education. Some parents indicated that mothers must be educated to be able to help the children to learn and check the quality of education being provided.

Box 23 describes two neighbouring families in the Central peri-urban area and their attitudes towards their boys' education. Both fathers are poor, but one works continuously to try to provide his sons with good education whereas the other has dreams but his attitude indicates that he has little ambition and drive.

Boxes 24 provide contrasting views of education. While most parents are interested in giving their children better opportunities than they had, if employment prospects are limited (rural North and rural South), there is less motivation to do so.

Feeding programme

The school biscuit programme is not being run in any of the schools in our areas, but some teachers had heard of it and all thought it would be a good idea. Parents too thought it would work well, and whilst they do not want to give up their stipend allowances (that pays for private coaching), they thought it would be good as all children could get it. Many teachers said children come to school hungry, *'Children come to school complaining about stomach pain. In fact this is not pain but hunger. How can these children pay attention during lessons when they have no energy?'* (Head GPS peri-urban South). A Unicef supported school in the peri-urban North is running a lunch programme, and a private school in the peri-urban Central ran a biscuit programme that was very successful but run out of funds.

Free tutoring and education

Mostly tutoring incurs fees, but the INGO operating in rural South study area has introduced a free tutor system (mentioned above) and the Government primary school in the same village also provided free tutoring to children with scholarship potential.

Several private schools offer support to poor students. One of these in the peri-urban Central area admits one free student per class to help families who are poor and the Principal hopes to extend this to more. He also allows some others to pay only 25-50% of fees. In another, they sometimes provide needy pupils with uniforms, pencils and books. This Principal has also been encouraging the attendance of children with disabilities and has ten such children currently enrolled.

Drop outs

The drop out numbers recorded in schools are generally inaccurate, and there is a broad interpretation of the term 'drop out'. For some schools it is children who are recorded as having discontinued at that school for whatever reason and so includes those who have transferred to other schools. There is no useful method to identify 'out of school children' in any of the areas as the annual survey carried out in January is interpreted as being a map only of school going children to show which schools they attend.

Some children who attend only for a few days after enrolment are dropped from the school register, and are thus not recorded as drop outs. Many Head teachers denied there were any drop outs (in the North urban GPS the Head was quite confrontational and refused to talk further on this issue) although we always met children who were not going to school any more in all areas.

In the South urban slum, the seven NGO schools for working children are recruiting children who are not drop outs but instead attend the NGO school after formal school in the evening. This is well known to the head of the government primary school, who believes as many as 85 of his children are also going to NGO schools in the evening. He feels this is not good for the students as *'they have a double load of homework'* and the NGOs are not following the same curriculum as the Government school, which confuses the students. These NGO schools provide free educational materials and cash stipends. They also provided relief to the students' families following Cyclone Sidr, but there was no evidence of enrolment purely to access relief. Parents were not forthcoming about the double enrolment; it was children who confirmed the assertion by the Head of the Government primary school.

Another government primary school head denied there was any double enrolment from his school and that if he found this he would *'cut them from the school register'*. But we had a conversation with nine children

Box 25: Examples of Double Enrolment

Mirajul goes to a madrasa school in the day and an NGO school for working children in the evening. He likes it; they do drawing, and he receives Tk75 per month. He has taken the money himself, so he can say it is true: they do get the money! Shortly the school will start with vocational training. Mirajul works on Fridays in a saw-mill. He helps out with cutting up and sorting left-over pieces of wood to be used as fuel. He shares whatever he has cut and sorted, 50/50, with the owner. Sometimes his family will use the wood, sometimes they sell it. (urban South)

The two eldest daughters of our (urban) HHH were going to primary school last year. The younger one was not registered but she used to go 'to prepare for admission in Class 1'. This year, however, she was officially registered. However, the ROSC centre opened nearby and offered the incentive of stipend, uniform allowance and exam fees. So her parents visited the ROSC teacher to try to get their daughter admitted. The teacher was anxious to take on students as the numbers were low and she needed to prove that she had full enrolment. So the daughter was enrolled under a new name to avoid any problems with the primary school. The parents were very happy about the 'kindness of the teacher'. (urban Central)

J, a 12 year old boy who sells vegetables was enrolled in the ROSC centre but he hated it. He prefers to work saying school is 'boring'. His younger brother, however, was in Class 1 at primary school so J persuaded his father to enroll him instead. Because the records could not be changed the ROSC teacher agreed to take the younger brother using J's name. His former school knows that the boy has transferred to the ROSC centre using his elder brother's name but cannot do anything. Meanwhile J is happy because he is now earning more at an ice cream factory doing just what he wants to do. (urban Central)

Play-time at the Government Primary School.

from his school who were all double enrolled. A parent overhearing our conversation told us, *'I have admitted my children to the NGO school in the evening to give them extra input and to make sure they are not getting up to any naughty things in the afternoon and evening'*. Another parent explained, *'The NGO teacher was instructed to open a school in the slum following the rules to recruit drop out students. But there were no drop outs in this area. So the school was facing a crisis before it started'*. In the peri-urban North there were examples of children transferring to the school for working children from the government primary school. The teachers at the working children's school explained, *'As this is a new area we are still collecting students. Some of our children are working children and some transferred from other schools. We have only achieved 50% of the enrolment'*.

Children attending BRAC schools are supposed to be those in the 'drop out' or 'out-of-school' categories, but in the peri-urban Central location, several of the current pupils attended other schools before admission. The government primary school teachers told us that they lost a *'lot of good students'* to the BRAC school. The BRAC supervisor said, *'Students are supposed to be poor and drop outs, but if there are not enough poor children we will admit others up to the ceiling of 33 students'*. A new admission is planned for January 2009 and parents we spoke to are already preparing to give their children the best chance of being admitted. They will claim their children are the right age (admission is for 8–10 year olds) and some are 'marking time' in the Government primary school until admission starts. One HHH told us that she is determined to get her daughter into the BRAC school. She has already attended the BRAC pre-school and is currently in Class 1 of the Government primary school. She feels that her daughter will perform well and will get in (implying there is some form of admission test). Others too indicated that admission will be on a competitive basis, based on ability not neediness. In the newer BRAC school in the area there are many children who have transferred from Class 2 and 3 of the Government primary school, including two brothers from

Box 26: Effect of Price Increases in the South on Education Spending

Mukta has three of her five daughters still living at home. Her husband is a vegetable seller and makes about Tk200 per day but with the price increases this year they feel that that they will soon not be able to make ends meet. He has taken his oldest daughter (class 7) out of school. She is sad about this and jealous of her friend who is still in school with ambitions to become a doctor. The private coaching for the youngest daughter (in class 2) has also been cut.

Another parent says, *'We need to survive first, and then we can take on a private tutoring. Now my daughter has one school uniform which will have to last for three years'.*

'I divert costs for education to essentials now, education is not essential but food is'.

Mukta (center) has been forced to leave school due to financial crisis in the family. Her friend (right) is more fortunate; she enjoys having a private tutor, and is aiming to become a doctor one day.

one family and their two cousins. The land for the school was donated by their father/uncle.

Numbers in Classes 4–5 are often less, for example in the rural Central area, where Classes 4–5 had less than two thirds of both boys and girls compared with Classes1–3 in all three schools (a drop of 40->25 on average). Children told us that their classmates are '*mostly going to other schools'*. Some move to stay with relatives, others go to the madrasa (in this case girls) or attend better schools further away. Some have gone to *'chase stipends'*. But the higher numbers in the lower classes is said to be because many students repeat Class 3 many times. Some government primary school boys stop at Class 3 when *'it gets difficult'* and there are other attractions – then they *'like to help fathers, fish and play games'*. Other girls, particularly older ones (who started school late because of attending the madrasa first or because parents felt they were too young to go to school), have left for employment e.g. a local juice factory. *'We started out having 30 in my class, but now in Class 5 we are only 19'* (boy urban South) but some of these (boys) had been expelled due to bad behaviour. In the peri-urban North, the government high school takes students from Class 4. Canny parents transfer their children at this point when there is less competition for places (40 places compared to only 10 available if they try to transfer in Class 6). Some Class 5 have many more girls. It seems that this is not just because boys have dropped out, but because girls have also transferred from private schools in order to sit the public examinations which lead to qualification for 'female secondary stipends' (as evidenced by the reduction in number of girls in private schools in Class 5).

Drop out is sometimes attributed to children who have been beaten at school who refuse to return (girl in urban slum North), and in the urban Central, there was evidence of sexual harassment by a male teacher which resulted in a few girls dropping out of school. But often the claim

Display of Citizen's Charter in Government Primary School.

Box 27: Older Siblings Help with their Younger Siblings' Education

Malla's older sister encourage their parents to ensure their younger sisters receive a good education.

Malla is in Class 2 at a GPS. Her parents are poor and their house was destroyed by Sidr but her eldest sister, who is working in a garments factory in Chittagong, sends Tk500 every month which she insists is spent on education for Malla and her other sister who is at a private high school. The eldest sister constantly puts pressure on the parents to ensure that her younger sister gets the education she herself never completed. Her parents agree, *'We will continue to support our daughters' education as long as our eldest daughter supports them'* (peri-urban South)

Unable to pay the Tk300 for private coaching, Koli has arranged for her younger sister who is reading for her HSC, to provide support to her two younger children after school. For this she sometimes pays her or buys her clothes and invites her to eat with them. (rural South).

A father told us, *'Although my daughter was an attentive student and did well in the first term exam, she said she did not understand English and maths. She asked me to arrange a tutor but I could not afford this. I knew she was good student and would not disappoint me with her results. Unfortunately, she failed both English and math. She told me she did not understand the exam questions and I realised that I had made a mistake not arranging a tutor. So I arranged one with money earned by my elder son* (a college student). Asked where this money came from the boy said, *'I earn Tk900 per month by providing coaching but I cannot coach my own sister. It is better that she gets outside help and she will be more attentive.'* (urban North)

We met R after dark on the busy main road waiting for customers for his rickshaw. He said he was 'about 12'. He had been to several schools but did not like school as, *'Nothing interested me, other students were always so undisciplined and teachers were always angry. Teachers had no interest to take lessons. They write on the blackboard and then go away'*. Eventually, he went to a madrasa but because of some problems the madrasa was forced to close. So R started to drive a rickshaw and now proudly pays for his two younger brothers to go to school. (peri-urban Central)

of beating is exaggerated, as it is seen as a legitimate excuse to stop going to school (see 'Boys' above and Box 21).

Parents in the North slum say that school should concentrate less on *'boring'* and *'useless'* things such as grammar and provide more sports and games, and that this would encourage children, especially boys, to remain at school. Parents everywhere told us that a more attractive learning environment and games and sports would motivate children to continue. Teachers and boys also said that more male teachers in primary schools would encourage boys as they could, amongst other things *'play games'*. It was noticeable that all the urban schools were predominantly staffed by female teachers.

Costs

The current financial situation has had a profound effect in terms of education on the families in the rural North study area. Many children have been taken out of school to help with economic activities; collecting firewood and working in the stone quarries. However these decisions are also related to the lack of economic opportunities and low expectations in this area any way. For example, a boy of 8 told us that he had lost his stipend, because the school is inaccessible in the rainy season and his parents could not afford tutors. He thinks, *'It is better that I start work and start earning for my family. I think I will be an agricultural worker like my father. This is the right time to do as my two elder brothers'.*

The impact of Cyclone Sidr and high food prices in the South has meant that some families have dropped private tutors, but there has been an increase in siblings and friends studying together. Some have also taken older children out of school (Box 26). Because of the high unemployment and rising prices parents of the urban slum children in the North have either stopped coaching or send their children for fewer months.

Box 28: Mita Contributes to her Own Education Costs

Last year we met Mita who wants to be a doctor when she grows up. Her parents were concerned that they could not, *'Help her with her studies as we are illiterate and we cannot afford the coaching she will need'*. She still says she wants to be a doctor but she failed English and Maths in Class 4 so is repeating the year. This means another Tk1400 has to be found by her family to pay for her uniform, shoes, exercise books, pencils, contribution to school cleaning and annual registration fee. Then, because she is weak in Maths and English, she needs extra coaching for an hour every day. This costs an additional Tk100 per month.

Mita's parents said last year that they could not afford coaching and things have got a bit tighter financially this year. Mita's father, who sells biscuits at the bus terminal, says that he could not make any savings this year. All seven members of the family earn and contribute to the family. Mita is the youngest of four children.

This year, Mita and her sister-in-law have started piece work at home. They sew sequins on to shalwar kamiz. At Tk5 per piece, Mita says she can easily make Tk300 per month working only an hour or two per day. She uses this money to buy pencils *('I need 12 per month- as they break and I lose them)* and she has also bought material to make her own shalwar kamiz.

Mita shows the dress she has made by herself.

We came across a number of instances where siblings support the education of younger children that was usually born out of a desire to ensure that they got a chance for education denied to them (see Box 27). We also met primary level children who were contributing to their own educational expenses (see Box 32). But some parents feel that this taste of economic independence is eroding their children's motivation to see the value of school; *'My daughter is busy with her sewing (or playing) rather than doing her homework'* (father of 12 year old girl, urban Central). *'He would rather look after the cows, go fishing or help in local shops than go to school. He likes his freedom. He likes being with his friends* (who are also out of school). *I have tried my hardest to get him to go to school but he prefers to work'* (mother of 9 year old boy, urban Central).

There continues to be requests made from schools for recovering a range of additional costs. Rarely (see complaints below) do parents complain officially about these, but they are often suspicious that they are not legitimate costs. In the North slum a standard Tk50 is added for all students ostensibly for extra-curricular activities and on paying it 15% marks are added to their exam marks. This school never undertakes any extra-curricular activities and the money is used to buy glasses and mats for the teacher's room.

Tiffin can be quite a socially divisive issue. Better-off children bring Tk3 every day and others feel ashamed that they cannot do this. Some students spend Tk300 per month on breakfast taken outside before school as it starts too early for them to take breakfast at home (urban South).

BRAC schools in peri-urban Central have their own after school study groups and both children and the teacher say that they therefore have no need for additional coaching. Box 29 provides some examples of parents calculations of costs associated with education at Government primary schools. The costs represent an increase of about 10% over last year. Box 30 provides a comparison of costs as carried out by a group of community mothers in peri-urban Central area.

Highlights Heard

Costs

- The economic crisis experienced particularly in the North study area has resulted in children being taken out of school to work. Here and in the South families have cut back on private tutor costs
- Elder siblings strongly support the education of younger siblings both with earnings and provision of moral support. Children earn money for their own education
- Costs associated with primary education are never less than Tk2400 per year

Box 29: Examples of Primary Education Costs

Peri-urban (South)	Urban (South)	Urban (Central)
Class 5 GPS	Class 5 GPS	Class 4 GPS
exercise books Tk580/yr	exercise book, pencils Tk120/m	books, pencils Tk360/yr
pens Tk120/yr	private tuition Tk200/m	private tuition Tk1000/yr
private tuition Tk1800/yr	additional requests	contributions to school (cleaner/ayah) Tk500/yr
(excluding uniform costs, exam	from school Tk110/m	registration Tk50
fee, sports and end of year party)	exam fees Tk90/year	uniform/shoes Tk500/yr
(excluding uniform costs)		
Total Tk2500/yr	**Total Tk5250/yr**	**Total Tk2410/yr**
Other costs		
tiffin Tk500/yr	breakfast Tk300/yr	

Newly established non-formal school for working children in a open place under the bridge.

School Functioning

Staff shortages

As last year (2007 report p38), several government schools were suffering from staff shortages. As observed before, rural areas have difficulty attracting and retaining staff (e.g. staff in rural Central area who were not local were hoping for transfers or planning to leave the teaching profession). The requirement for teachers to attend the Certificate in Education training has resulted in severe staff shortages in many schools again this year. Many teachers told us that the need to attend regular meetings, training and teachers taking time off means that remaining teachers are regularly covering additional classes. Some suggested that there should be a permanent *'stand in teacher on staff'* (urban South) and others suggested that there should be *'para teachers'* from the community who could be temporary substitutes at short notice (peri-urban Central).

Student: teacher ratios

Box 31 provides some examples for student teacher ratios in the schools in our study area. Government primary schools are all, with the exception of one, over the Government's policy target of 40:1 and are much higher than NGO or private schools.

Certificate in Education training

With the intensive drive for all primary school teachers paid by the Government to receive Certificate in Education training, we particularly looked for signs of qualitative change in teaching practices. There are some examples of teachers using more play and resource materials in their teaching but the importance of a conducive environment to enable change is very important. This is exemplified by a story from a school in the South slum (Box 32) and in comments below.

Box 30: Comparison of Costs in Public, Private and NGO School (Source: Community Mothers)

Costs	Public	Private/KG	NGO/BRAC
Admission fees	Tk10 once in a year	Tk200-250 once in year	none
Monthly Fees	none	Tk80=KG Tk100=I & II Tk200=IV & V	none
Examination fees	Tk20-25/exam three times a year	Up to Tk150/exam three times a year	none
Books once a year	Free	Might be Tk500= I & II Tk1000=III, IV, V	free
• Dress	Tk200-300	Tk500+	not required
• shoes	Not mandatory	Tk300	
• school bag	Usually don't buy bags	Tk100-200	
pencil/pen & others	Tk100/month	Tk150-200/m	free
others (Tiffin)	Tk5-10/day as can't come home for lunch-it's far from community	Not required as its close to community	Not required as it is close to community.
Total	**Approx Tk3700**	**Tk3300 (class 1)**	**None**

Last year head teachers had complained that there was little point in the Certificate in Education training because, *'When they come back, they don't do anything differently'* (2007 Study p39) and this opinion prevails. For example, the head of the Government primary school in the urban South is appreciative of the short course offered to teachers, but is less convinced by the Certificate in Education training which results in staff shortages. Other teachers in the rural Central area told us that the idea of the Certificate in Education is to make school and learning *'more joyful'*. But, they said during school hours, *'We have so many classes to manage, each only 35 minutes, it is very difficult to do'*. They felt that it was easier for BRAC teachers as they spent three hours with the same children (whereas *'We always have to be thinking about the next class'*). The male teacher attended Certificate in Education training recently along with his Head teacher and so feels it is easier to make changes, *'to motivate children and make more joyful'*. The Head is young (only 6 years older than the teacher) and, *'We can share and endorse changes'*. This, they felt was in contrast to working with older teachers; *'We cannot be free with older teachers'* and *'Older ones perception is so narrow'*.

Teachers from another government primary school (rural Central) said the training that lasts one year was much too long and felt that three months would be enough. They are concerned about the rumour that there is an intention to increase it to two years. The following is an excerpt of our conversation with two teachers. One (T) has just received Certificate in Education training and the other (N) is about to go on training:

Us to N: *What do you hope to learn from the training?*
N: *Different ways of teaching, modern ways, how to motivate students and how to make lesson plans.*
Us to T: *Do you make lessons plans?*
T: *There's no time. Within 40 minutes there is so little time and I have to take more classes because of the teacher shortage. We rush from class to class.*
Us to N: *So why do you want to be able to lesson plan?*
N: *Actually I am going to Certificate in Education training because it is compulsory.*

We asked some children to compare these two young teachers at their school. The children actually prefer the untrained one, N, and see no

Box 31: Some Examples of Student: Teacher Ratios

Government	Non government	Private
52:1 (urban S)	27: 1 (rural S)	1: 25 (peri-urban C)
66: 1 (urban S)	33: 1 (BRAC schools)	1: 20 (peri-urban C)
52: 1 (peri-urban S)	30: 1 (working children's schools)	
66: 1 (peri-urban S)		
40: 1 (rural S)		
107: 1 (urban N)		
74: 1 (urban N)		
101: 1 (peri-urban C)		
57: 1 (rural C)		
42: 1 (rural C)		

Box 32: Clash of Old and New Styles

The school recently took on four new teachers as part of a government programme to increase quality and status of schools. When they joined the school and started to teach the students noticed straight away that their teaching was different from that of their older colleagues. They became much liked by the students, and when it became clear that they were more popular than the old teachers this led to a conflict and jealousy. The old teachers then presented the head master with an ultimatum. *'You must choose: take us or them! We don't want to work with these new teachers'*. Shortly thereafter the young teachers were transferred. The students were hurt and upset; they had lost their new popular

All primary school teachers must attend a one year Cirtificate in Education training. But teachers say the course is not related to their practical reality but is mostly theoretical.

difference in the way the two teachers teach. They said that T does not use any new methods. Others in the community regard N as 'qualified' and parents send their children to her for coaching indicating their satisfaction in the way that she teaches.

RNGPS teachers in the same area felt that most of the Certificate in Education training is *'useless'*. They said there is a lot of emphasis on the theoretical and it is not practical. *'We need to know how to manage 80 children in 30 minutes'*, one teacher told us. They explained that in the three month school attachment part of the course, they learnt how to plan lessons but, *'If we have 10 classes per day how can we plan like this?'* Of the 11 subjects taught, they felt that almost nothing related to their actual situation and was not child-oriented. Rather, the course was, *'Oriented to us, our betterment – the curriculum is for us'* and was designed, *'So we can pass the exam and not for our students'*. In sum the one male teacher said that he felt the Certificate in Education *'was not worth doing'*.

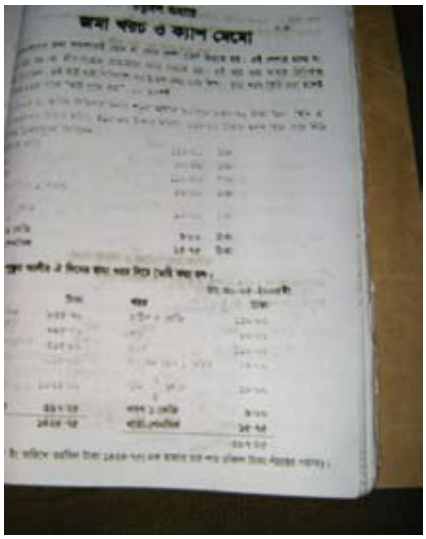
Box 33: SMC Role

teachers, and they complained to the head master. According to students and parents the head master and the old teachers went against government plans, and against the will of the students. As it is now the school has the old teachers, and four vacancies.

The SMC Chair (a GPS in peri-urban South) of 8 years is local and has previously served as the UP Chairman. He told us *'We are here to look after the children, so we are checking that the headmaster and the teachers are coming to school on time and they are not sitting idle. Because if we leave it to them they will just teach in their own time at their own pace… which means slowly! Yesterday I called in at the school to see the headmaster but he was not there. So I called him and he explained that he was attending a meeting in town. And we also check that teachers don't beat the children'*.

By contrast the SMC other GPS in the same location is not at all active. The Chair, who originally donated the land for the school, is elderly and has not been actively engaged in the school for a long while.

Students showing torn books.



The problem of second hand text books.

Timing

The Government has issued a recent directive enabling schools to institute flexible timing which suits the needs of their areas. We only came across practice of this in primary schools in the urban South where they open half an hour earlier in April–September. However, this has not been universally welcomed, as some students here say that it would be better to start school at 10am to give them time to prepare their homework in the morning and play after school in the evenings. Others like the early start although this may mean that they have to leave home without having breakfast and they either go hungry or incur further costs to take breakfast outside.

The adoption of the option for flexible timing is probably most needed in the flood-prone North (see above for examples of children facing difficulties to meet stipend attendance criteria because of flooding) but this option was either not known by head teachers or, they told us, that the Upazila Education Officer *'did not sanction it'*.

Box 34: Comments on BRAC Schools

'The BRAC school was good. They have some cultural activities such as song and dancing and they teach well. The teacher's care and show affection. She used to visit our home. And we did drawing and the teacher used to read interesting stories from books. And we made dolls and pots using mud. So there were some special things there that I did not get elsewhere' .(Girl, age 16, who has experienced four different schools - peri-urban South)

A child complained to her parents, *'Why did you not let me go to the BRAC school like my sister. My sister who is in class 2 can read and write better than me and I am in Class 5'*. (peri-urban South)

'When you read in BRAC school the cost is only Tk100 per year. I have sent my grandchildren there because of the low cost and it is close to my house. And the teacher takes care so there is no need for a private tutor. This is good because we don't have much time to take care at home' (Grand parent). Another parent agreed, *'Private tutors are not needed for students of the BRAC school because they make the lesson easy for the children and they can learn instantly!'* (peri-urban South)

'BRAC school is good, it is different because we get to play and dance more'. (urban South child who is double enrolled at GPS)

'We like taking children from the BRAC pre-school as they already know so much (Teacher GPS peri-urban Central). *'The atmosphere in BRAC school is very good, making school enjoyable. It is good to have these pre-schools as the resources in Class 1 are very difficult for children who have never been to school'* . (Teacher, GPS rural Central)

'We really like our teacher - she teaches in a different way', 'uses singing and dance' and ' makes learning enjoyable'. (Children of BRAC school, peri-urban Central)

Teachers from School B told us that, *'Of course BRAC schools* (meaning cohort schools not

The teachers in both schools in the Central slum indicated a huge problem in getting children to attend after tiffin time, *'Our attendance drops to 30% or less after tiffin. Mothers like their children to watch TV with them in the afternoon'* (Principal of one of the schools), *'Dish connection is the biggest problem'* (teacher of the other school). Both feel that a single shift system would be much better and if children were offered biscuits at school, attendance would be much higher.

Text book supply

Teachers in all schools noted that they got their text books on time this year and attributed this change to the Caretaker Government. The poor condition of text books was highlighted to us on many occasions. In the North people wondered, *'Where are the promised 50% new books we are supposed to get each year?'*

Effect of SMCs

The School Management Committee (SMC) for the Government school in peri-urban South is considered to be quite active, *'The SMC is working better here than other places'* (Head). Its primary role is to select students who are eligible for stipends, but it is also active in ensuring the school is run properly but, in contrast the SMC for the other government school in the area is dormant (see Box 33). The head of the Government primary school (urban South) is frustrated by the politics involved in appointing the SMC. The comparison of the two urban schools in the North provided below (under Quality) indicates that the better school has a functioning SMC. It is formed from better-off people who have personally donated display boards, fans, benches, cleaning materials and the salary of a peon/cleaner. Members of the poorly functioning school SMC, on the other hand, did not even know they were members!

School construction

We observed quite a bit of school construction work, all built under the auspices of PEDP II. The new two-storied extension to the urban government primary school in the South is much appreciated just like the new

Box 35: Comments on Government Primary School Quality

feeder schools) *do better as they have children who should be in class 9 studying with them and teachers only have to focus on one class and no extra tasks. But we always have to think about our next class'*. Teachers from School A said it is, *'Easier for BRAC teachers because they have 3 hours with the same children'*.

Typical BRAC preschool.

'We have six different teachers; one for every subject - that is good'. (student urban South)

'If the (GPS) school had been as good as it is now when my boy was young, I would have sent him there'. (Mother referring to the excellent school in rural South)

'Teachers don't really care and don't motivate the students... students have to have private tuition to get on and most parents cannot afford this'. (BRAC teacher, peri-urban Central)

'It is noisy', 'Overcrowded', 'Often closed', 'Teachers are often not there' and *'Teachers don't care if you are there or not'*. (BRAC students views of the GPS, peri-urban Central)

The school is empty after tiffin time (snack break) – children don't return to school.

Children have to wait for school to start – they're on time, but the school is late.

A deep tubewell has been sunk on the grounds of the Government Primary School, but it is faulty and has been abandoned by the construction company.

Government Primary School.

single-storied extension in the Central peri-urban area; *'We like it because it is nice and clean'* (students). In the peri-urban South area, a new Cyclone shelter-cum-school has been built, but the building has not been officially handed over and the plan to commence use in January 2009 seems unlikely. The contractors have left but the windows have not been installed. Despite the concern that the building is not needs-based, teachers are pleased that the extra space will enable them to run one shift instead of two. A new two-roomed resource centre in the peri-urban North area remains uncompleted, due to a court injunction resulting from a land dispute.

Two new classrooms have been provided in one of the three government primary schools in the rural Central area, but the building cannot be handed over as there is a dispute over the exact site of the teachers toilet. This has created tension between LGED and the school's neighbour. Final completion was halted and the teachers have now been told they will not have a new toilet. A toilet and deep tubewell have been installed at the rural South school, but the tubewell is not functioning and the toilet is locked since it has not been officially handed over.

The intention for the new extension in the rural Central area is that this school is to become a pilot 'one shift' school. The teachers say this is, *'Better because children will be able to complete everything at school'* and expect that this one-shift system will start in the new school year (2009) provided new teachers have been recruited by then.

As noted last year (2007 Report p37) there were concerns about the standardisation and lack of local consultation. In the South slum school, construction was done without any local consultation and attempts by the headmaster to influence the plans were re-buffed. He told us, *'The Government should assess specific needs, not use the same design for everyone'*. In fact parents did not even know that this new building was to be the new school. There was no consultation about making the rural Central school a pilot one-shift school.

Location

The government primary schools in the peri-urban location of all areas are situated on or near busy roads and in both cases students died crossing the road this year. The school in the rural North also functions as a flood shelter, but it is in very poor condition and parents are getting increasingly worried about the safety of the building for their children.

Highlights Heard

Functioning

- Many schools are suffering from staff shortages made worse by the compulsory attendance at Certificate in Education training
- Government schools have very high student to teacher ratios - at least 30% more than any other type of school and often two or three times as many
- The Certificate in Education training is thought by teachers to be too long and irrelevant to practical needs. Children see little difference in the behaviour of teachers returning from training although a conducive environment to implement change is vital and depends a lot on leadership
- The option for flexible school timing is either not known or not endorsed even where need is great (e.g. flood prone areas)
- Post tiffin (children go home for snack) absence from school is a big problem in the Central study area
- New construction under PEDP II is appreciated but more local consultation and less standardisation is needed

People's Perceptions of what is a Good Primary school

- Enthusiasm and commitment of the teachers, often expressed in terms of s/he 'shows love' but also including punctuality, continuous presence during school hours, helping children to understand lessons (rather than rote learning), being attentive (not pre-occupied with personal business, using mobile phones, eating, smoking, sleeping in class time), coming to visit the children at home and informing parents about progress.
- Opportunity for children to play and learn through games and songs. This also means that playground space is important and sports opportunities should extend beyond an annual sports day. Sports and male teachers/assistants to take regular sports activities are regarded as particularly important for attracting and retaining boys.
- Small classes where children get individual attention.
- Toilet and safe water facilities.
- Education provision is sufficient to pass public exams without the need for private coaching.
- Safe and secure location which is reached easily and safely (proximity to busy roads a particular problem).
- Less concern about the physical facility as parents feel some of the best schools are in simple huts. The quality of teaching is most important.
- Transparency around requests for money and fees.

Quality

There is some perception that since the Caretaker Government, Government schools are functioning better; *'Now suddenly teachers become more caring'* (mother, urban South). Some told us that they have been called by teachers to discuss their children's progress, although others are disappointed that teachers do not make the home calls parents know they are supposed to. Teachers at a rural government primary school (Central) say there is lots of corruption in transfer posting as people always want to be transferred near their homes. Teachers in another rural Government primary (Central) told us that there is less of this sort of problem since the Caretaker Government but this has meant that one of the teachers has been unable to get transfered near her home!

Teachers shared their concern that as more better-off children move to private primary schools, then Government primary schools will be regarded as *'schools for the poor'*. As one head (GPS, urban South) told us, *'Nowadays the government primary school is considered to be for the poor. With kindergarten and other types of school, the image of the government primary has gone down and people think it is a poor people's school. One of our SMC members has four grandchildren and they all go to a private school. So he is a member* (of the SMC) *but he does not like this school.'* And in different conversations, teachers echoed this, *'Government school, like government hospitals, are for the poor… kindergartens have divided the community into two groups regarding education. This will spread. It will be a division felt nationally'*.

There is huge variation in the ways different Government schools use their limited resources. Box 36 provides comparisons of schools located in the same area but are qualitatively different. We have found that one can tell immediately how a school is run on entering. For example, the rural Government primary school in the South is far better than all the others the South team visits; there are paintings on the wall, chairs and tables for

students in the teachers room where teachers provide free extra tuition, the office is covered in charts and pictures and a photograph of one of the teachers with the label 'A good teacher', all the classrooms have their own glass-fronted cupboards with teaching resources that are visible and easily accessible. Teachers here say, *'It is not right when others say they do not have time to use these materials… using them means ensuring good quality education and that depends on the motivation of the teacher and cooperation and encouraging supervision'*. It is widely acknowledged in the area that this is an exceptional school, and parents attribute this to the Head whom *'Is active in trying all the time to do good for the school'*. These parents say that other schools fail because of lack of incentives for good heads and teachers as well as the lack of good supervision.

But, generally the Government schools are regarded as offering inferior quality and there are many reasons put forward for this. We often heard the comment that because teachers are on the Government payroll, their tenure is secure and they therefore *'don't bother'* or *'are not motivated'*. One

The box of school resource school materials remains unpacked in the teacher's room. (School A – see box 36)

Box 36: Same but so Different!

The story of two urban Government schools

School A and School C are both three storey Government Primary Schools built around the same time and situated about half a mile from each other in our urban location in Central Bangladesh. Although the asset base is rather similar, as we enter the school, we immediately feel the difference. The following are some of the clear contrasts which highlight the key difference: the attitude and behaviour of the school staff, in particular, the Principals/Head teacher.

School C	School A
Same assets……..	
Three storey, 5 classrooms, no play area, no toilet, no working tube well, six women teachers, 422 students	Three storey, 5 classrooms, no play area, one toilet, no working tubewell, six women teachers, unclear enrolment number – around 500
But completely different….	
Classrooms neat, organised, children engaged and disciplined. Three scholarships gained this year. Children met outside and on steps polite and confident	Classes held on verandah as well as in classrooms, children running all over the place during lesson time, teachers do not appear in control *'Teachers are very relaxed'* (say children)
New teaching materials supplied by AEUO. Have been unpacked, ready for use in the teachers room, some have been used already (see picture next page)	Exactly the same teaching materials received at the same time as School C but Principals says they are 'in almirah- we do not have time to deal with them' (see picture above)
Plants in pots at entrance labeled 'Our nursery' and other initiatives to beautify the classrooms	No attempts at make the learning environment attractive
Good knowledge about the SMC from the teachers/Principal and clearly good relationship-supportive, three members have children at the school	SMC members not closely involved, members do not have children in the school and all names of members not known by Principal
Principal very concerned about non attendance and the problem of non attendance after tiffin break (drops to 30%), teachers share home visits, very aware of problems facing boys	Principal denies problem of poor attendance post tiffin although children tell us that they often don't return to school and watch TV instead
Consultation and good informal relationship between Principal and her teachers who sit together and join in our conversations	Principal sits all day in teacher's room, teachers given orders, teachers do not sit in her presence. First thing she asks us on meeting is *'Can you get a job for my daughter?'*
Principal concerned about the nutrition of her students, has encouraged quail egg seller and banana sellers at school gates and banned sweets/ice cream sellers	Sweets, achar, snack foods and ice cream sold at school gate
Teachers always on time and children like them (particularly the young ones)	Children say teachers are late, sleep sometimes and some are angry

Resource materials ready to use in the better Government school. (School C – see box 36)

father, whose promising daughter failed her exams this year said: *'Is there anyone who can say that there is quality education in the Government school? Why did my daughter not understand the lessons in school? Why must she have private tutoring to make her understand? How can a poor person like me afford to continue education of children spending so much money on private coaching?* (Father of girl in Class 2, slum North)

We observed a similar stark contrast in the urban North as the following describes in box 37.

These examples illustrate the importance of good leadership, and not just the provision of resources. Last year we noted how the Head teacher of the North peri-urban Government primary was extra-ordinary and the school had been recognised with an Ideal School award and attributed to his exeptional leadership.

As noted last year, there is a preference for NGO schools, particularly BRAC schools. Parents say that their children can read and write better

Box 37: Comparison of two Government Primary Schools (urban North)

School A	School B
All teachers are female and have Certificates in Education. Equal ratio of boys and girls. Two storied building	All teachers are female and have Certificates in Education. Equal ratio of boys and girls. Two storied building
Teacher : student ratio 1:105	Teacher : student ratio 1:74
Uniforms rarely worn	Uniforms always worn
Teachers late and unmotivated. Have ready made educational charts but are not using	Lively teachers, work in a team, develop their own teaching materials. Teachers encourage students to make models and pictures
No scholarships ever awarded in this school. Children leave this school every year in search of better education and so, according to the teachers, only the less able students remain	Good exam results, 2-3 students get scholarships each year. UEO awarded it a certificate of appreciation this year for the best exam results
Inactive SMC, some members do not know that they are members	Active SMC which meets regularly
No sports or cultural programmes	Sports and cultural programmes organised
Toilets dirty and sometimes locked	Toilets clean, with soap, towel and cleaning brush and always open during school hours

Box 48: Notes from a Debate

One of our team listened to a debate between two mothers on the merits of Government school vs the BRAC school.....

Mother 1 – Goverment Primary school	Mother 2 – BRAC school
It exists for long time-well established in the area, but BRAC is recent	Yes, it's new in our area but it has existed in the other areas for a long time
Majority students in the whole country depend on this type of school	Number of BRAC school is also rising
BRAC takes students who are experienced and already learned in primary school	As the number of students are small compared to primary, teachers are sincere and teach with personal care
During exams, to avoid copying from each other/cheating students seats are kept apart but in BRAC they sit side by side and copy from each other; so knowledge is not properly assessed	But there is an oral exam to judge the students individual learning along with written
Most students are of similar age group, BRAC has so much age variation; two brothers/sisters of same family reads in same class	But what is the problem? If brothers/sisters are in same class they can help each other
Children can get stipend money which can be used for private coaching	Private coaching is not required as group reading in the afternoon enables children to help each other

The first pre school class (for 3–4 year olds) is called 'Playschool' in this private school, but it doesn't involve much play.

In this school there is discipline and orderliness and lots of resource materials being used.

than those in Government schools. Box 38 presents notes from a debate between mothers on the merits of BRAC versus government primary schools (peri-urban Central).

In one of the rural NGO schools, one of our team noted in his field notes, *'The teachers use unconventional techniques and are performing and moving about when they teach; they sing, act, demonstrate what they teach and don't just lecture. They emphasise story telling, tell jokes, repeat lessons, sing and encourage students to play'.*

While BRAC teachers are generally regarded as caring and loving, Government teachers are often described by people as being uninterested and uncaring. But we also came across many examples of Government primary teachers who bucked this generalisation, and children were quick to point out which teachers they liked (the young ones, the kind ones and the ones who 'made it easy for us to understand').

Box 39: Comments on Quality of Madrasa Education

'We sent our children here because we thought they would be more pious and could get jobs as imams'. (Parent, urban North)

'My son should have been in class 7 now if he had been reading in the government school. But now he is reading in class 5 in madrasa. But I am happy about this because the education in madrasa is better. Now my son pays more attention to school, there is more pressure from the madrasa for him to do his homework. He is taking responsibility for his own education and reading now.' (Parent, peri-urban South)

'I like the madrasa the best because now I have learnt so much about religion. And here I am bound to pay attention to school because there is very strong supervision and pressure from the teachers. And it is close to home. Now we are reading 11 subjects, and if there is something I don't understand I can raise it with the teacher… he is very helpful and makes whatever I don't understand clear to me. Also, now when I have been ill (she got burnt while cooking and has not been able to go to school for a while) *the teacher came to see me, and the school asked my class friends to come and look after me'.*(Class 10 girl, who has experienced BRAC, government and madras schools, peri-urban South)

'Cost in government school is lower than in madrasa but I have decided to send my son to madrasa anyway, so that is where he goes now. They take more care and take action if the child does not attend regularly.' (Mother, peri-urban South)

Box 40: Comments on Private Primary Education

'The teachers recruited to private schools are not qualified so these schools are in fact not good but they make them look good to the parents. They set up as a business that is all, but education is not good. We here in the government school are qualified, trained, we go on courses but we are now left with less able children '. (Teacher, GPS, urban South)

'It is much better than Government; the teachers are punctual, their way of teaching using songs and games is much better and all the teachers are serious about education'. (Guardian, peri-urban Central)

Children demonstrate the punishment they get at school.

An urban slum boy (South) shared his ambition to be a teacher; *'As a teacher I would be regular in attending class, well-behaved and not use slang language'*. Others said it is important that, *'The teacher shows she loves us and that we are allowed to play and that she pays attentions to the students while teaching… and she is lively, humorous, and she smiles. And the teacher should love all equally! The teacher should come every day and help us to learn practically, showing us…. And we like if they come and check on us if we don't come to school. Also it is good if the teacher goes to our parents and asks them push us to work on other things at home'* (children Class 1-4 South slum)

Despite the experience of the excellent rural South Government primary school and the two better urban schools mentioned above, there is a general reluctance in most schools to use resource materials such as charts. It is regarded as time consuming and 'messy'. Teachers commented that the short classroom sessions prohibits use of the resource material effectively and is a burden to organise for successive classes. As mentioned above, some teachers told us that it was difficult to introduce new ideas and ways of teaching if the older teachers were not supportive. The teachers at the rural government primary school in the South also indicated that a supportive environment was essential, and they spoke also of an Assistant Upazila Education Officer who *'Inspired us a lot. He requested us to work also on one Friday per month. Although we found this inconvenient, he nevertheless convinced us. As an officer, he showed commitment to change and was successful in transferring this feeling to us'*. Many of his ideas have been taken up such as weekly tests, encouraging peer follow up for less regular students and the provision of free coaching.

Beating

'Reasonable' beating is considered normal in the schools, and regarded as an important aspect of discipline by teachers and parents alike. It is seen as acceptable if the beating does not cause lasting injury, and usually

Box 41: Comments on NGO Schools

'One of the key characteristics of our school is that the teachers really love their students and show affection'. (Headmaster of the preferred school in rural South)

'In the Government pre-school it is a school just in name. The teachers don't attend sessions. But in the NGO pre-school, they take care and the children learn something'. (Parent, rural South)

A girl, who lost her stipend for irregular attendance and failing her exam, was admitted to an NGO school for working children. *'I found my friends there. I got free books, pencils and exercise books. Apa is so nice and lovely. She never shouts or beats us. She sings and plays with us and teaches us with care. I am so happy to be in this school. Compared to my previous school (GPS) this is the best for me'*. (Girl age 11, peri-urban North)

Missionary School.

refers to swipes across the palm of the hand for *'naughtiness, lateness and not doing homework'. 'No child likes to be punished by beating… sometimes when the child has not been to school, first thing that happens when they get back is they get beaten! Beating should not happen'* (SMC Chair peri-urban South). Both parents and grandparents during a long conversation in the rural Central area told us that teachers should beat their children, as it is the only way to *'get discipline and respect'*. One girl who is an older child (probably 14) but still in Class 4 demonstrated to us how children are beaten across back with a stick for not knowing answers. For being naughty in class, they have to crouch under the bench. She feels she deserves this punishment, but feels ashamed in front of her classmates and is fearful of it happening again. She told us that it has worked, because she doesn't get beaten often now. Another mother says, *'Of course punishment is needed. This makes them serious, respectful and focused on their learning'*. She thinks the best form of punishment is a stick across the palm. *'Of course I have to hit my daugh*ter (who is four*) myself to make her behave'*. But as we have noted above, excessive beating (or claims of excessive beating) are considered by many parents to be legitimate reasons to keep children out of school.

In one rural NGO school (South), the teachers use positive approaches and incentive systems rather than beating. They reward timeliness and neatness and cleanliness with 'stars', and the Head explains that children are not beaten for bad behaviour but have to write lines such as, *'I will never hit a friend'*. This way, he says, the students know exactly what they are punished for and the punishment also improves their writing skills.

Walls are covered in illustrations at Government Primary School to inspire students and teachers.

Children score the qualities of their teachers. The qualities listed (left to right): kind, angry, absent, helps us to understand, sleeps.

School Level Improvement Plans (SLIP)

Nearly all the Government primary schools in our study areas had initiated SLIP programmes (except the urban North), as compared to last year where tentative initiatives were only found in the one location in the Central area. The confusion about SLIP that were observed in 2007 seems now to be resolved. Where SLIP has recently been introduced, teachers were generally able to explain its purpose. Suggestions for and actual use of the grant money included; replacing fans and water pump which had been stolen (urban South), repair the latrine, repair the roof, purchase of games (Central rural). A rural school (Central) has received its SLIP money (Tk20,000) and have posted a list of things done with the first tranche in the teachers' room. Last year they told us of a number of problems with the school including a leaking roof, lack of electricity and fans, and dangerous steps up to the verandah but none of these were

Box 42: Qualities of a Good Teacher Described by Children in Drawings

Mostly mentioned qualities

- Affectionate/does not beat/rarely beats
- Explains well/everybody understands
- Encourages extracurricular activities like games, singing/dancing, drawing

Other qualities

- Prays regularly
- Does not sleep in class
- Provides personal care for good students
- Never/rarely late

This little boy is five years old. He has never held a pen or tried to draw a picture before. He was beaming with joy when we invited him to join in the other children during a drawing session – describing qualities of a good teacher.

Highlights Heard

Quality

- Some improvements in government schools have been noticed this year; more punctual and attentive teachers and more follow up of students
- Government primary schools are acquiring an image that they are 'schools for the poor'
- Government teachers are often regarded as poorly motivated and not as good as BRAC or private school teachers. The qualities of a good teacher include being kind, showing affection and attention to children, teaching in a lively way which includes play, songs and games
- Government teachers say they are reluctant to use resource materials because it is time consuming and too much trouble for short lessons
- "Reasonable" beating is considered normal and acceptable to ensure discipline
- SLIP is better understood and organised this year. Teachers appreciate the local decision making which can result in better quality of work (e.g. repairs) and quicker action. But the SLIP grant often seems to be used for a lot of administrative actions of the school (meetings) rather than improvements
- English language teaching is regarded as very important as many jobs require it as does mobile phone texting. Quality of teaching English has gone down compared to the parents experience of English language at school

included in their SLIP plans. Rather the money has been spent on lots of meeting costs (more than 25%), some repairs (25%), materials and equipment (25%) and a sports day (25%).

In another rural Central school, teachers said they feel that they got better quality of work on the roof repair. It was also quicker than LGED, because they could organise it locally themselves. They had been asking the authorities for this repair for over three years. The teachers said they really appreciated the SLIP as it was *'de-centralised – for the school and for people'*.

There is some confusion over a resource provision that has reached schools in the Central and South areas in the form of a standard box containing teaching resources, a first aid box, a set of weighing scales and play equipment to the value of Tk10,000. Several of the schools told us that these were SLIP materials. Subsequent investigation has revealed that these are actually resource materials provided under a Unicef programme. Such confusion can easily undermine the operation of SLIP as there is no consultation on these resources and teachers emphasised the importance of local decision making in the SLIP programme.

In the Central area, parents and students told us that English language is essential in schools and regard it as is vital *'to get on'*. They said that it is needed for some vocational training (e.g. computer training), for jobs abroad, for mobile phone text messaging and for reading prescriptions. The Class 5 public exam took place while we were present. The exam paper was in English and we found basic spelling and grammatical mistakes. Children who had sat the exam described how it was arranged. They were allowed to ask for clarification and the invigilating teachers told them the questions in Bangla (collectively and individually – going to their desks and gave hints on how to answer the questions. They put these hints on the blackboard. The children said they were not allowed to copy from each other, although they are sitting three to a bench. If caught copying they were told to stop writing for 5 minutes, and then were allowed to resume. However, they were allowed (even encouraged!) to help each other (as long as they did it quietly!). Parents and elder siblings who were visiting shared with us that they think that English teaching is weak these days. It used to be much better taught, but they explained that it is difficult to get English taught well in these schools nowadays because teachers are weak in English and there are no local teachers.

Box 43: Different Strategies Adopted to Avail Good Education and Incentives

- Attending GPS or full time madrasa and school for working children simultaneously
- Attending GPS and transferring to ROSC
- moving from urban area to stay with relatives to avail stipends
- BRAC pre-school, marking time in GPS until place available in BRAC school
- Madrasa first to provide religious/moral foundation or because safer/closer when child young and delayed entry to GPS
- GPS first (closer to home and less important to do well, assess potential) followed by transfer to Private school when investment considered important (more serious)
- Private school until class 4 when girls transferred to GPS class 5 so they can take public exam entitling them to secondary school stipends
- GPS first and transfer to madrasa to ensure a disciplined environment for boys, safe environment for girls
- Elder siblings not performing well at school drop out to earn/save family from further expense which is used for younger sibling education
- Keeping boys in class 3 or 4 –have to repeat but also keeps them 'out of mischief

Voice and Complaints System

As noted last year, there are no known formal channels for complaints about education services to be heard by the authorities (2007 Report p41). Mostly parents do not complain, saying that they are *'trying to avoid conflict'*, that *'nobody will listen'* or *'nothing will change anyway'*. Some feel that they should join together to protest. Some also told us that they do not know who they should complain to and that they had never had any interaction with SMC or teachers. They never go to the school, partly for lack of time, and partly because they lack confidence since they are less educated. Some do not complain because they recognise that the teacher has a difficult job with a low salary and as a local resident they don't want to embarrass him. Some parents in the rural Central area are concerned about late stipend payment (the third payment is delayed) and the continuing unfair distribution but say they would not complain alone; *'I would (complain) only if others were prepared to do so'* (father), other parents seem to be philosophical about this and say it is not the teachers fault but rather some office problem. They say they have heard that the money is at local education office but they (and banks) are too busy to distribute. They do not see any point in complaining. A mother (peri-urban Central) says she would never go to the school to complain, *'What I do in my home is my business, what they do in the school is their business'*.

Some Heads are found by people to be very approachable. The Head of an NGO school in the rural South invites students to come to see him about any problems, and while we were there a student came because a button had fallen off his trousers and they were falling down. The Head broke off our conversation to find a replacement pair of trousers. Similarly, the Head of the ideal Government primary school in the North peri-urban area knows all his students, makes house visits and is ready to talk to any parent. As a result parents say they rarely have any complaints!

An exception to the general reluctance to complain was one father who reacted strongly to the requests for additional money to replace stolen fans and contribute towards doormats and refused to pay. His son faced problems with the teachers as a result but the father then went to the school again to complain about this harassment and the demands for payments have stopped (slum South).

As mentioned under Health, service providers too are frustrated by the lack of consultation and opportunities to raise their concerns. The Headmaster of the Government school in the peri-urban South was frustrated that there was no local consultation regarding the design of the new school building. He also wants to be able to discuss the principles for allocation of stipends with higher authorities and put forward his ideas, but there is no way of sharing experiences with them; *'Our voices don't reach beyond the Upazila Education Officer … so in the end the bureaucracy is ruling decisions and this does not always fit the needs of the community'* (see above).

Teachers in the rural Government primary schools (Central) complained that there is no system for teachers to raise issues except sub cluster meetings with Assistant Education Officer, and they don't really do so here. The decision in the school with the new extension to enable it to be a pilot one-shift school was made without any consultation and they are not informed about the stoppage in construction. *'We are unhappy about a lot of things but nobody asks us'* (teacher).

In the urban slum (South), we came across an instructive if perhaps a rare story of a children's agency. A boy had omitted a comma in his writing and the teacher, who had a reputation for getting angry, pun-

Highlights Heard

Voice and Complaints

- Parents do not want to complain because of their own lack of education, feel there may be negative repercussions, feel they should not interfere or feel they should not embarrass a local teacher. But some principals are very approachable

Highlights Heard

Access to Information

- Communication between school and parents is poor
- Very little knowledge of the Citizens Charter

Highlights Heard

Why do some actively opt out?

- Where there are few employment opportunities or plenty of work which does not require education, then the motivation for education is low
- Children who delay entry into primary want to leave when they get too big for their class year
- As mentioned before, boys increasingly opt out themselves

ished the boy and ridiculed him in front of the class. The same teacher had sometimes locked the school gate to prevent students going to get lunch and had cut short their recreation time for 'no reason'. So a group of boys locked the teacher in the classroom. Parents supported their action and the teacher is behaving better now!

Access to Information

As pointed out in last year's report, parents rely largely on the publicity in the news media to understand their entitlements, for example regarding the stipend programme. The Citizens Charter was seen in two schools; in peri-urban Government primary school (South) and one of the urban government primary school (North) but in the latter it was hidden behind a screen.

The communication between schools and parents remains poor as last year. In two locations, parents did not know that their children's schools were closed. PTA committees were rarely active and few parents visit the school (see above). Only in the urban Government primary school in the South were teachers making home visits in their designated catchment areas. They ask parents to sign a card indicating they have visited. Parents confirm that the teachers are being more effective in communicating with them in this way.

Why do Some Children Actively Opt Out?

In order to be consistent with last year's report, we have included this section but much of the substance has been dealt with above under the issue of 'Boys'. So this section is primarily a summary.

As discussed more fully above, this year we were able to confirm that boys are actively dropping out of school on their own initiative and against the wishes of their parents. In all areas, parents worried about the distractions which readily divert boys; street culture, play, fishing, TV and videos. Boys told us they like to loiter.

Where employment opportunities are limited in the area the value of education is reduced and parents and children are unwilling to invest further money and effort in unnecessary education. This was particularly apparent in the rural North study area. In the rural South, there is a high motivation for education but an acceptance that jobs need to be sought outside the community.

Where there are lucrative job opportunities that do not require high levels of education (e.g. some overseas construction work, tempo helpers, drivers, some factory work and mechanics) boys will decide themselves to leave school to earn what they generally regard is their own income rather than a contribution to the family.

Children who have delayed entry into primary school because they attended madrasa first, or where the parents were worried about their safety when they were young, or were not interested to go to school, find it very difficult as they get older. Fourteen year olds who are still in primary school feel embarrassed among younger children and *'feel big'*. These children often leave for employment.

Differences in Education in Urban, Peri-urban and Rural Areas

Urban	Peri-urban	Rural
No stipend programme but schools for working children partially compensate for this. Increasing numbers of such schools.		Harder for children to meet stipend requirements than in peri-urban area as regular physical access may be difficult (flooding, distance, rain) and availability of private coaching less so academic performance compromised.
Parental and community involvement in schools is lower than in peri-urban and rural areas.		
Some urban schools lack play grounds which is regarded as a major problem. Post tiffin absence prevalent as children stay at home to watch TV		
Wide choice of education providers. A trend towards government schools being regarded as being for the poor.		With the exception of the South study area, less choice of education providers than in other study areas.
Schools located on busy roads poses safety problems.	Schools located on busy roads pose safety issues and may contribute to decisions to move children to other schools.	Long distances to get to school are a problem for young children and 'easily distracted' boys. Flooding (e.g. North study area) is a major deterrent to regular attendance.
Majority of teachers are female.	Less teachers are female than in urban areas.	More male teachers.
		Difficulties attracting and retaining staff. Long travel times for teachers mean schools start late and end early.

Differences in Education by Location

North	Central	South
Although motivated to send their children to school, the lack of job opportunities in the area and low expectations mean that completion rates are lower than in the other study areas.	Very high parental motivation to send children to school, careful choices made and willingness to spend money on private coaching (and even private schooling) perhaps driven by good job opportunities (factories, transportation, overseas) and success stories.	Very high parental motivation to send children to school and acceptance, in rural area, that jobs will have to be sought outside the area.
Less choice of education providers than in other study areas. Basically only Government, one NGO provider and fewer private providers.	Widest choice of private education providers (of the three study locations) which include philanthropic providers.	Wide choice of education providers including many different NGO and missionary schools.
Economic crisis has hit education more than other study areas; children taken out of school for economic activities or to reduce costs.	No impact of the economic crisis on schooling.	Some families have dropped private tuition as a result of economic hardships due to food price increases and Cyclone Sidr. Increase in child to child support with homework etc.
	PEDP II activity further advanced than in other two study areas.	

Comparing Earlier Indications with what People Living in Poverty say:

Boys Enrollment

Government statistics indicate:

- more girls than boys attend primary school
- girls out-perform boys in primary school

Reality Check participants say:

- boys drop out because they prefer to play, have poor experience of school and tend to be out shone by girls which leads to loss of confidence
- girls outperform boys in Class 1 because many have been to NGO pre-schools (where there are twice as many places for girls than boys) which results in confidence and privileging by teachers - this undermines the self esteem of boys who have never been to school before
- from this poor start, boys often continue to under perform and are more likely to have to repeat years
- boys leave school in year 3 and 4 because they are old for class, feel it is futile to sit for year 5 exams, particularly as there is no secondary stipend possibilities for them
- girls who may have been educated elsewhere return to GPS for year 5 to take the public exams to qualify for secondary school stipends

Unicef Report on Social Inclusion (2007) notes:

- only 20% of Class 5 children are allowed to sit the scholarship exam and these children get preferential coaching at school while others are excluded

Reality Check participants say:

- those selected for scholarship coaching are mostly girls and this contributes to lowering self esteem of boys
- schools should do more to attract and retain boys

Drop outs

The Comprehensive Assessment/Evaluation of the Primary School Stipend Project (2008) suggests:

- national statistics which indicate 33% drop out rates are actually inflated and are closer to 19%
- children drop out because they are not getting books, not getting stipends, child labour, exam fears and rude behavior of teachers
- enrolment increases from 78% in 1990 to 97% in 2007 due entirely to the stipend programme

Reality Check participants say:

- many boys make their own choice to drop out (against parents wishes)
- many drop outs are actually transfers to other schools
- many poor children go to school without stipends - stipends are not essential but usually seen as recognition of being a good student and a means to pay for private coaching

Quality of Education

PEDP II emphasises quality education and promotes 'joyful learning' and has embarked on massive teacher training programme

The Reality Check participants say:

- preference is for schools where learning is fun, games and songs are used, classes are small and children feel loved by their teachers
- teachers in many NGO schools teach better than Government teachers even though they have received less training

Themes

In this section, we use Sida's Participation, Non-discrimination, Transparency and Accountability (PNTA) framework to analyse some of the key themes emerging from this year's study. The PNTA framework was developed by Sida to provide guidance in operationalising the two perspectives, the *'rights perspective'* and *'poor people perspective on development'*, that are promoted in Sida's policy for global development (see ref 1).

Participation

Sida sees participation *'as a goal in itself and a way to increase the awareness of those whom the assistance is intended to reach, increasing their influence, so they can demand change and social justice'* and that *'participation in decisions that affect private life and the governing of the country is a human right'.*

The most striking theme emerging this year within the context of participation is the high level of agency that parents are demonstrating in their strategies to ensure the best education for their children. Box 43 presents a number of examples which illustrate how important decisions around who will receive education, for how long and in which school are.

Parents do not on the whole interact much with the teachers (mainly because they lack the confidence to do so, often because many have only a low level of education themselves) and so do not involve them in such decisions. Nevertheless, parents are making careful decisions about their children's education. In Box 31, we noted an example of parents who were prepared to move house just so that they could access better schooling for their daughter.

Mothers are heavily involved in these decisions, and may even take the lead. We came across several mothers with very strong ideas: *'The rickshaw puller husband is a little afraid of the strong and straight forward wife but always gives his full support to her decisions regarding education of the children* (woman, rural Central).

Non- Discrimination

Sida notes that *'excluded, marginalised and discriminated groups must be given special attention and must be identified'* (ref 1). The marginalisation of men and boys comes through as a very strong theme from this year's Reality Check. As noted in the section on 'Boys' above, boys are self excluding from school despite their parents' strong motivation for education. The reasons are many, including low self esteem, preference for the attractions of 'street life' and recreation, low expectations of employment, poor achievement particularly in contrast to girls. Some underlying reasons for this could be positive discrimination of girls in enrolment in pre-schools and in secondary school education with the provision of female secondary school sti

pends and also that employment in garment factories, which requires some educational background, is mainly for young women.

Similarly, men tell us that they feel often excluded from decisions around their children's education. It is the mother who collects the stipend, the mother who is called to parent meetings (often referred to as mothers' meetings) and the mother who gets the NGO loan which is often used to pay for education. The focus of family planning support has also been on women and men were often anxious to use the opportunity of conversations with us to find out more about the different family planning methods and how these could be reconciled with religious teachings. They felt there was nowhere they could go to get advice and understand more about the issues their wives were facing regarding choice of family planning methods. They told us they rely only on what their wives are prepared to share with them.

Transparency

Sida notes that *'in order to hold decision makers at local and central levels accountable, citizens must stay informed .... and 'the right to information is a condition for active participation'* (ref 1). The theme which emerges markedly this year is the disconnect between local needs and policy and practice. Our three study areas differ and the impact of the price increase this year demonstrates just how different they are. The North study area (noted in District context) is backward and neglected by extension/outreach programmes. It is a more conservative area with few employment opportunities, it has large numbers of migrants with limited local networks and the highest levels of poverty among all our study areas. Hence, the need for special programmes for the poor in this area is paramount. However, there is no nutrition programme, no home visits by health workers, no extension to reduce travel costs (mothers even have to travel 5km to collect stipends as the bank officials will not come out to the village) and any programmes for the poor are urban based and often not known to them. In the North the families tend to be large and family planning difficult to access. Education costs support is needed by all families in the North study areas. By contrast, in the Central rural area, immunization, family planning awareness raising, and nutrition programmes which proliferate are regarded as redundant these days and stipends are being given to families who do not need them.

Several UHCs are being expanded but the numbers of in-patients have reduced drastically as people prefer the district hospital or private health services. Yet in the rural areas in the North and South study areas, the UHCs are busy as there are few or no alternatives when a condition requires hospitalisation and these hospitals are not currently being expanded.

Two BRAC feeder schools have opened to feed into one school which suffers severe staff shortages and is always overcrowded (rural Central). An expansion has been made of another school to enable one-shift system but this school has the least enrolment of all the GPS in the area and has currently only two staff (rural Central). The teachers and community wonder who made this decision.

The questions which lack transparent answers are many and the following are some raised by our families. Why does the Government continue to provide a high dose contraceptive pill for free when everyone complains about the side effects? Why are family planning programmes only for women? Why does the DOTS programme for TB patients not

include direct observation any more, putting patients and their families at risk and fuelling a potential public health crisis? Why do doctors and pharmacies prescribe only high dose anti-biotics which are more costly, full courses are less likely to be completed and make people feel unwell? Why don't they include food supplements to make the taking of these more acceptable? Why are there no health workers in our village? Why are there so many health workers doing the same thing in our village? Why isn't the government re-opening community clinics? Why do primary school students have to have private coaching to ensure good results in public examinations? Why are government teachers going on long training when BRAC and working children's school teachers are better and only have a few days training?

People, community and local service providers alike, generally do not know what policies and programmes exist and do not have opportunities to influence these. When they do know what should be in place (for example, provision of free medicines) and find that they are not getting their entitlements, they can do little about it. The local needs and realities are rarely taken into consideration and standard programmes are delivered irrespective of need or not delivered at all where needs are greatest.

Accountability

Many of the accountability issues highlighted last year have been ameliorated. Government service providers in health facilities and schools have been more punctual and diligent, dalal activity is down, more notices clarify prices, medicines and text books have been delivered on time and with little apparent leakage and the stipends are distributed through bank officials. All this has been attributed to the Caretaker Government's initiatives.

So this year, the area of biggest concern emerging from the Reality Check in relation to accountability is that of commercialisation of service provision and the regularisation of the private service providers. This is particularly an issue in health service provision. Pharmacies operate with few restrictions and medicines are freely available in the market without prescription. Diagnostic Centres vary in their service and adherence to health and safety measures. SBAs and self professed 'doctors' operate beyond their competence in pursuit of profit, putting particularly the vulnerable, at risk. Some herbalists and polli doctors work is valued and medically sound (and often catering particularly to the needs of the poor) but they are forced to offer some services clandestinely because of fear that they are not officially registered and thus create potential risks for patients. Similarly those operating private schools and home schools cannot avail Government materials and children cannot sit public examinations and yet many are providing important services particularly for slow learners, 'problem children' and children with disabilities.

Government needs to accept that there is a thriving private sector, which can provide many benefits for the poor and rather than assuming responsibility, which it cannot meet for the health and education of all, needs to regulate the privatization which is taking place. People worry that the attempts that have been made by the Caretaker Government to enforce greater accountability in private service provision, such as checks on pharmacies and diagnostic services, will be diluted after the National Elections and the re-installation of a political Government and the resumption of its patronage system.

Woman living in urban slum.

This little girl goes to pre-school. Everyone points out that she is a very good student, as is her sister.

Sattar, a boy of class 5.

Conclusions

What does the Reality Check tell us? The report shows the ways in which people living in poverty are highly active in the ways they make decisions about accessing health and education services. People actively explore the range of choices open to them, comparing the quality and costs as best they can.

From the point of view of people living in poverty in our study areas, public education and health providers are unfortunately all too often the least attractive option. Wherever possible, people are choosing private for-profit or not-for-profit providers over public or Government providers.

Most people lack the opportunity to exercise 'voice' in order to improve government services. Since people lack the avenues and/or the confidence to demand better Government services, they simply 'exit' by going elsewhere. The fact that many people 'vote with their feet' in relation to public provision is yet to be fully accepted by Government and donors.

It is particularly worrying that the growth of commercialised private market provision in Bangladesh is complex and largely unregulated. In these growing markets, traditional healers co-exist with modern diagnostic centres, and private tutors operate alongside NGO schools, leaving consumers in our study areas - especially people living in poverty – highly vulnerable to predatory, unaccountable or low quality service providers.

This report confirms much of what is already known about the health and education sectors in Bangladesh. But in some areas, it also challenges the accuracy of information and assumptions contained in some recent programme evaluation and stakeholder consultation reports. For example, the reasons for school drop-outs, are found to be more complex than often reported. This will require further monitoring, investigation and testing, but should also be discussed within the programmes with a view to improving performance.

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Annex 1.
Host Households – Changes 2007–2008

2007	2008
Central – Urban HHH 1	
Living together in a one room house (rent free) made of rusting CI sheets and matting, the family comprises an elderly couple (in 60s), their three daughters, one of whom is unmarried and pregnant, one is married with a 2 ½ year old daughter. These seven people sleep on two wooden double beds which almost fill the entire room. Assets include two cabinets, a very old black and white TV without any knobs and a rusty ceiling fan. They use the kitchen of a neighbour where they are allowed to use the tubewell and a gas burner which costs Tk170 per month. The 'toilet' is just a ditch screened by a piece of plastic sheeting. The elderly man buys and sells vegetables and his wife makes pitta to sell at the railway station and at the entrance to the slum. Their son in law is a rickshaw puller. The family's combined income is Tk1775 per week.	There have been quite some changes over the year; the pregnant daughter has married the father of her child and has a daughter (9 months). All three live at this house, but the boy does not earn. With the help of the Chairman the son in law who used to live here has a new job as a sweeper at a new drug manufacturing factory nearby. This has enabled him, his wife and small daughter to move out to a rented room next door. His wife is expecting their second child. But, another of elderly couple's daughter's has been abandoned by her husband, who has gone to live with another woman he met at the factory where he works. So the daughter has moved in along with her two daughters (aged 3 and 1). She earns only TK200 per month as a maid servant. There are now five adults and three children living in this room all dependent on the income of the elderly couple. The elderly mother has TB and so has not been able to work regularly. The elderly man's eyesight is worsening *'he gives people the wrong change and is cheated at the market because he can't see that he is buying rotten vegetables'* The house, contents and surroundings are exactly the same except the TV is just a shell. They gave it to be repaired and the repairer took out all the usable parts and ran away.
Central – Urban HHH 2	
The family comprises of a man (50+) who is a rickshaw-puller and woman who sells saree door to door and their one surviving daughter (12 yrs). They live in a one room house (Tk300/month rent). They have a wooden bed, one table with a chair and 'meat safe' to keep food. They use a common kitchen, tube-well and toilet along with 8-9 other families. Most of the times they manage to eat two meals a day. They cannot afford three meals a day as they have to repay a loan which was borrowed for the treatment of their elder daughter who died recently.	The family moved to a house at lower rent in a nearby slum. They are still repaying the loan for their eldest daughter's medical treatment. The father is working a double shift rickshaw pulling as his wife cannot earn now due to psychological and physical illness. They only have the wooden bed and the 'meat safe' as they have either sold their other possessions or they have been broken. In the new premises they continue to use a common kitchen, tube well and toilet along with 8-9 other families. Their only surviving daughter (13) was married this year to her late sister's widower husband (garments worker). Her parents selected him as there was no dowry and he is trustworthy. The daughter conceived within a few months and returned to stay with her parents. She is now 7 months pregnant.
Central – Urban HHH 3	
The father (about 35 years) works in a tailoring shop on contract basis. On average he earns Tk3000–4000 per month depending on the workload. He lives with his wife and four children (all under 8 years old) in a rented room. There is one old wooden cot, one electric ceiling fan and a few utensils in the room. He is paying Tk600 per month for house rent and Tk120 for electricity. Because of their new baby, he could not pay his house rent for the last 6 months.	This year they moved away from this area apparently because they could not meet their expenses. NB: We have therefore taken one of the FHHH as the HHH this year (see below HHH4).
Central – Urban HHH 4 (substitute for HHH 3)	
The Father (40yrs) is an ice-cream factory worker and seller with a monthly income around Tk5000. He is the only income earner. He lives with his wife (30years), two daughters (10 and 7), and two sons (4 and 2). The family has lived in this area for 10 years in a one room rented house (Tk700/month). They have a TV, VCD, one cabinet, one wooden bed, one rack (Alna). In their village they have a small parcel of land, which is being cultivated by the man's brother.	This year the family moved to a bigger room at an increased rent of Tk800/month. The father's salary increased by Tk500/month His wife is actively saving with two organisations 'for her daughters'. For unclear reasons the eldest girl has stopped school (B) although her parents said it was economic but they plan to admit her into the Government primary school next year (2009) in Class 3. The second daughter attends the ROSC school at Class 1 (boro one).

2007	2008
Central – Peri-urban HHH 1	
Living area comprises of four one roomed buildings, two of which were simple jute and mud constructions. The smallest house is home to one of the grand-daughters and her new husband. The second smallest house accommodates the grandparents and their unmarried daughter, the third house accommodates another daughter with her husband and four children and the fourth house accommodates another daughter and her three children. The two sons in law are both rickshaw pullers (owning their own rickshaws) but the main income for this family is earned by the daughters who work in garments factories nearby. This leaves much of the childcare to the husbands and the grandmother. As well as agricultural land and a fish pond, the family owns three cows, two goats, six ducks and six chickens.	The family has faced some economic shocks this year as, unknown to other members of the family. One of the daughters had taken a number of loans from relatives which were called in. The second smallest house, land and livestock were sold to service some of the debts Tensions continue to exist over this and the grandfather does not talk to his daughter. He now lives with neighbours and his wife and unmarried daughter have moved into the fourth house. The rickshaws have been sold and both sons in law now rent. One is working much harder than before because of the money problems but the other claims he is in poor health. The three daughters continue to work at the garments factory, including overtime when they can. It turns out that the cows and goats were not fully owned by the family and were share owned. Now the family only has three ducks.
Central – Peri-urban HHH 2	
A female headed household comprising of widow (50+), daughter (25+, separated from husband) and granddaughter, are living in a thatched house. The wooden bed is the only furniture of the house. They have a milking cow (attached to their living room is a cow-shed) and a few chickens from which they have additional income from selling milk and eggs. They do not have any land except the homestead. They also earn from stitching quilt.	The family's socio-economic condition has improved with the support of the widow's youngest son who worked for a while as a helper on a long distance truck. He now lives with them and is a share-cropper and also works as earth-worker during non-harvesting season. He manages to provide 6 months rice for the family. They have now one new wooden table and some utensils. One calf from the cow and few ducks are added to their livestock resources. The widow and daughter are working hard as before, supporting the man and maintaining the educational costs of the daughter (Class 2, primary school).
Central – Peri-urban HHH 4 (substitute for HHH 3)	
	The father runs a grocery business in the market and is a farmer. He is influential and respected in the area. He is cousin of the head of HHH 1. Since the argument with his daughters, Grandfather of HHH1 now lives with this family. They have seven children, 4 boys and 3 girls; 5 of whom attend school (older ones in the government high school and the younger ones in BRAC). They have two houses in their courtyard. One is made of CI sheet and another is being rebuilt in brick and CI sheet with money they raised from selling land. They have TV, VCD, one milking cow with calf, chickens and ducks. Their eldest son (16) went back to school this year after dropping out for over a year.

2007	2008
Central – Rural HHH 1	
The family, comprising of mother and father, three unmarried sons, one married son, wife and daughter and paternal grandmother, occupies three one room houses around a common courtyard and share an outside kitchen, latrine and tubewell. One son is disabled as a result of polio. They collectively own 1 cow, 1 goat and 7 chickens and few household possessions including an old black and white TV and mobile phone. The father is a farmer and his eldest son drives buses.	No changes in the physical household have taken place in the year. The eldest son has a new permanent job as a driver for a pharmaceutical firm and works away from home a lot. The two sons who live away from home have both had promotions at the factories where they work. The disabled son has started study with the Open University (Class 9) and also attends coaching classes. The youngest son sat his Class 5 exams the week we stayed with them. The cow is being fattened up for sale for this Eid. The goat has been sold and two chickens died. The daughter in law looks after 4 ducks. The family now has three mobile phones between them.
Central – Rural HHH 2	
The mother (60+, widow, deaf and mentally retarded) lives alone in her own house with another house inhabited by her elder daughter and son-in-law and their only daughter (16 yrs). The man is the caretaker of the adjacent Madrasa (earning Tk3000 per month). There is an outside kitchen; one tubewell is surrounded with polythene sheets and a separate temporary space with slab latrine.	The elderly grandmother is very weak. The granddaughter, married and 7 months pregnant has returned to stay with her parents along with her unemployed husband (who owns land). Her father continues as a caretaker on the same salary as last year but is finding it hard, with his daughter and son in law living with them and repayment on a loan taken out to resolve a legal case following his arrest by police due to a false case filed by a neighbour following a serious quarrel. The son-in-law provided both moral and financial support to cope the crisis. The outside kitchen was destroyed by the recent storm so the mother now cooks in an open space, which cannot be used in rain. The condition of the tubewell and latrine remained unhygienic as before. Recently, the family were provided with a 'short term VGD card' entitling them to 30 kg rice per month. The grand daughter could not sit the SSC exam last year due to infection in her eyes and now she has married and pregnant she is not able to prepare for the SSC exam.
Central – Rural HHH 3	
The household head is a vegetable seller cum share cropper mostly living with his second younger wife in a rented house. His elder wife and two sons live in tin roof houses with jute and bamboo walls. They own 30 decimal agricultural land. Their assets comprise of an old black and white television, 2 wooden chowki, 1 milking cow with calf, 1 rack, 1 wooden box and 3 chickens.	The household head has stopped providing any help to this family and the first wife feels very stressed and frustrated. Even her two sons do not pay heed to her. Fortunately the younger one has become a professional MAXI driver earning Tk200/300 per day. He expects to do this full time next year and earn about Tk500/day. The elder son is preparing his documents to go to Qatar and his mother will take loans and, if need be, she will sell her 16 katha lands to enable this. Their TV is now out of order. They have only one pair of pigeons now. They have two milking cows and one calf. They have more than 15 ducks and some chickens.

2007	2008
South – Urban HHH 1	
An elderly couple of about 70 years lives in a small room with walls of CI sheet, and mud floor, used as a pass-through by other people. The room has a high ceiling with two large raised beds with storage underneath. Their few household items include a black-and-white TV that is out of order, an almira and kitchen utensils. There is a small kitchen outside the room. They have electricity, and use a common tubewell and latrines located nearby. The couple owns three more rooms which they rent out for a monthly income of Tk3,000. The wife works as a dai (without income). Sons and daughters have all moved out.	This year the elderly man has started a business with the help of loans. His grandson with wife moved in some time ago, helping out with his new business. However, during our stay there was an argument resulting in the grandson moving out. The husband now earns about Tk9,000 per month, and a considerable part of this goes towards repaying his business loan. His wife continues to work as a dai providing service for women in the community, but does not charge for this activity. .
South – Urban HHH 2	
Living in a brick house with CI sheet as roof, this family share the house with the paternal aunt and her husband, who are also housing a young girl with her son (relatives of theirs). The families have separate kitchens but share some space. The host family has a latrine inside the house. Apart from the kitchen and the shared room, they have a small room and an attic which they use as storage. In the shared room there is an almira, a broken TV, and a fan. The family consists of wife and husband, who run a tea stall, and a son in his late teens and their young daughter in Class 1.	This year the family's middle daughter has returned to live with them after an argument regarding dowry with her husband's relatives. The disagreement seems irreconcilable and the family is depressed over this. The son is determined to make money in order to be able to migrate abroad for work. He now owns two vans that he lets out, and he is operating as a middle man in bhangari (scrap-collector) business. The young mother and son left the paternal aunt's family, partly due to financial crisis. Both families suffer from the price increase and lack of income from bhangari and tea stall business.

South – Urban HHH 3	
This family lives in a brick house with CI sheet roof. They share a small courtyard with several other families, sharing tubewell and latrines with others. This particular part of the slum appears to be less congested with only one-storey buildings which let in light and fresh air. The family has three children aged 3-9. The father is a meat seller, earning Tk6,000/ month.	With three young children the wife continues to spend time at home, looking after the household. The one notable change this year is that the family has faced increased costs for treatment of various diseases among family members. This has caused frustration since it hampers the family budget.

2007	2008
South – Peri-urban HHH 1	
The couple (in their 40s and 50s) have four children and live close to the river in a small fragile house with an adjacent cowshed. The father and one son work as day labourers and sometimes catch fish from the nearby river to sell in the market. They also rear a cow and sell milk. The father also works as the village kobiraj. The family's total monthly income is approximately Tk4,000. The family has loan from two NGOs	The wife has given birth to a fifth child and is very unhappy about having an additional young family member. Last year the family was badly affected by Cyconle Sidr. Their house was destroyed and has since been rebuilt with the help of an NGO loan, but the same materials have been reused leaving the house in a poor and fragile condition. The local fishing has been affected by the cyclone and the husband can go days without catching any fish. The second oldest son has dropped out of school and moved to live with relatives, and works in a tea stall. The family is not communicating with the son. The family is clearly in a vulnerable condition.
South – Peri-uban HHH 2	
The family consists of a young couple with their two young children (daughter 5 years, son 1 year). They live in a small house, consisting of two small rooms, made of a patchwork of CI sheets. The husband is working as a van puller. They share bari with his older brothers. They have some land where they cultivate vegetables for their own use and some pans that they sell in the market.	The house was completely destroyed in Cyclone Sidr and the family now lives in a makeshift house. After taking loans with NGOs they have bought building materials and are about to start constructing their new house. They have lost their vegetable and pan crops, and have not restarted cultivation due to financial constraints. The daughter has started government primary school, and the family pays for daily private tutoring.
South – Peri-urban HHH 3	
This female-headed household includes one adult and three children, who although enrolled in school have poor attendance. The husband has left the wife for a second marriage. The wife is mentally unstable and is unable to work. She has no assets or land and owns only a few household utensils. She gleans left-over rice from the market, and is facing real problems managing food for her children. The small house is built of bamboo and straw and is in a rather poor condition.	The family continues to struggle, facing constant financial problems and cannot find food for the family every day. The husband, who has left, does not support the family leaving the wife and children with neighbours and well-wishers to care for them.

Rural household (Central).

2007	2008
South – Rural HHH 1	
The head of the household is a tea seller. He lives with his wife and two young children, a son and a daughter. His earning comes from his tea stall business and partly from manual labor. His monthly income is around Tk5,500. The family lives in a double storied tin shed house. The house is recently built with the help of loans from BRAC, BRDB, DPKS and a local NGO. Part of the loan has also been used for business purposes. The family appears quite concerned over the debt they are in and do not always manage to pay their weekly installments. The homestead land was donated by the wife's father. Family assets include three beds, an almira, one bench, one chair and a table.	There have been drastic negative changes over the year due to Cyclone Sidr. The house was partially damaged and the tea stall collapsed. He has not been able to restart his tea-stall business. With the help of a relative he has arranged work in the Middle East and is leaving shortly. The rest of the family is moving to another village to stay with his family, whilst trying to rent their house out. Since the family is migrating we have taken on a new household, see below HHH 4.
South – Rural HHH 2	
Husband and wife are both in their 50s, with two daughters living at home. Their house is very spacious. Until a few years ago three younger brothers of the husband lived here, but they have since moved out and built their own houses adjacent to this house. The husband has been working as a clerk in a land-register office in town. He commutes every day. The oldest daughter has finished her HSSC and taken a course in paramedics. The house has electricity with fans and light. They have few but rather expensive pieces of furniture, such as beds and two large almiras.	The oldest daughter has left home to work in Dhaka as a paramedic. She lives there with her paternal aunts family, helping her aunts husband look after their small children while the aunt is in Libya working. The younger daughter has started to work as a private tutor, and has also been engaged by an INGO as a tutor coaching a group of local students.
South - Rural HHH 3	
The household comprises of 7 family members, including three unmarried daughters (8, 15 and 18 years old), one working and one school-going son (an elder son has moved out). The family lives in a small but nicely decorated tin-house on land purchased recently with NGO loans. The husband is a sanitary carpenter, earning Tk6,000/month. His wife also helps out with his business. The family also works as sharecroppers.	The oldest son has married. Including the new wife the family now consists of 8 members. The father of the household now gets help from his wife and his older son in his work. Economic condition has slightly improved compared to last year since they got some rice from sharecropping. Their joint monthly income is Tk10,000.
South – Rural HHH 4 (substitute for HHH 1)	
	This family is a new host household, since previous household has moved. The husband has migrated abroad for work and wife and children have relocated to his home-village. The new Hindu host family consists of husband and wife with two children (son 15 years, daughter 10 years). An older daughter has just married and left home. The husband works as a carpenter and day labourer, and his wife helps him out in his work. Their son is no longer in school but helps his father out in his work. They live in a two room house made of a sturdy wood frame, bamboo and CI-sheet, with a wooden door.

2007	2008
North – Urban HHH 1	
Household head is a petty moa (snacks made of puffed rice and molasses) producer and sellers. Total land owned by the household is 30 x 10 feet. The house is made of CI sheet roof and fenced. The house consists of only one small room to accommodate the family of seven (husband, wife, two adult sons and three minor daughters). A small kitchen is attached to the house for cooking and storing kitchen utensils. The family has one cot for sleeping all the family members. Other assets include one cloth hanger, one small reading table and a chair. One open latrine is just behind the house on the bank of the canal. Electricity facility is available but water is collected from the only water supply point in the slum. One corner of the house is used for offering prayer to the goddess.	The house is in the same condition as last year except the cloth hanger is gone. The middle-daughter failed in the final exam (Class 3). And so they have taken on a private coach for her (Tk500), which is paid for by the elder son who is coaching other students. Family head and elder son had invested in a temporary snacks stall installed in a religious fair with the hope of earning more money within short time, but, they incurred heavy financial loss by running that business. As a result, the money kept in the bank for the daughters' marriage and some the wife's gold ornaments are lost.
North – Urban HHH 2	
The home has a brick wall with CI sheet roof, with one bedroom and one kitchen cum bedroom. The house head is a retired service holder with six children. His previous house was in a dilapidated condition so local people provided support to construct the present brick wall building without plaster about two years ago. The elder son works in a workshop and earns Tk2,500 per month. The second son is an apprentice in a workshop and earns Tk30 per day, his wife does stitching quilt and earns some money. The third son helps the Imam of local mosque to collect food from different houses in the community. The Imam gives him the leftover food which is the only food the boy takes for the whole day. The family uses the community latrine constructed by local rich people.	The wife is now working as a maid but the family tries to keep this quiet because of social status. She earns between Tk20-25 per day (with food sometimes). The house head has received a rickshaw registration plate which he has rented out (Tk600 per month) and he is now receiving old aged allowance (TK 5000 for 24 months). The house is more crowded this year as the elder daughter has come back from her in-laws house with her baby. With the current economic crisis and these extra mouths to feed, the family only takes one meal a day now whereas last year they took two. They take this in the early evening and it comprises rice and leaves (collected from road side) with occasional fried chilli sometimes.

North – Urban HHH 3	
The family lives in a one room house made by brick which was constructed with the support of local rich people. The house head is a retired private service holder. The family has a son and three daughters. The son works in a transport garage and earns Tk2,700 per month. The elder daughter studied up to Class 4. The second daughter is in class 9 and manages her education expenses through private coaching. The wife does sewing and earns Tk800 per month. They collect water from others' tube well. Assets include one old cot and a table.	There have been some changes over the year. The house head now has a job in a grocery shop earning Tk1500 per month. The elder daughter has been sent to a relative's house and earns Tk300 per month. The second daughter is still engaged with her tuition earning Tk400 per month. But the son does not earn regularly now but takes casual work earning much less than last year (Tk900-1000 only). With the help of the Ward Commissioner they got a rickshaw license which is rented out earning Tk500 per month. The Head is still getting the old age allowance Tk210 per month. The wife has become sick and has been forced to give up her sewing job. The family's combined income is Tk3800 per month. The second daughter took the SSC exam and the younger daughter moved up to the next class.

2007	2008
North – Peri-urban HHH 1	
The family has only one house with two rooms. A very small kitchen is attached to the house. The house is made of mud with CI sheet roof. The family has eight members including the elderly parent (house head), wife and four sons. Elder son is 19 years old and learning welding in a local workshop. The house head is a carpenter but without a regular job. The wife works for a local NGO as a teacher of an adult learning programme. Total assets include two cots for sleeping, a pair of chairs and few utensils for cooking. One cot is used by the two elder sons and the other is used by the father of the household head.	The elderly father of the family head died in November 2007. There were no changes in the condition of the house except that they had reorganized the bed used by the diseased father. The elder son gave up his welding training and is now working in a shop in the city as an apprentice. The wife is still working with the NGO but does not get a salary regularly and has decided to resign. The head of the family has been injured by timber falling from a truck and will not be able to work for a month. The younger son is always suffering from fever and asthma. The second and third sons have moved up to the next class (8 and 3 respectively).
North – Peri-urban HHH 2	
The house comprises of two rooms, one used as bedroom and the other is a very small kitchen. The house is made of jute straw wall and CI sheet roof. The family has two sons. The elder son completed primary education from BRAC school but is currently suffering from arthritis. The younger son is in Class 1. The house head is a van driver and earns average Tk150 per day. His wife collects fire wood from the forest to sell in the village. They collect water from the tube well of the neighbours.	The wife took a loan of Tk10,000 from an NGO and has purchased RCC pillars for re-construction of the house and repairs to her husband's van. The elder son continues to suffer from arthritis and stays alone at home, The younger son bought a second hand video recorder for him against the wishes of the parents
North – Peri-urban HHH 3	
The head of the house is a widow with three daughters. She has a house with two rooms (bedroom and kitchen) on land allocated by the government. All daughters are students and study in Class 5 and 3 and Maktab (religious education) respectively. The widow works as housekeeper for wealthier families and earns Tk900-1000 per month. She uses the neighbor's tube well for getting water.	There are no positive changes over the year. The family continues to depend on the charity of the widow's employer. Her elder daughter passed Class 5 and is now going to a local high school. She gets stipend from the school of 150 per month and studies without tuition fee. Her second daughter was promoted to class 4 and gets a stipend of Tk100 per month. The younger daughter is reading at the local Madrasa free of cost. They received Tk13,000 as charity. The house contents and surroundings are exactly the same.

2007	2008
North – Rural HHH 1	
The family has a small house with mud walls and straw roof. The roof condition is very poor and rain water pours down the house. The house has two rooms, one big and one small. The big room is used for both keeping cows and sleeping the wife and children. The small room is where the household head sleeps. The family comprises of household head, wife and three children. The elder son studies in Class 4 but currently is not interested in attending school. The daughter is studying in Class 1. The younger son is not yet of school age.	No changes in house condition. The two older daughters who were living with their grandmother in another village have returned and there are now seven living in the house. Due to the flood last July (2008) they lost crops. The family head was badly injured while collecting stone from a quarry and incurred huge expenses for treatment. He had to sell his cows to start a business of repairing mobile phones in a partnership with his brother in law. Unfortunately, that business collapsed and he lost the money. The first daughter did not appear in Class 2 final exams. The second daughter graduated Class 1.
North – Rural HHH 2	
The household is a joint family of two brothers and their parents. The elder brother has two sons and the younger brother has one son. The elder brother is a small farmer and labourer. The younger is serving in a Madrasa as teacher in the district town. He gets a monthly salary of Tk3000. The house is made of bamboo with CI sheet roof on two decimals land. The house has three rooms. One room is used as bedroom for two families with cloth partition in between and the other small room is occupied by the old parent and the last is a kitchen cum cowshed.	Everything remains the same this year except a small extension has been made for the cows. The younger brother's son had to repeat class again – this now for the fourth time, and another had to repeat his class for second time. One of the wives is now pregnant.
North – Rural HHH 3	
The house head works as an agricultural labourer as well as a farmer. The family has a son and four daughters. The son is 10 years and does not go to school. He earns for the family by collecting firewood and catching fish. The house is made of bamboo with CI sheet roofing. The house has only one room for sleeping and cooking. The two elder daughters are studying in Class 1 and the other two are minors.	There are no changes at all in this family. Both older daughters are still in school, with the elder one promoted to Class 2 but second one did not get promoted. Their cow delivered a calf a few months ago and they are getting ½ litre milk per day which is feeding their younger baby. During the rainy season they took a Tk2000 loan from a relative and bought a fishing boat for Tk2500 but within few days the boat was stolen. They still have to repay their loan.

The wife of our Host Household preparing a rich meal for extended family. (rural, South).

Annex 2.
What Household Families Think of the Reality Check

This year during the course of conversations with our families we asked them what they thought of us staying with them and why they thought we were doing this. All our families were very happy to have us return this year and most expressed surprise that we bothered to come back as they had not believed our promise. They tell their neighbours that we are from Dhaka and want to know more about how poor people live. They say they admire us for giving up our comfortable lives to do this and say we must care about them. *'This is the first time we have ever seen people like you actually living with us and this should be how others do it'* (slum South), *'We have never known anyone to stay in our homes and take meals with us'* (slum North).

They welcomed us like members of the family e.g. when one of the team asked the head of the household to remind her now many daughters he had he said five. *'Five?' 'Yes, five you are my fifth daughter'* (Central peri-urban). Another referred to a team member in the South, *'He is my elder brother - of course he visits his sister's house'* (urban slum). There was none of the suspicion that we encountered last year. Some spoke of how they have to explain to their neighbours what we are doing; *'They are teachers and learn from us', 'They are some kind of researchers', 'They are not linked with any programme – they are interested in knowing about our lives for themselves', 'They are students', 'They are listening to us so they can help us better'.*

Although last year a few assumed there might be some future benefit, they are not anticipating this now; *'Neighbours say because you visit me that I will be rich soon but I tell them I am not a beggar, What I earn is my income and I can run my family. I tell them you come to my home because you like me'* (slum Central), *'We know you will not provide any financial benefit but because you are here with us we will gain somehow'* (peri-urban Central). A pharmacist said, *'Don't please the Government, try to hear the real things'* (urban South).

Annex 3.
List of People Met During the Course of the Study

North	Central	South
Health		
• Staff of district hospital, UHC and private clinics • Private health practitioners/ qualified doctors • Medicine sellers/ Pharmacy • Kobiraj and village quack • Traditional Birth Attendant • NGO staff working on health • City Corporation staff working on health • Patients in the hospitals • Ward Commissioner of City Corporation • UP ward members • Community leaders	• Doctors of UHC, District hospital • RMO district hospital • BRAC shebikas • DOTs technician • Nurses at UHCs, District hospitals • Medicine sellers, pharmacies • Diagnostic centres • In-Patients and out-patients in UHCs and district hospitals • Cleaners, store keeper in UHCs • Registration booth staff UHC and district hospital • Skilled birth attendants • Traditional birth attendants • Family welfare assistant, health assistant • Community nutrition providers • Women and girls attending satellite clinic in village • Polli doctors • Kobiraj • Informal healers • Trained homeopath • Pharmaceutical representatives • NGO programme officers and field workers	• Doctors (government, MBBS) • Upazila Health and Family Planning Officer • Nurses • Urban health clinic counsellors • Urban health clinic manager • Urban health clinic 'doctor' (not sure about degree of exam here but not ordinary doctor) • Polli doctors • Paramedics • Pharmacists (with certificates, government approved) • Dalals (operating at main district hospital) • Hospital clerks • Traditional birth attendants (dai ma, i.e. not trained) • Community health worker (under INGO/ government programme) • Patients in hospitals (and family members) • Medical company representatives • Trained homeopath
Education		
• Teachers of GPS, NGPS, RNGPS, Madrasha teachers • Retired school teachers • SLIP members • SMC members • NGO staff working on education programme • Parents of students • Ex students of the schools • Drop out students of the schools • Private coach/ tutor of coaching centres • Staff of Upazila Education Office • Local elites • Ward Commissioner • UP members • Book sellers	• Teachers of GPS, RNGPS, BRAC schools, private schools • BRAC school teachers • BRAC school supervisor • Private coaches • Teachers of private philanthropic schools • Parents • School children and out of school and drop out children, their elder siblings • Book seller	• Headmasters • Teachers • Chair of SMC • Parents • Students • Nobody from PTAs as they could not be found! • Informal community leaders • Former Union Parishad Chairmen • Union Parishad members and Chair • NGO staff- managers and field staff

Annex 4.
Citizen's Charters

For services at District Hospital

The Service Seekers reserve the rights for the following services:

1. Essential health care services are provided to all who have access to an Upazila Health Complex (UHC) irrespective of male or female, young or old.
2. The Emergency department remains open for 24 hours round the clock and required services are provided to the patients.
3. Oral Rehydration Therapy (ORT) corner is available for patients suffering from Diarrhoeal Diseases.
4. Necessary pathological tests, ultra sonogram, x-ray and ECG facilities are available for the patients seen at the outpatient department (OPD) or admitted indoors.
5. Emergency Obstetric Care (EmOC) services are provided round the clock to women needing essential obstetric care.
6. Patients of Inpatient department (IPD) get appropriate treatment related to Medicine, General Surgery, Gynaecology, Orthopaedics, Eye, ENT or of other discipline under the guidance of Specialists. Major or minor operations, wherever required, should be done at the facility.
7. National Tuberculosis and Leprosy Control Program ensures that facilities are available for sputum examination for patients suffering from Tuberculosis. Medicines are provided free of cost to patients suffering from Tuberculosis and Leprosy.
8. Under Expanded Program for Immunization (EPI), vaccinations are provided to women of child bearing age (15–49) and children (0–15) everyday.
9. Health, Education and Promotion (HEP) program disseminate behaviour change communication as regards maintenance of proper health giving emphasis on role of healthy diet and reproductive health care.
10. Activities related to women friendly hospital initiatives (WFHI) are conducted wherever applicable.
11. Activities related to child friendly hospital are conducted wherever applicable.
12. Training programs for Skill Birth Attendants (SBA) are conducted wherever required.
13. Attending adolescents and couples of reproductive age groups are provided with reproductive health care and family planning awareness.
14. In order to popularize Alternative Medical Care with the attending patients, related medical care is also provided wherever needed.
15. The patients referred from various District Hospitals and Upazila Health Complexes are provided with appropriate treatment in the DHs. The more complicated cases are referred to Medical College Hospitals and Specialized Hospitals for further treatment.
16. Medicines are provided free of cost to the patients subject to availability of the medicines. In some cases, for the sake of proper treatment, some medicines are to be bought from outside by the service seekers.
17. Lists are displayed at different wards/departments showing stock of medicines available, types of services provided and the names of the service providers.
18. Health care services are ensured to the patients of the nearby prisons.
19. Necessary tests are done for detecting and diagnosis of patients suffering from Hiv/aids.
20. Arrangements for Safe Blood Transfusion (SBT) are available.
21. Standard procedure is followed for the waste management.

For services at Upazila Health Complex

The Service Seekers reserve the rights for the following services:

1. Essential health care services are provided to all who have access to an Upazila Health Complex (UHC) irrespective of male or female, young or old.
2. The Emergency department remains open for 24 hours round the clock and required services are provided to the patients.
3. Oral Re-hydration Therapy (ORT) corner is available for patients suffering from Diarrhoeal Diseases.
4. Necessary pathological tests and x-rays facilities are available for the patients seen at the outpatient department (OPD) or admitted indoors.
5. Emergency Obstetric Care (EmOC) services are provided round the clock to women needing essential obstetric care.
6. Patients of Inpatient department (IPD) get appropriate treatment related to medical, surgical, gynaecological or of other discipline under the guidance of Specialists. Major or minor operations, wherever required, should be done at the facility.
7. National Tuberculosis and Leprosy Control Program ensures that facilities are available for sputum examination for patients suffering from Tuberculosis. Medicines are provided free of cost to patients suffering from Tuberculosis and Leprosy.
8. Under Expanded Program for Immunization (EPI) program, vaccinations are provided to women of child bearing age (15–49) and children (0-15).
9. Health, Education and Promotion (HEP) program disseminate behaviour change communication as regards maintenance of proper health giving emphasis on role of healthy diet and reproductive health care.
10. Activities related to women friendly hospital initiatives (WFHI) are conducted wherever applicable.
11. Activities related to child friendly hospital are conducted wherever applicable.
12. Training programs for Skill Birth Attendants (SBA) are conducted wherever required.
13. Attending adolescents and couples of reproductive age groups are provided with reproductive health and family planning awareness.
14. In order to popularize Alternative Medical Care with the attending patients, related medical care is also provided wherever needed.
15. The patients referred from Union Sub-centres and Family Welfare Centres are provided with appropriate treatment in the UHC. The more complicated cases are referred to District Hospitals for further treatment.
16. Medicines are provided free of cost to the patients subject to availability of the medicines. In some cases, for the proper treatment, some medicines are to be bought from outside by the service seekers.
17. Lists are displayed showing stock of medicines available, types of services provided and the names of the service providers.

Citizens Charter Education

Services available	Service recipient	What to do to avail the services	Role of service providers
2	**3**	**4**	**5**
Admission of children	Parents/ student	Children attained 6 years should be admitted to the nearby primary school	Teacher should receive birth certificate and inform parents/ student after enrolment
Free distribution of books	Parents/ student	Children should be admitted in the nearby primary school	Distribute books immediately
Draft list of stipend (where applicable)	Parents/ student	Attendance of students should be minimum 85% and student should get at least 40% pass marks	Prepare draft list of students with the support of SMC and send to Upazila Education Office
Formation/ reformation of SMC/ PTA	Parents/interested persons/Teacher	Persons interested to be a candidate should apply to the Head Teacher	Take necessary action as per government circular and guideline
Writing annual confidential report	Teachers	Should fill up the prescribed form and submit the Head Teacher by 31st January	Ensure sending of confidential report to the countersigned officer of Upazila Education Office and inform the concern teacher in written within date mentioned in column 6
Resolve application for release of student	Parents/ student	Should apply to the Head Teacher in written/ verbally during school hour by the legal guardian stating reasons clearly	Give release order free of cost within time mentioned in column 6
Resolve application for certificate	Parents/ student	Should apply to the Head Teacher in written/ verbally during school hour by the legal guardian stating reasons clearly	Give certificate free of cost within time mentioned in column 6
Different types of application/ prayer	Anybody/Parents/ student	Should apply to the Head Teacher in written/ verbally during school hour stating reasons clearly	Should take necessary action within time mentioned in column 6; if not within the jurisdiction then forward the application to right place
Ensure effective lessons in the class	Students	Attend school regularly and stay in the classroom	Prepare lesson plan, attend class with necessary materials and teach student
Provide/ supply information	Any responsible persons/ Parents/ Students	Apply to the Head Teacher in written with full name and address stating reasons	Will provide necessary information within time mentioned in column 6; if not within jurisdiction then give advice to submit application to the right place

Annex 5
Methodological Approach

Summary of the Reality Checks Methodological Approach (from Annual Report 2007)

The Reality Check is a longitudinal study and it is expected to track changes and people's perceptions and experience of these changes with regard to health and education. Repeating the study in the same locations, at approximately the same time each year and, as far as possible, with the same households it will be able to find out what change occurs over time.

The Reality Check is primarily a qualitative study with focus on 'how' and 'why' rather than 'what', 'when' and 'how many'. It is not intended to provide statistically representative or consensus views but deliberately seeks to explore the range of experiences concerning health and education of people living in poverty. It complements other forms of research by providing valid, up to date, people-centred information.

The Reality Check has been undertaken in the tradition of a 'listening study'. This is a term that covers a range of techniques that have been used by policy researchers, activists, and market researchers to engage in depth with the views of service users and clients. Listening studies have three main strengths: a) engaging in more depth than conventional consultation exercises normally allow; b) representing a wide range of diverse views on complex issues, and c) creating an arena in which frequently ignored voices can be better heard.

Reality Checks:

- Include staying overnight with host families living in poverty
- Longitudinal (5 years) to track change
- Qualitative
- Use a listening study approach emphasising informal conversations
- Involve interaction with people living in poverty in their own homes as well as the service providers w th whom they come into contact
- Examine people's lives holistically rather than from single sectoral perspective
- Includes the marginalised

The study team members live with host households for four nights in each location (except some slum areas because of lack of space) and adopt an approach which draws on the ideology of participatory processes which encourages non extractive forms of engagement. The emphasis is thus on two-way conversations, shared and visualised analysis, listening and observation. Conversations are conducted at different times of the day/evening and with different constellations of household members throughout their stay. Conversations have the advantage over interviews and some other participatory approaches of being two-way, relaxed and

informal, and can be conducted as people continue with their chores and other activities thus keeping disturbance to normal routine to a minimum. The study thus adopts the principle of sensitivity to people's routines and flexibility in relation to timing of conversations.

Creating informality by having conversations does not detract from them being focused and purposive in nature. In order to ensure that the conversations are purposive dialogues, a Checklist of Areas of Enquiry was developed by the team during the pilot work (April 2007). The checklist takes consideration of the four guiding principles of Participation, Non-discrimination, Transparency and Accountability (PNTA) which Sida uses to operationalise people's perspectives on development and the rights perspective. The checklist provides structure for the conversations and provides a basis to ensure sufficient probing of issues and clarification of issues arising. This checklist is reviewed and updated each year based on new studies and information provided by the Reference Group.

In the field, as well as conversations, the teams uses a range of PRA approaches which emphasise the use of visualised tools such as diagrams, dramatisation, and illustrations (drawings, photographs and video recording). The team encourages their host community members to take photographs and video footage themselves to explain their experience and to document change over the five years of the study.

Conversations are complemented by observation. As the team members spend several days with their host families, there is ample opportunity to observe and experience day to day life. Inter and intra household dynamics can be understood and provide important contextual information for interpreting conversations. Living with host families builds trust and informality is promoted providing the best possible conditions for open communication.

Furthermore, in order to put the conversations with household and community members in context, the study team members observe informal and formal health and education service provision and engage in conversations with service providers. This includes, for example, traveling to hospitals, clinics and schools using rickshaw, boat or bus, or by walking, making medicine purchases, accompanying patients and school children. The team visits schools and health facilities of different types (government, private, NGO) and at different levels (district and local). This type of triangulation (i.e. seeking multiple perspectives) is not only used to verify information but rather to explore the range of multiple realities among poor people.

Location Selection

There are nine locations in the study; one urban (slum), one peri-urban and one rural in each of the three selected Districts. Initially Divisions were selected to provide a geographical spread for the study covering North, Central and South Bangladesh. A range of secondary data was then examined (under five mortality, Human Development Index, relative food insecurity and recent poverty data) and consideration given to levels of 'urbanisation' and a range of social factors so that the final selection of Districts would provide a range of contexts where people living in poverty live and work.

In each of the three Districts selected, an urban, peri urban and rural location was identified with the assistance of a range of local key informants including school teachers, local government representatives and

NGO workers in order to select study sites which were considered to be 'poorer'. Following team visits to shortlisted locations, final selections were made. The three locations in each District all relate to the same Municipal town. The urban sites are defined as wards or part wards of the Pourashava having a distinct boundary (e.g. railway line, main road). These sites are classified as slums and comprise squatters, those renting and some owning small plots of land. Main occupations include transport services, informal sector, factory employment, domestic service and construction. The peri-urban location is defined as a ward or part ward of the Union Parishad, 8-11km from the centre of the Municipal town centre. Occupations tend to be a mix of urban and rural such as transport, construction, factory work, informal trade as well as cultivation and agricultural day labour. The rural location is defined as a village or para within a ward of the Union Parishad which is at least 32km from the centre of the Municipal town. Main occupations are agriculture and fishing.

Host households are the main unit of study and are defined as 'a family unit which cohabits around a shared courtyard and often cooks together'. All the host households are regarded in the community as poor and include children of primary school age and were selected on the basis of local information and direct observation and engagement by the research team. The host households in each community are far enough away from each other for the team members to maintain separate interactions. Between three and five focal households are included in the study by each team member in each of their locations. These are neighbours of the host household and are also poor. Interactions with these are less intense than the host household and often focus on particular topics.

Annex 6
School Differences

Differences between BRAC Primary* and Government Primary Schools

* This information refers to the 37,500 BRAC primary schools, not BRAC pre-schools

BRAC Primary School	Government Primary School
Provides 4 years (48 months) primary education (5 year Government curriculum contracted into four years). BRAC Primary School: • Class I and II (9 months) • Class III through V (10 months) for children aged 8-12 years • BRAC adolescent primary school for children aged 8-14 years (who are supposed to be school drop outs). Schools follow BRAC's own curriculum for Class I and II, a mix of BRAC and Government curriculum for Class III and follows the Government curriculum in Class IV and V.	Provides 5 year primary education for children aged 7-11 years and follows the Government curriculum throughout.
(Generally) one teacher per class who works with the children over the full four years.	Five classes with different teachers for different subjects.
Teacher: student ratio not more than 1:33. 2/3 of enrolled students are girls.	Teacher: student ratios vary but average 1:45 and may be as high as 1:90.
Simple small one room classroom usually built at a site selected by the community. Seating on mats on the floor. Provided with blackboard, teaching resources and student materials.	Purpose built classrooms, equipped with desks and benches for students and teacher, blackboard and teaching resources.
Learner-centred and participatory approach to learning. Integration of physical exercise, singing, dancing, drawing, crafts, games, story telling in curriculum.	Recent teachers' training promotes 'joyful learning' but often more traditional pedagogy prevails.
Since 2007, students are prepared for Class V public examinations. Additional study circles organised for children after school where children study together sometimes with an older college student leader.	Students are prepared for Class V public examinations. Scholarship students coaching provided.
Flexible timing of school based on discussions with the community.	Option for flexible timing but rarely adopted.
Teachers are wherever possible local. They have to have either SSC or HSC qualifications and are provided with 7 days training each year before teaching the next level, which is supplemented by monthly in-service training. 99% teachers are female.	Teachers required to have one year Teachers Certificate. May be recruited outside the community.

Annex 7

SWAp Programme Summaries

Health, Nutrition and Population Sector Programme (HNPSP)

Goal

Within the over all development framework of the Government of Bangladesh, the goal of the health, nutrition and population sector is to achieve sustainable improvement in health, nutrition and reproductive health including family planning, status of the people particularly of vulnerable groups including women, children, the elderly and the poor with ultimate aim of their economic emancipation and physical, social, mental and spiritual well being and thus contribute to the poverty reduction strategy.

Priority Objectives

Within the context of poverty reduction strategy paper, the health, nutrition and population sector will emphasize reducing severe malnutrition, high morbidity, mortality and fertility, reducing risk factors to human health from environmental, economic , social and behavioural causes with a sharp focus on improving the health of the poor and promoting healthy life styles. The success of the programme should be measured by;

1. reducing maternal mortality rate;
2. reducing total fertility rate;
3. reducing malnutrition;
4. reducing infant and under-five mortality rate;
5. reducing the burden of Tuberculosis and other diseases and
6. prevention and control of non-communicable diseases including injuries.

Duration

Original- July 2003 to 2006, Revised-2003 to 2010

Total Cost

Approved taka 94100 million, GOB (Dev 14000 m + Rev 48100m)
PA 32000m
Revised taka 324503m, GOB (Dev 54297m + Rev 162271m)
PA 107935m

Primary Education Development Program (PEDP-II)

The fundamental aim of Second Primary Education Development Program (PEDP-II) is to ensure the quality of primary education for all children in Bangladesh.

The program has been designed by the Ministry of Primary and Mass Education (MOPME). It is based on a coordinated, integrated and holistic sub-sector wide approach.

Important features of PEDP-II include Government led Planning and Implementation, and joint Financing and Monitoring by the Government and Development Partners. A Program Performance Management System under PEDP-II will contribute to strengthen the Primary Education Management in Bangladesh.

Key Objectives:

- Increase primary school access, participation and completion in accordance with the Government's 'Education For All' (EFA), Poverty Reduction Strategy, Millennium Development Goals (MDGs) and other policy commitments
- Improve the quality of student learning and achievement outcomes to Primary School Quality Levels (PSQL) standard.

Aims of Educational Reforms:

- Defining and implementing a minimum standard of educational services through Primary School Quality Levels (PSQL)
- The proposed PSQL would focus on access to educational services and the quality of education provided
- Designating and forming a Primary Education Cadre to provide an appropriate career and promotion structure for permanently recruited officials, including primary school teachers
- The Cadre would consist of officials having expertise and experience in primary education
- Building organizational capacity and systemic change, consistent with a policy of increased devolution of authority and responsibility
- Ensure improved management, monitoring and the institutionalization and sustainability of interventions of PEDP-II, and those made under PEDP-I.

Total cost

1815M US$: GOB 1161m (63,9%) and 654m (36,1%) from 10 multilateral and bilateral organisations.

Source: www.bangladesh.gov.bd and www.dpe.gov.bd

Acronyms

ANC	Ante Natal Care
BMI	Body Mass Index
BRAC	Building Resources Across Communities (formerly Bangladesh Rural Advancement Committee)
BTV	Bangladesh Television
CI sheet	Corrugated Iron Sheet
CNP	Community Nutrition Promoter
CTG	Care Taker Government
CS	Civil Surgeon
C/S	Caesarean section
DOT	Direct Observation Treatment
DNC	Dilation and curettage refers to the dilation (opening) of the cervix and surgical removal of the contents of the uterus. It is a therapeutic gynecological procedure as well as a rarely used method of first trimester abortion
EPI	Expanded Programme for Immunisation
FHH	Focal Household
FMRP	Financial Management Reform Programme
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
GoB	Government of Bangladesh
GPS	Government Primary School
HHH	Host Household
H/FHH	Host/Focal Household
HNPSP	Health, Nutrition and Population Sector Programme
LGED	Local Government Engineering Department
KG	Kindergarten
MBBS	Bachelor of Medicine & Bachelor of Surgery
MCHC	Mother and Child Health Clinic
MC	Micro-credit
MFI	Micro Finance Institution
MR	Menstrual Regulation
NGO	Non Government Organisation
ORS	Oral Rehydration Solution
OT	Operating Theatre
PEDP II	Second Primary Education Development Programme
PHC	Primary Health Care
PLA	Participatory Learning and Action
PNTA	Participation, Non-discrimination, Transparency and Accountability
PRA	Participatory Rural Appraisal
PSQS	Primary School Quality Standards
PTA	Parent Teachers Association
PTI	Primary Teachers Training Institute
RAB	Rapid Action Battalion
RC	Reality Check
RH	Reproductive Health

ROSC	Reaching Out-of School Children Programme
RNGPS	Registered Non-Government Primary School
SBA	Skilled Birth Attendant
SLIP	School Level Improvement Plan
SMC	School Management Committee
SSC	Secondary School Certificate
STD/STI	Sexually Transmitted Disease Sexually Transmitted Infection
SWAp	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
UHFPO	Upazila Health & Family Planning Officer
Tk	Taka
TNO	Thana Nirbahi Officer, also known as UNO
TW	Tubewell
TT	Tetanus Toxoid
UHC	Upazila Health Complex
UNO	Upazila Nirbahi Officer
UP	Union Parishad (Union Council)
UPHC	Urban Primary Health Care
USG	Ultra-Sonogram

Bangla Terms used in the text

Ayah	Female paid attendant in the hospital
Boro lok	Literally 'big person' – higher status, elite, rich
Dai	Traditional birth attendant
Dalal	Broker, middleman
Madrasa	Islamic religious education institution
Musclemen /Mastan	Person involved in organized crime, local strongmen or mafia
Para	Neighbourhood of village
Pitha	Homemade rice cake
Pukka	Made of brick or very well made/permanent
Qaomi	Madrasha that provides only religious education (learning by Holy Quaran and Hadit)
Ruti	Bread
Sadar	Headquarters
Tabiz	An amulet (steel or metal made small hole where small folded paper written with holy words are kept. This is given by a religious person, Fakir or Kabiraj to patients. Patients tie this to their body for a long time.
Taka (Tk)	Bangladesh currency (see exchange rate below)
Tiffin	Snack/food
Union	The bottom level administrative unit consisting of nine wards. Several unions make an Upazila.
Upazila	Several unions make an Upazila (sub-district). All the GoB services are channelled to the union from the Upazila.
Ward	Political constituency within a union. Nine wards in each union
Zila	District

Local currency exchange rate (October 2008):

Tk100 = US $1.45
Tk100 = SEK 10.78
Tk100 = GBP £0.84
Tk100 = EURO 1.08

Source: www.exchange-rates.org

Terms and Programmes

Health Sector (** denotes a programme under the HNPSP)

Boro doctor
Literally 'big doctor' refers to MBBS doctor or specialist fully trained doctor and recognised by the Government.

Citizen's Charter**
An initiative of the Caretaker Government, Citizen's Charters have been introduced in a number of public services. The Directorate of General Health Services website (Dec, 2008) provides two Citizen's Charters (see Annex 4 for these in full). These Charters are supposed to be displayed in public areas in Government health facilities and list the rights citizens are entitled to from these services.

Choto doctor
'Small doctor', refers to medical staff with different backgrounds. In rural areas, Choto doctor is usually a pharmacist or a village level medical practitioner who has taken a short training course. Urban people using the term Choto doctor often refer to paramedics, pharmacists or other medically trained persons.

Community-based Nutrition Programme**
Originally launched under the National Nutrition Programme in 1995, this comprises several components including micro-nutrient intervention, household food security interventions and supplementary feeding for pregnant and lactating mothers with low BMI and severely malnourished children under two years old. Community Nutrition Providers (NGO employed) organise education and information programmes, make home visits and organise supplementary feeding programmes at community level and in collaboration with FWAs. Packets of food are provided 6 days per week.

District Hospitals
District Hospitals are 100 bed government facilities with a variety of out-patient and in-patient services. For the sake of concealing the locations, Medical College Hospitals (there are seven in Bangladesh) are also referred to as District Hospitals in this report as they are similar in most ways except that they are also teaching hospitals.

Direct Observation Treatment Short Course (DOTS)**
TB is a major public health problem in Bangladesh. Bangladesh ranks 6th of the 22 countries regarded as having the highest TB burden in the world. The DOTS strategy started in Bangladesh in 1993 under the National TB control programme and is supported by the WHO. It comprises five components including the free diagnosis, direct observation treatment and supply of drugs. BRAC works in collaboration with

Government on the DOTS programme, organising Shastho Sebikas (health volunteers – see Shastho Sebika for further information) who are supposed to disseminate information and identify suspected cases through home visits, refer them for sputum tests and supervise the daily intake of medicines (although in certain cases they support self administration with the support of family members). At the start of treatment, patients deposit Tk200 which is refunded when they have completed the course. This provision is waived in the case of very poor patients. By late 2008, the programme was operating in 42 districts and five city corporations covering 86 million people.

Essential Drugs Programme**
Since the 1980s, Bangladesh has had a national essential drugs policy and a list of essential drugs to be procured and used in health services. Despite these advantages, government-run health facilities have never had sufficient essential drugs to meet their actual needs due to inadequate budgetary allocation for the procurement of drugs. Some additions such as anti-histamines, vitamins and pathedine have been included.

Fakir
A fakir is a spiritual healer. A fakir's treatment is mainly based on superstitious beliefs, and he uses prayers, holy water, tabiz and ceremonies. A fakir is consulted for protection of children from 'evil wind' and 'bad eye', and for similar reasons by pregnant women. They are also consulted by childless couples, couples with marital problems and in cases of undefined mental illness.

Family Welfare Assistant**
A FWA has attended a three month training course from the Regional Training Centre under the National Institute for Population Research and Training (NIPORT) System. They are posted at ward level in each union under the Union Family Welfare Centre. They make house visits providing services related to maternal health, birth, family planning and child care.

Family Welfare Visitor**
FWV is posted in the Union Family Welfare Centre (FWC). They have undergone 18–36 month training course provided by the National Institute for Population Research and Training (NIPORT) under the Health and Family Planning Ministry. They work at grassroots level, providing services related to maternal health, birth, family planning and child care.

Health Assistant**
The HA is the lowest tier of Government health staff and are responsible for EPI (immunisation) outreach centres along with FWA and of surveillance of patients with TB and polio.

Hujurs
Religious person who sometimes leads the prayer at the mosque. His main job is to assist people in performing rituals. Some Hujurs treat patients using religious texts.

Kobiraj
Kobirajs have no official training and cover a wide range of expertise. The traditional kobiraj are based in rural areas and provide herbal treatment. People see kobirajs for a wide range of reasons (pain, fever, headaches, jaundice and sprained ankles etc). There are registered kobiraj, who have undergone seven or more years training in herbal and alternative medicines who prescribe a growing range of commercially manufactured herbal remedies.

Nurse**
A nurse has undergone three years of training, leading to a Governmental approved certificate. Nurses are mainly found in Government hospitals where they treat patients in wards and assist doctors.

Ojha
In most cases they are from Hindu or other tribal community. They have pet snakes with them to attract people and are known for providing treatment in case of snake bite. They also dispel evil spirits.

Paramedics**
Recognised by the Government, paramedics have undergone training for a duration of 1–3 years. They can assist MBBS doctors during surgery, administer saline drips, provide family planning counselling and can deliver babies.

Pharmacist
Many pharmacists have undergone training varying from two months–one year. Short diploma courses are offered by different organisations, including pharmacy companies. It is required to have some sort of acknowledged training in order to open a registered pharmacy. Pharmacists are also used as counsellors, providing explanations of diagnosis and treatment provided by doctors in Government hospitals.

Polli doctor
This person has undergone a special training 'Village doctor course'. This training was introduced in the mid 1980s to ensure that primary health care was available at community level where there were no MBBS doctors available. The training is not available anymore, but Polli Doctors still exist, often running their own private pharmacies or a private clinic that serves the local community.

Sadar Hospitals
Sadar Hospitals are the main state general hospitals situated in the district town. They pre-date the expansion programme which involved construction of 100 bed district hospitals, often situated at the outskirts of the district town. Sadar hospitals continue to function as 50-100 bedded facilities in parallel with newer district hospitals or medical college hospitals. People often refer to the Sadar Hospital as the 'old hospital'. Sadar hospitals have more facilities than the UHCs and conduct a range of operations but are smaller and may have less programmes than the district hospitals.

Skilled Birth Attendant Programme **

Sponsored by the WHO and UNFPA, this programme started in 2003 originally as a pilot in six districts. The goal is to

- develop the midwifery skills of Family Welfare Assistants (FWAs) and Health Assistants (HAs) so that they can ensure quality services for women, children and the family;
- ensure the best healthy outcome for mothers and baby during pregnancy, delivery and post partum.

The programme provides a total of 6 months training comprising classroom, clinical and community practice which leads to official accreditation. It is now being implemented in 19 districts.

Traditional Birth Attendant**

A TBA is a midwife, also known as 'Dhatri' or 'dai'. The TBA assist in home deliveries, when complications arise, they are supposed to refer the issue to a reliable institutions. Different organisations have been providing them with training in safe birth procedures over many years.

Education Sector (** denotes a programme under the PEDP II)

BRAC Primary School

In 1985, the Non Formal Primary Education model school was initiated as a three-year programme for children between the ages of 8 and 10 years. Eligible children were those who had never enrolled in any school or who had dropped out of the formal schools. More recently, the 3-year cycle has become a 4-year cycle so children attend 4 years of primary school and cover the entire 5-year curriculum (Grades 1–5) with all the competencies set by the National Curriculum Textbook Board (NCTB). A similar programme exists for older children, 11–14 years old, which is run along the same model. In both cases, the schools cater primarily to girls (60–70%), as, according to BRAC girls in rural areas of Bangladesh were often neglected and kept out of schools for various reasons (e.g. gender issues, safety issues, male teachers, cost issues, etc.). (Reference: http://www.braceducation.org/brac_schools.php)

BRAC pre- primary schools

These schools cater to five year olds and provide a one year course for 30 children after which children are expected to enrol in Government primary school or RNGPS. The overall objective according to BRAC is to promote children's holistic development in a joyful and child-friendly environment and prepare them for formal primary school. The schools are one room buildings, usually of mud and thatch, and children sit on the floor. Classes are for 2 hours per day five or six days per week. Two adolescent girls, currently studying in secondary schools in grades 9–10, are recruited as teachers. Both teachers come from the school's community and have been trained as Kishori supervisors. The curriculum emphasises play and interactive exercises. With the establishment of each pre-primary school, an agreement is signed between BRAC and the respective formal primary school which requires that after completion of pre-primary school, parents will enrol their children in the respective GoB formal primary school and that this school will give priority to

these children for admission in Grade I. (Reference: http://www.brace-ducation.org/brac_pre_primary.php)

Certificate in Education **

This is a one year course of training given to newly recruited teachers of Government Primary Schools and non-trained teachers of Registered Non-government Primary Schools through 54 Primary School Training Institutes (PTI). Every year about 2000 teachers receive this training. It is a nine month course which is compulsory for all primary teachers working in schools supported by the Government, even if the teachers already have degrees. If the teacher does not undertake the course within a given timeframe their salary is frozen and increments and promotion denied.

Citizens Charter for Primary Education**

An initiative of the Caretaker Government, Citizen's Charters have been introduced in a number of public services. An English translation of the primary school Charter has been provided in Annex 4. The Charters are supposed to be displayed in public areas in Government Primary Schools and lists the rights citizens are entitled to from these services.

Government primary school**

These schools operate under the Ministry of Primary and Mass Education Ministry (MoPME) and are fully financed by the Government. There are more than 37,000 Government Primary schools in Bangladesh. PEDPII covers 61,000 schools that include RNGPS and community schools.

Madrasa

The madrasa system of education is controlled by the Madrasha Board and is Islamic based education. The Ebtedayee Madrasa is an independent five-year primary level educational institution, which is parallel to the primary school. They are, therefore, incorporated in primary education statistics. The World Bamk estimate 6,871 madrasas in Bangladesh. Other estimates vary.

Non-government primary school (registered and non-registered)

Registered non government primary schools are partly supported by the Government. The RNGPS teachers receive salary up to a maximum of 90% and the RNGPS schools receive school books and other resources. There are over 19,000 RNGPS. Unregistered NGO schools are those operating without registration with the Directorate of Education and receive no Government support. Data varies but estimates suggest that there are over 3,000 non-registered NGO schools.

Primary School Stipend programme**

The stipend programme started in 2002 under PEDP II and was intended to increase primary school enrolment by providing incentives for parents to send their children to school. It is supposed to target 40% of the poorest students, particularly children of widows, fishermen, cobblers and landless. It only operates in rural areas. It provides Tk100 per month for the first child and Tk25 for each additional school going sibling. In order to qualify children have to have 85% attendance record and achieve a minimum 40% pass mark in examinations. 4.73 million school

children receive stipends each year.

Reaching Out of School Children (ROSC)

This programme has been undertaken to create opportunities for primary education from Class 1–5 for out-of-school children and dropout students. It is supported under a separate agreement by the World Bank and SDC and is not part of PEDP II. Under the programme learning centres are established in areas where the dropout rate is very high because of extreme poverty. This project will cover 60 Upazilas during the period July 2004–2010.

School Feeding Programme

Through the World Food Programme (WFP) assisted School Feeding Programme, high-energy biscuits are distributed to primary school children in nearly 4000 schools in high food insecure areas of the country. These are given to children under supervision by the teachers every day.

School Level Improvement Plans (SLIP)**

This is an initiative under PEDP II and first started in 2007. It is intended to develop a local interest by providing grants directly to the school for them to use in a way which makes the school a more attractive place for children and and help in improving the quality of education and motivates them to continue in school. Grant use is decided in a participatory way through a locally convened SLIP committee comprising teachers, local leaders, guardians and school children. Five members of the SLIP committee receive a two day orientation and are encouraged to develop plans which contribute to the achievement of the primary school quality standards (PSQS - 20 indicators).

The Reality Check Team

Dee Jupp PhD is the overall team leader for the Reality Check as well as team leader for the Central sub-team and author of the Annual Reports. She has worked in development for more than 23 years, including 12 years living and working in Bangladesh. As an expert in participatory approaches, she has led a number of initiatives including the first participatory poverty assessment (PPA) in Bangladesh, a series of listening studies and the Views of the Poor study in Tanzania and has contributed to Action Aid's Immersions programme.

Enamul Huda MSc is the team leader for the North sub-team and overall co-ordinator in Bangladesh. He has been working for over 30 years with different development programmes, focusing on people's participation and rural development within and outside Bangladesh. He is a freelance consultant and the author of three books on people's participation. Currently he is involved with an action research programme on water and sanitation, initiated by the Institute of Development Studies, University of Sussex.

Malin Arvidson PhD is the team leader for the South sub-team has been working for over 10 years with development research, focusing in particular on Bangladesh and NGOs. Starting in 2009, she will be working at 'Third Sector Research Centre' at the University of Southampton, UK.

Nasrin Jahan, MBBS, MPH, is a public health physician with more than 30 years experience working with a range of actors from community level to NGOs, Government and donors. She worked in ICDDRB for four years where she gained experience on community-based public health research. Since then, her experience expanded to the application of participatory approaches to social, gender and other human development issues beyond the health sector.

Md. Ghulam Kibria MA has extensive experience in the fields of policy research, advocacy and training focusing on poverty alleviation. During his over 23 years experience in the development field, he has contributed to a number of important studies in Bangladesh where he focused on socio-economic analysis and people's participation. He is currently Senior Programme Coordinator in Proshika (Bangladesh NGO) Human Development Training Division.

Nurjahan Begum MSc has been working as development researcher for the last 10 years and is currently working for UNICEF ROSA. Her key research interests are in livelihoods approaches, environment, education, health, institutional development, poverty and gender.

Rabiul Hasan BA has been working as a participation facilitator for more than 16 years. He is currently a freelance Participatory Development Consultant.

Amir Hossain MSS has over 20 years experience working with participatory training, research and monitoring in Bangladesh. He has undertaken extensive field work and has been working with PromPT since 1995 and is currently engaged with the research project 'Rat Management for Rural Communities in Bangladesh.

Syed Rukanuddin PhD is a freelance Training, Monitoring, Participatory Research consultant with 26 years experience in development. He has been involved in a number of participatory listening studies and has considerable experience of local government and rights issues. He is author of a number of books on facilitation techniques.

Dil Afroz MSc has working experience of over 19 years with development research and development studies in the NGO sector and development in Bangladesh. She specialises in the use of participatory approaches. She is a member of three research and training institutes in Bangladesh.

Hans Hedlund PhD is an associate professor in Social Anthropology and Director of GRM International AB. He has worked in the field of development anthropology for some 40 years, particularly in East and Central Africa and more recently with a number of rural development projects in the Balkans and Southern Caucasus. His research has focussed on farmers associations and rural development.

David Lewis PhD teaches in the Department of Social Policy at the London School of Economics. An anthropologist by training, he first went to Bangladesh in 1985 to undertake doctoral research in a village in Comilla District, and has been returning ever since. He has undertaken research on a range of subjects, including rural development, politics and policy, aid and agencies, civil society and non-governmental organisations. He has also undertaken consultancy work for many agencies in Bangladesh, including BRAC, Danida, DFID, Proshika, and Sida.

Jessica Rothman BSBA/PMP is the Project Manager for the Reality Check and has been managing development projects and NGO initiatives for 14 years. She is based at GRM's Head office in Stockholm. She has considerable experience in managing complex and multi-faceted projects, studies and evaluations in developing countries together with donors and governments.

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SWEDISH INTERNATIONAL
DEVELOPMENT COOPERATION AGENCY

SE-105 25 Stockholm Sweden
Phone: +46 (0)8 698 50 00
Fax: +46 (0)8 20 88 64
sida@sida.se, www.sida.se

Sida