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APRIL 2008 • GRM INTERNATIONAL

Listening to Poor People´s Realities about Primary Healthcare and Primary Education

Bangladesh Reality Check Annual Report 2007

Published by Sida 2008

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Printed by Edita Communication, 2008

Art. no.: SIDA44809en

ISBN: 978-91-586-8075-3

This publication can be downloaded/ordered from www.sida.se/publications

Foreword

The last ten years have seen a changing donor environment in Bangladesh. Development partners are moving from projects to programmes and beyond, and greater emphasis is placed on ownership and alignment with government systems. The Embassy of Sweden/Sida in Bangladesh is aligning with the Government of Bangladesh through its support to the sector programmes in primary health and primary education (HNPSP and PEDPII).

However, the more 'upstream' development assistance gets, the wider is the gap to the field and to the people whose living conditions and opportunities we aim to improve.

Reality Check is an initiative to bridge this gap, and to listen to the voices directly from these people in order to learn if change is taking place. Quite simply, to check the realities on the ground.

By hearing about ordinary people's experience of the provision of health and education, by looking at their photographs and drawings as well as their tales, we hope to create a platform for their voices to be heard within the sector programmes.

This report gives us the opportunity to encourage the sharing of opinions, experiences and perceptions of people living in poverty, and it is anticipated that this Reality Check in due course will contribute to important insights that can inform policy level discussion.

The report is the first of five consecutive studies, planned to be produced from the same nine villages over five years. Being full of small observations, insights into poor people's daily difficulties and their ability to make choices, the study gives a snapshot of the huge potential of people in Bangladesh to improve their quality of life.

Britt Hagström
Ambassador
Head of Mission
Embassy of Sweden
Dhaka, Bangladesh

Executive Summary

This report presents original data from the first year of the Sida 'Reality Checks' initiative, based on fieldwork carried out in October-November 2007. The study documents the views of ordinary Bangladeshi people living in poverty in relation to their changing experiences of health and education services. The study aims to complement more conventional forms of monitoring and research work by operating in the tradition of the 'listening study'. We have thus attempted to understand the human dimensions of policy change and implementation from the perspective of those whose voices often struggle to be heard within the 'upstream' cacophony of sector programmes and targets.

Three study areas were selected: one in the North, one in the South and one in the Central part of the country. In each area people were consulted in a rural, peri-urban and an urban area. Teams spent five days in each location living with families and documenting their experiences and perceptions. This report covers the first year of what we expect will become a five year study, allowing us to report on changing perceptions over time in each location by revisiting the same households. The Reality Check emphasizes the use of pictorial records, photographs and people's own drawings to demonstrate change. In subsequent years, these reports will elaborate more on this form of storytelling.

Generally, the situation with regards to health services is:

- Local private pharmacies and homeopaths are preferred to Government health facilities (and to some extent NGO clinics) because they are cheaper and more accessible, particularly as Government health facilities are open in the morning, the least preferred time for people living in poverty.
- Measures designed to improve access by poor people are under-performing. Government outreach services are not usually free and are rarely accessed. The Government list of 41 basic free medicines to be dispensed by Government outlets has functioned poorly due to supply problems (this situation is improving under the Caretaker Government).
- The range of basic free medicines is however limited and does not cover common diseases such as diabetes and heart disease.
- There is less evidence of the use of intermediaries and speed money due to better policing under the Caretaker Government. Unofficial fees are still charged at some Government health facilities.
- The attitudes and behaviour of health professionals in Government health facilities is a critical variable in whether a facility operates successfully. Unsatisfactory professional culture is often perceived as a key problem (e.g. disrespect of doctors).
- There are no functioning watchdog groups or working complaints procedures to improve accountability (one NGO clinic provides a possible example of a workable model that could be learned from).
- Access to information about healthcare and services has improved slightly, but is still below standard.
- There has been a recent rise in the choice of health providers with the proliferation of private clinics and private diagnostic centres which people living in poverty will use because of their accessibility and efficient service.
- Diagnostic tests are more frequently availed. This is perceived as another route for money making but is increasingly demanded by people living in poverty as it is considered to be more technologically advanced.

Generally, the situation with regards to primary education is:

- Public and private facilities are more extensive in urban and peri-urban areas than in rural areas.
- BRAC schools are regarded more highly than Government schools or Madrasa schools. The emphasis on the importance of 'play' in learning in BRAC schools is widely appreciated.
- Rather than parents restricting children's attendance at school due to economic considerations of household labour, drop-outs are more often an outcome of children's own low motivation. Particularly boys who see no benefit in school and truant or in urban areas girls marry early to pre-empt scandal.
- 'Free' primary education in Government schools carries high hidden costs which discourages school attendance of children living in poverty.
- The stipend system is the subject of widespread criticism due to a lack of transparency in making awards and suspicion of malpractice.
- Students with disabilities suffer discrimination which prevents most from attending school. Poorer children often face discrimination from teachers which discourages their attendance in school.
- An education is considered highly desirable among people living in poverty (even though many teachers denigrate parents for being ignorant about its value).
- The physical design of schools (standard sized classrooms, poor toilet facilities and play areas) are frequently criticised by people living in poverty who seem to suffer from this 'one size fits all' approach.
- Registered non-government primary schools are preferred to Government schools and are generally perceived to deliver a higher quality service despite their staff being paid much less, due to a strong service culture among staff and local community roots.

- As with health, accountability systems are poor or non-existent making it difficult for parents and children to achieve any influence over quality of services.

So what do we learn from this first round of the 'Reality Check' study? A key point which is revealed from the conversations is the active roles played by households living in poverty to seek to better meet both their health and educational needs but who face serious structural obstacles in their efforts to access and influence the nature and quality of services provided. Whilst people living in poverty tend to value health and education, these aspirations are frequently thwarted by service provider failure and social exclusionary pressures.

The SWAps are already addressing many of the issues but with the rise of private alternatives in both health and education, which are, perhaps surprisingly, being accessed by people living in poverty because they address their needs better, more emphasis needs to be made on the service culture which is lacking in Government facilities. Where loss of productive time has a direct economic implication, efficiency in provision of health services is particularly valued. Since providing education for ones children incurs associated costs even at Government schools, parents are increasingly willing to protect this investment by accessing private coaching to complement poor quality teaching.

A range of basic issues are included within the overall aims of the SWAps – such as the supply of basic schoolbooks and medicines, the design and maintenance of infrastructure, the quality of skills of front-line staff and the need to increase the capacity of people living in poverty to access and to influence the quality of public services more effectively.

Also, a range of more complex second order issues need to be considered and fully addressed. One of the issues is the unsatisfactory 'culture of professionals' within the system of service provision which people living in poverty identify as real hurdles to access. This specifically covers the lack of respect shown by doctors and teachers towards people living in poverty. Another issue is the lack of accountability mechanisms through which poor people can demand better services – through a complaints procedure, user's groups or through balanced dialogue with professionals and officials with whom they come into contact.

All these findings feed back strongly into Sida's four principles of development cooperation: Participation, Non-discrimination, Transparency and Accountability (PNTA). The following table provides a summary of the main issues:

Sida's principles	Issues raised by Reality Check study
Participation	• Some progress is being made by the Caretaker Government to reduce the role of intermediaries whose fees exclude the poorest • High levels of motivation among people in relation to health and education services thwarted by exclusionary institutions and processes • Stipends suffer from poor targeting and is often captured by the elite
Non-discrimination	• Hidden costs to education services excludes the very poorest people • While access to education for some children with some physical disabilities is improving, access for children with learning disabilities remains low
Transparency	• Access to useful information about services remains poor • Representation of people living in poverty on school and other committees is low and selection procedures unclear
Accountability	• Complaints procedures and civil society watchdogs do not operate effectively • Cultures of professionals and front-line service providers are not welcoming to people living in poverty • Limited range of medicines does not reflect basic needs

Acknowledgements

The Reality Check is an initiative by the Swedish Embassy in Bangladesh and Sida (Swedish International Development Agency).

This Report represents the first substantive output of the Bangladesh Reality Check work. The Reality Check initiative initially takes the form of a short term consultancy input during 2007-2008 and it is expected to continue for a five year period. GRM International is the implementer on behalf of The Swedish Embassy and Sida.

The Reality Check study has been carried out by Dr. Dee Jupp, Dr. Malin Arvidson, Enamul Huda, Dr. Syed Rukanuddin, Dr. Nasrin Jahan, Dil Afroz, Amir Hussain, Mominur Rahman and Fatima Jahan Seema.

The approach and methodology used in the study has been developed together with Dr. David Lewis from the London School of Economics and Dr. Hans Hedlund, in collaboration with Helena Thorfinn from the Swedish Embassy in Bangladesh and Esse Nilsson from Sida's Policy and Methodology Department.

The Reality Check study team members express their sincere gratitude to the people living in poverty of nine different locations in Bangladesh who contributed their valuable time and allowed the team members to live with them and shared their day to day life experiences. We hope that this study contributes in some way to improving the understanding of policy makers so that policy and practice in health and education becomes more pro-poor.

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Acronyms

ANC	Ante Natal Care
ASA	Association for Social Advancement
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
CRHC	Comprehensive Reproductive Health Care
CS	Civil Surgeon
C/S	Caesarean section
DOT	Direct Observation Therapy
DSS	Department of Social Services
ECG	Electrocardiogram
EOC	Emergency/Essential Obstetrics care
EPI	Expanded Programme for Immunisation
FGD	Focus Group Discussion
FHH	Focal Household
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
GB	Grameen Bank
GoB	Government of Bangladesh
GPS	Government Primary School
HHH	Host Household
H/FHH	Host/Focal Household
HbSAg	Hepatitis B Surface Antigen
LGED	Local Government Engineering Department
LGRD	Local Government Rural Development
LMP	Licentiate Medical Practitioner
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 Salt
OT	Operating Theatre
PEDP II	Second Primary Education Development Programme
PHC	Primary Health Care
PNC	Post Natal Care
PNTA	Participation, Non-discrimination, Transparency and Accountability
PRA	Participatory Rural Appraisal
PTA	Parent Teachers Association
PTI	Primary Teachers Training Institute
RAB	Rapid Action Battalion
RC	Reality Check
RH	Reproductive Health
ROSCA	Rotating Savings and Credit association
RNGPS	Registered Non-Government Primary School
SBA	Skilled Birth Attendant
SC	Satellite Clinic
SLIP	School Level Improvement Plans
SMC	School Management Committee
SSC	Secondary School Certificate
STD / STI	Sexually Transmitted Disease Sexually Transmitted Infections
SWAp	Sector Wide Approach Programme
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
USAID	United States Assistance for International Development
USG	Ultra-Sonogram

General Glossary

Abashik	Residential
Adarsha gram	Model village (Government re-housing programme for poor on khas (Government) land)
Ayah	Female paid attendant in the hospital
Boro lok	Literally 'big person' – higher status, elite, rich
Dai	Traditional birth attendant
Dalal	Broker, middleman
Fakir	A spiritual healer
Forkania	Root level religious institution providing religious education
'Fuu'	Blow on water to drink or on body or head after holy prayer by religious person known as Hujur/fakir
Gher	A big fish-field managed by government or private organisation.
Ghat	A loading and unloading place of a river
Guccha	Cluster
Gram	Village
Haor	Marshy low land, often under water during most part of the year
Kobiraji	Herbal treatment (as practiced by a Kobiraj)
Katcha	Something usually made out of clay which is often temporary. In the case of roads –mud road
Lakri	Fire wood
Maktab	An informal education institution which provides religious education
Madrasha	Islamic religious education institution
Maimol	Fishermen communities. (Often derogatory as it can indicate low caste)
Moa	A cheap tennis ball shaped snack made with puffed/ flattened rice and molasses. One standard size moa cost Tk1
Musclemen / Mastan	Miscreants/ control through using physical power
Para	Hamlet or small village/town or part of a village/town
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)
Sadar	Main/ central
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. An elected body called Union Parishad is the legal authority of an union
Upazila	Several unions make an Upazila. All the GoB services are channelled to the union from the Upazilla.
Ward	Political constituency within a union. Nine wards in each union
Zila	Alternative name for District – an administrative unit

Glossary of Health Service Providers

Boro doctor: Literally *'big doctor'* refers to MBBS doctor (sometimes referred to as 'MBBS') or specialist fully trained doctor and recognised by the Government. *Boro doctors* are consulted in a wide range of cases, from minor to serious illnesses in Government hospitals.

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 course (six months –one year). Urban people using the term *choto doctor* often refer to paramedics, pharmacists or other medically trained persons. C*hoto doctors* are used for various treatments although not for surgery (apart from sutures).

Polli doctor: This person has undergone a special training (three - six months) 'village doctor course'. This training was introduced under Ziaur Rahman 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. Patients come to the *polli doctor* for various medical reasons. Based in the community, we found they are often preferred since they generally take time to talk to patients, can do home visits and they know the community people where they work.

Paramedics: Recognised by the Government, paramedics have undergone training for a duration of 1-3 years (provided by private/NGO or government institution). They can assist MBBS during surgery, administer saline injections, provide family planning counselling and can deliver children.

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.

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 play an important role in primary health care. This is often the first person a patient would go to for treatment or advice regarding a medical problem. Pharmacists are also used as counsellors, providing explanations of diagnosis and treatment provided by doctors in Government hospitals.

FWV: *Family Welfare Visitor*, 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.

FWA: *Family Welfare Assistant* has attended a three month training course from the Regional Training Centre under the 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.

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 (using locally available plants). Knowledge is passed on from one generation to the next. People see kobirajs for a wide range of reasons (pain, fever, headaches, jaundice and sprained ankles etc.). They may also provide treatment so called '*bad eye'* or *'evil wind'*, and other undefined (mental) health problems. The kobiraj is popular with women and children since it is thought that the treatments provided are mild i.e. does not have any side effects. There are *registered kobiraj*, who have undergone seven or more years training in herbal and

alternative medicines. They prescribe a growing range of commercially manufactured herbal remedies.

Fakir: A fakir is a spiritual healer. A fakir's treatment is mainly based on superstitious beliefs, and he uses prayers, holy water, tabis (amulet often with a small paper with religious words put in small metallic case and carried on a string around neck or waist), 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.

Hujur: 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 words.

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.

TBA: *Traditional Birth Attendant*/ midwife, also known as '*Dhatri'* or 'dai' The traditional midwife 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.

SBA: *Skilled Birth Attendant*: often a FWA or HA who has been trained for six months. They can conduct normal deliveries and will refer women with complications to hospital.

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

Local currency exchange rate (January 2008):
Tk100 = US $1.46
Tk100 = SEK 9.4
Tk100 = GBP £0.75

Glossary of research terms

Action research

Research that aims to involve both researchers and research subjects in a collaborative process to change the current situation by solving problems in mutually agreed ways.

Appreciative Enquiry

Appreciative Inquiry is a form of action research originally conceived to promote organisational change (Cooperrider and Srivastava, 1987). The key data collection innovation of appreciative inquiry is the collection of people's stories of something at its best. It thus focuses on the positive and enables people to explain what peak moments they have had and apply the learning, ideals and values from these to construct 'dreams'. Aspects are used in social enquiry to focus on the positive rather than the negative in people's lives.

Listening study

Listening study is a term that covers a range of techniques used by policy researchers and activists to engage effectively with the views and experiences of service users. A listening study aims to capture experiences and perspectives without taking sides or guiding conversations according to preconceived ideas. It has three main strengths (a) engaging in more depth than conventional consultation exercises normally allow; (b) representing a wide range of diverse views on complex topics, and (c) creating an arena in which frequently ignored voices can be heard by all sides.

Longitudinal study

A longitudinal study is correlation research that involves repeated studies and /or observations of the same items over long periods of time.

Exploratory and Reflective Enquiry

Reflective and explorative enquiry is in this case seen as an important complement to the listening-approach. While still having an inquisitive mind and not guiding the conversations according to predetermined interpretations, the study team explores and reflects over the meaning of what is said *together with the interviewee*. The aim is to gain deeper insight into the meaning of the interviewees' experiences through exploring part of this experience and through reflecting over 'what' and 'why' questions.

Triangulation

In the social sciences, triangulation is the process of multiple checking (at least three different checks) of findings to increase confidence in a result if different methods lead to the same result. By combining multiple observers and/or respondents and different methods researchers can hope to overcome the weakness or intrinsic biases and the problems that come from single method, single-observer, single-theory studies.

1. Background and Introduction

Sweden's Policy for Global Development (PGD) which, in December 2003, was adopted by the Swedish Parliament through the Government Bill, *Shared Responsibility: Sweden's policy for global development (2002/03:122)* emphasises two perspectives which are intended to be the base for and permeate all Swedish development cooperation. These are the ***rights perspective*** and ***poor people's perspectives on development.*** Sida's (Swedish International Development Agency) document *'Current Thinking on the Two Perspectives of the PGD' (November 2006)* describes these as follows:

> *The rights perspective includes democracy, good governance and human rights, with gender equality and the rights of the child as key areas. These aspects are also included in poor people's perspectives on development, which also means that poor people should not be viewed as a homogenous group, that poor women, men and children must be seen as individuals, and that development should be something arising from within a society, created through the participation of poor people.*
>
> *and*
>
> *Poor people's perspectives on development present a great challenge for ensuring that the problems, needs and interests of poor people are given a genuine and undistorted impact on development cooperation. It's a question of improving the possibilities poor people have to express their needs and advance their interests.*[1]

To provide guidance in operationalising the two perspectives within development cooperation, four principles have been identified as follows: Participation, Non-discrimination, Transparency and Accountability (PNTA). Both results and processes of development cooperation are intended to be based on these principles. The working paper recommends that social analyses are routinely conducted which accommodate methods to include the views of people living in poverty.

The expected strategy for Sweden's cooperation with Bangladesh (2008-12, pending) endorses the two perspectives of *poor people's perspectives* and *rights based approaches* and has elaborated this further under what is known as Bangla-APPA (Applied Perspectives and Principles in Action) which details an approach to ensure dialogue from *above* (development partners, Government of Bangladesh), from *within* (the sector programmes) and from *below* (NGOs and men and women living in poverty).

This Reality Check study in Bangladesh thus constitutes an important element of the '*from below*' approach. It is a means to bring the perspectives of people living in poverty into the planning and policy agenda. Sida hopes that learning from this pilot in Bangladesh will lead to developing a methodological approach to ensuring that the *problems, needs and interests of poor people* have an impact on the way development cooperation is understood and carried out.

The Paris Declaration on Aid Effectiveness (2005) encourages joint financing, including through Sector Wide Programmes (SWAp) which are a means of funding by Development Partners and Government in a coordinated fashion under a single policy and expenditure programme and with government leadership. Sweden will continue to provide substantial support to the two SWAps in Bangladesh; Health, Nutrition and Population Sector Programme (HNPSP) and the Primary Education Development Programme (PEPD II). Both these programmes involve large consortiums of development partners and large investment as indicated in the table below:

Two SWAps in Bangladesh

Programme name	Period	Number consortium donor partners	Total Budget	Sida's contribution
Primary Education Development Programme (PEDP II)	2004-10	11	US$1.8 billion (GOB $1.16)	1.6%
Health, Nutrition and Population Sector Programme (HNPSP)	2003-10	18 (7 in Multi-Donor Trust Fund)	US$3.5 billion	2.1%

[1] *Current Thinking on the Two Perspectives of the PGD,* Sida Nov 2006. Department for Policy and Methodology, POM Working Paper 2006:4

However, there is concern that within these vast programmes under the SWAps, both the Government of Bangladesh and development partners do not have ready access to information on how policies and strategies within these sectors are being translated into ground realities. Sida has thus identified an opportunity to influence the SWAps through its emphasis on the '*from below*' approach. The Reality Check is intended to provide information about how this investment is actually being understood and experienced by people living in poverty themselves. The Reality Check will complement existing monitoring and evaluation mechanisms *from within* and is expected to provide qualitative field experiences and insights which can inform dialogue *from above.*

The overall goal of this Reality Check is to ***listen to and try to understand the perspectives of people living in poverty on the national health and education programmes in Bangladesh***.

The Reality Check, starting in 2007, is structured as a qualitative longitudinal 'listening' study over five years. It gathers experiences, opinions and insights of people living in poverty, which complements the more conventional monitoring and evaluation mechanisms within the Health and Education SWAps. This approach provides an opportunity to put faces and voices to the numbers as well as some answers to 'how' and 'why'. It deliberately explores the range of experiences of poor people and consciously embraces context specific differences.

The approach used is a combination of immersion (actually living with poor households and joining in their lives for several days and nights) and conventional participatory approaches. This combination creates the best possible environment for open communication and enables the study team to experience, to some extent, for themselves, what people are talking about (e.g. the difficult journey to the heath facility, the chores needing to be done before going to school, the shortage of water that has to be faced each day, etc).

The study focuses on households and their neighbours rather than public forums to include voices which are rarely heard such as elderly, young, persons with disabilities and minorities. It is a longitudinal study over five years with the same communities, same households and at the same time each year so that changes can be tracked over time. The field work takes place over a period of one month each year in October/November in three different Divisions (regions) of Bangladesh; one in the North, one in the South and one Central. In each Division one of three field teams stays in a rural, an urban and a peri-urban community. These three communities all relate to the same municipal town. Thus, in total nine communities are included in the study. This report provides a synthesis of the findings for the first year Reality Check conducted in 2007.

2. Methodology

The Reality Check is primarily a qualitative study with a focus on 'how' and 'why' rather than 'what', 'when' and 'how many'. It is not intended to provide statistical, 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 the '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. For example, it has been used recently in the UK by Macmillan Cancer Research to better understand the views of people with cancer about current cancer research agendas[2] and in the US by Conservatree non-profit advocacy group to gauge diverse views on sustainable paper production. Listening studies have three main areas of strength: (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 by all sides.

[2] Corner, J.;Wright, D.;Foster, C.;Gunaratnam, Y.;Hopkinson, J.; Okamoto, I. The Macmillan Listening Study: Listening to the Views of People Affected by Cancer about Cancer Research Published Report. London, UK: Macmillan Cancer Support; 2006.

The study approach has a number of important characteristics which differentiates it from many other qualitative studies:

Longitudinal study: This is a study over five years. It is expected to track changes and people's perception 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.

Participant observation: The study relies on spending time with households in the tradition of participatory research and learning and uses two way 'conversations' to generate information and insights. It also draws on recent ideas about 'immersions[3]' as a way for 'outsiders' to live with households living in poverty and, to some extent, experience their day to day life. In this study the team members spend four nights with each host household. This enables the best possible conditions for open communication. By spending this concentrated time with households, high levels of trust and informality can be fostered; invaluable experiential triangulation can be undertaken and less extractive forms of communication results by narrowing the power distance between outsiders and insiders.

Cross-sectoral: The study examines experiences of families in terms of both health and education whereas most studies focus on one sector only. Family decision-making does not follow sectoral lines but rather involves weighing up the ability to meet health, education and other needs based on consideration of a range of economic and social dimensions. By looking at both education and health together, further insights into how households meet social needs as a whole are ascertained.

Inclusion: Listening to marginalised voices is a challenge which many qualitative approaches fail to embrace. By living with households, opportunities emerge to spend time with family members who rarely participate in other forms of participatory studies, in particular the elderly, young, persons with disabilities, religious and other minorities. Spending several days in the community and having informal conversations will enable the team to build trust and include other 'small voices' (adolescents, ethnic and religious minorities, other excluded people). Unlike many other studies, this study also involved interaction with non-users (those that actively opt out as well as those who feel excluded).

Focus on poor households: The focal unit of the study is the household, rather than on individuals or wider groups. A household focus provides insights into household dynamics including those constructed by gender and age. It enables a better understanding of how information is shared and how decisions are made and acted upon.

Observation: The immersion approach provides the teams with opportunities to understand the context, live (to some extent) other people's reality, experience the community dynamic both in the day and night, observe coping strategies and witness unintended interpretations of programmes and the difference between knowing and doing. The findings from household and community members will be contextualised by enhanced observation and action (e.g. making the journey to the Upazila Health Complex by rickshaw and bus, walking to school, etc).

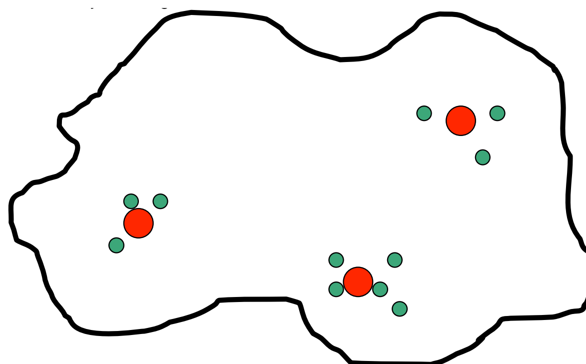
2.1 Locations

A total of nine locations were included in the study; one rural, one peri-urban and one urban in each of three districts. The Divisions and then Districts were selected to provide a geographical spread. One is in the North, one is Central and one is in the South. A range of secondary data was examined before the choice was made, including under five mortality, Human Development Index, relative food insecurity and recent poverty line data. Consideration was also given to the level of 'urbanisation' and development as well as the range of social contexts. The three sites in each district were selected with reference to the same municipal town, i.e. representing points on the same radius from the town.

[3] Immersions are 'opportunities for development professionals to spend a period of time living with and learning from a poor family'. They have become recognised as important because current aid practices have moved away from contact with the grassroots towards more emphasis on policy dialogue and co-ordination, with endless workshops which leave little space for spending time in the field. This means that aid agency staff have less time than ever to spend with the very people they are supposedly employed to assist, even though aid policy rhetoric currently stresses the perspectives of the poor. 'Immersions: learning about poverty face-to-face, *Participatory Learning and Action 57*. IIED, December 2007.

Sketch of community showing Host HH and focal HH

Community boundary Host HH Focal HHs



The 'Urban location' is defined as a ward or part of a ward within the Pourashava, having a distinct and recognised boundary (e.g. railway line, main road). These sites are classified as slums and comprise squatters, those renting property and some owning small plots of land. The main occupations of inhabitants include transport services, informal sector, factory employment, domestic service and construction.

The 'peri-urban location' is defined as a ward or part of a ward of the Union Parishad which is within 8-11 km of the municipal town centre but also within access of an Upazila Health Complex. Because of the proximity to the municipal town there is some observable evidence of urbanisation. 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 32 km from the municipal town centre and having closer access to an Upazila Health Complex than the town centre. The main occupations include agriculture and fishing.

Advance teams visited the districts in October 2007 to select the locations for the study. The intention was to select locations which would be objectively defined as 'poorer'. Using a variety of key informants familiar with the areas, including NGO workers, local Government representatives, Government administration and school teachers, shortlists were prepared and physical visits made. These advance teams also identified potential host households as defined below.

2.2 Units of study

The study focuses on four empirical units: Host households (HHHs), Focal households (FHHs), wider community and key informants.

Host Households (HHH): The HHH was the main focus of the study. A household is defined as 'a family unit which cohabits around a shared courtyard and often cooks together'. The HHHs were all poor. The definition of 'poor' is contextual and described in each field report in detail (and summarised below):

South Urban

HHH 1: Well established family who has lived in the area for a couple of generations. They have a proper house (brick walls, corrugated iron roof, bathroom, separate kitchen, electricity). Although relatively better off in assets they are in deep debt.

HHH 2: Elderly couple, very poor, living in very congested area of the slum. People use their one room to access their family-units further inside the slum.

HHH 3: Relatively better off family, with assets that allow them to lend money to neighbours and others.

South Peri-urban

HHH 1: Poor family with poor housing conditions, adjacent to richer brother considerably better off. The family is in debt after illness.

HHH 2: Poor family, very few assets, lives on flood-prone area.

HHH 3: Female headed household, mother has a slight mental disability and is barely able to provide food for the day.

South Rural

HHH 1: A family of high status and presently owns relatively substantial assets, although a generation ago very poor.

HHH 2: Newly relocated family who moved from temporary house on the river bank. Through NGO loans the family has built a house and started a tea-stall business, but is finding it difficult to repay the loans.

HHH 3: Family newly relocated from river bank, in new house, with big loans to repay.

Central Urban

HHH 1: Living together in a one room house (rent free) made of rusting CI sheet and matting the family comprises of an elderly couple (in 60s), three of their daughters, one of whom is unmarried and pregnant, one is married with a 2 1/2 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 12" ceiling fan. They use the kitchen of a neighbour where they are allowed use of 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.

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, tubewell and toilet along with 8-9 other families. Most of the time 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.

HHH 3: The father (about 35) works in a tailoring shop on contract basis. On an average he earns Tk3000-4000 per month depending on the workload. He lives with his wife and four children (all under 8 yrs old) in a rented room. There is 1 old chowki (wooden cot), 1 electric ceiling fan and few utensils in his 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.

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 one unmarried daughter, the third house accommodates another daughter with her husband and four children and the fourth house accommodates another daughter and her husband and 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.

HHH 2: A female headed household comprising of widow (50+), daughter (25+, separated from husband) and grand daughter, 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.

HHH 3: Having two tin roof houses (one medium and one small) with half of the walls of tin and half bamboo. One house is divided in two with one room for the household head (widower) and other for his widowed elder daughter who works in a fish feed mill. The second one-room house is occupied by the son, his wife and 2yr old daughter. The elder man works as a day labourer and his son is a day labourer and part time rickshaw puller. They own 12 decimal agricultural land. They also own a rickshaw, a paddy crashing machine (valued at Tk2000), 2 wooden chowki, 2 ducks and 3 chickens.

Central Rural

HHH 1: The family, comprising of mother and father, two 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.

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) and husband. 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.

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 milk cow with calf, 1 rack, 1 wooden box and 3 chickens.

North Urban

HHH 1: Household head is a petty moa (snacks made of puffed rice and molasses) producer and seller. Total land owned by the household is 30 feet by 10 feet. The house is made of CI sheet roof and fenced. The house consists of only one small room to accommodate family of seven (husband, wife, 2 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 family members. Other assets include one cloth hanger, one small 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.

HHH 2: The home has a brick wall with CI sheet roof around a house with one bedroom and one kitchen cum bedroom. House head is a retired service holder with 6 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. Elder son works in a workshop and earns Tk2500 per month. Second son is an apprentice in a workshop and earns Tk30 per day. His wife stitches quilts and earns some money. Third son helps the Imam of the 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 eats for the whole day. The family use a community latrine constructed by local rich people.

HHH 3: The family lives in a one room house made by brick which was constructed with the support of local rich people. Total land is 1 decimal. House head is a retired private service holder. The family has one son and three daughters. The son works in a transport garage and earns Tk2700 per month. Elder daughter studied up to class four. Second daughter is in class 9 and manages her education expenses by providing private coaching. Wife sews and earns Tk800 per month. They collect water from others tubewells. Assets include one old cot and a table.

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 family members, including elderly parent (house head), wife and four sons. Elder son is 19 years old now learning welding in a local workshop. House head is a carpenter but without a regular job. 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 used by the father.

HHH 2: House comprises of two rooms, one used as bedroom and the other is a very small kitchen. House made of jute straw wall and CI sheet roof. Family has two sons, elder son completed primary education from a BRAC school but is currently suffering from arthritis and younger son is in class 1. House head is a van driver and earns average Tk150 per day. His wife collects fire wood from the

forest and sells some in the village.

HHH 3: The head of the household is a widow with three daughters. She has a house with 2 rooms (bedroom and kitchen) on 6 decimals land. The land is allocated by the government. All daughters are students and study in class 5, 3 and Maktab (religious education) respectively. The widow works as housekeeper for wealthier families and earns Tk900-1000 per month.

North Rural

HHH 1: The family has a small house with mud walls and straw roof. Roof condition is very poor and rain water pours into the house. The house has two rooms, one big and one small. Big room is used for both keeping cows and sleeps wife and children. Small room is where the household head sleeps. The family works in agriculture on leased in land. Family comprises household head, wife and three children. Elder son studies in class 4 but is currently not interested in attending school. Daughter is studying in class 1. The younger son is not yet of school age.

HHH 2: The household is a joint family of two brothers and their parents. Elder brother has two sons and the younger has one son. Elder brother is a small farmer and labourer. 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.

HHH 3: This house head works as an agricultural labourer as well as a farmer with 56 decimals agricultural land. The family has a son and four daughters. Son is 10 years and does not go to school. He earns for the family by collecting firewood and catching fish. House is made of bamboo with CI sheet roof. The house has only one room for sleeping and cooking. Two elder daughters are studying in class 1 and the other two are minors.

Wherever possible the HHH included primary school-age children. Where this was not possible it was important to include focal households with primary school-age children. Each study team member stayed with each HHH for four-five days, living and sleeping with the family. The only exception was in the urban locations in the central and southern districts where space limitations in the slums precluded staying overnight. Study team members nevertheless spent long days with their HHH, from early morning until households retired to bed.

Focal households (FHH): These households are neighbours or live close to the HHH and are also poor. Approximately 3-5 FHH were included with each HHH (thus approximately 80-130 FHH in total). Interactions were less intense with the FHH and often focused on particular topics (e.g. experience of giving birth, school preference).

Interactions with wider community members: During the study, team members also engaged in conversations opportunistically with other members of the community e.g. while walking or traveling, at gathering places such as markets, tea stalls, clinic waiting areas, etc. Where gaps in terms of participation were apparent, study team members facilitated focus group discussions or PRA sessions.

Key informants: The study team members also systematically engaged with school teachers, School Management Committee members, Guardian Committee members, private tutors, madrasa teachers, booksellers, doctors, nurses, dentists, technical medical staff, field health workers, kobirajs, homeopaths, traditional and skilled birth attendants, diagnostic centre workers, pharmacists, medicine shop owners, Civil Surgeon's staff, Local Government Engineering Department engineers, Union Parishad members, ward commissioners, religious leaders and more.

2.3 The Approach

Whilst the purpose of the study is to gain insights and understanding of the way people view and engage with primary education and primary healthcare the approach 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. The study emphasised *conversations* as the most appropriate approach considering the study team members were staying with their host families. Conversations were conducted at different times of the day/evening and with different constellations of household members throughout the five days.

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 adopted the principle of sensitivity to people's routines and flexibility in relation to timing of conversations.

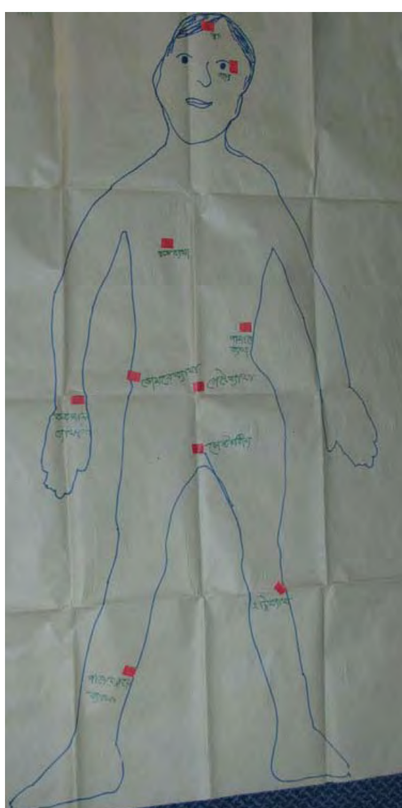
Creating informality by having conversations does not detract from them being focused and purposive in nature. In order to ensure that the conversations were *purposive dialogues*, a Checklist of Areas of Enquiry was developed by the team during the pilot work (April 2007). The checklist takes consideration 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.

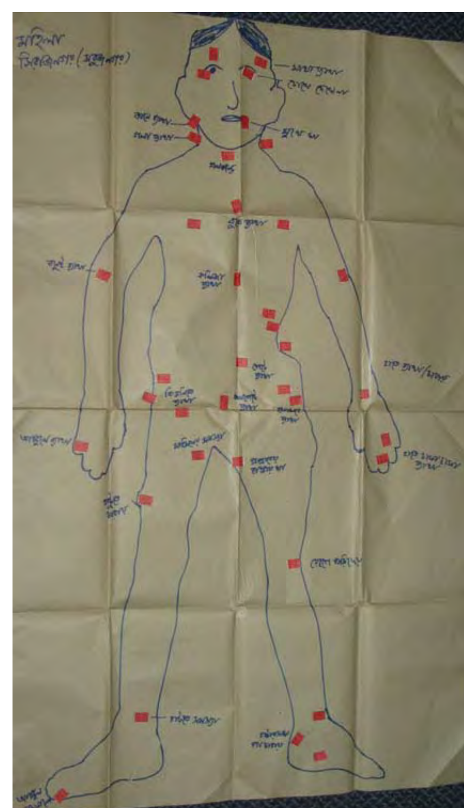
Emphasis was given to appreciative enquiry, reflective enquiry and exploratory enquiry approaches. The team also used a range of PRA approaches which emphasise the use of visualised tools (diagrams, photos, dramatisation and illustrations). These included:

- Community maps showing location of facilities
- Household diagrams showing the layout of the household, assets owned, distance from services and facilities
- Household members 'relationship map' showing each member of the household, their age and relationship to each other
- Drawings illustrating the story of an illness (i.e. sequence of events, key decision points and basis of these decisions, etc.)
- Oral stories and reminiscences of older people
- Drawings/descriptions of 'ideal' school/health facilities (to gain insight into perceptions of quality)
- Matrix ranking of service providers (alternative service providers and the criteria by which people judge them)
- Flow diagrams showing story of a complaint/need to raise an issue/problem solving
- Proportional expenditure/income charts to examine issues of affordability of services
- Body maps of illnesses/ailments
- Children's pictures of what they like/dislike about school, their ideas of an 'ideal' school (to understand their perceptions of quality), what worries/concerns them about school, a typical school day, what has changed (positive and negative) since they started to attend the school
- Children's dramatisation of behaviours they like/dislike at school
- Photos taken by children of what they like/dislike about school
- Drawings, photos of what people like/dislike about health providers and difficulties accessing health services
- Photos taken by young mothers of where they recently gave birth
- Photos taken by elderly of what they like and dislike about their environment

It is intended that this study will build visual stories with the drawings and photographs taken by people living in poverty themselves and complemented by photographs taken by the study team. These visual documentations will provide vivid illustrations of how people see the changes in their lives and experiences and in particular, those which have health and education implications.

Triangulation, or getting multiple perspectives on the same issues, has a rather different purpose in this study than in conventional studies. It is not only used to verify information but rather to explore the range of multiple realities among the poor. These not only provide a wealth of perceptions but also help to fine-tune questions within the purposive dialogues.





Body maps

Far right: Woman's diseases include headache, eye infection, mouth sore, pain in ear, throat pain, goiters, chest pain, heart pain, menstruation irregularities, infection in urinary tract, pain in arm & fingers, sore on legs, joint and leg pains, finger disorder, hand pain & hardness.

Right: Men's diseases include joint aches, urinary infection, heart pain, kidney & liver pain, eye infections. (North Peri-urban)

2.4 Contextual information

In order to put the conversations in context, the study team members also made observation visits and experienced transport and other services such as

- Observation of Government Primary Schools and Government Health Facilities (Upazila Health Complexes, District Hospitals, Mother and Child Health Clinics, Outreach Centres, Immunisation Centres)
- Observation of private schools, Government Registered Schools, private tutor sessions
- Observation of private clinics, NGO clinics, homeopaths, kobirajs, pharmacies, private diagnostic centres
- Experience of travel to schools and health facilities by foot or using rickshaws, local buses and ferries
- Diagnostic experience; team members actually consulted homeopaths and kobirajs on their own ailments

3. Main Findings

As far as possible, the authors have not overlaid their own interpretation of what people living in poverty told them but have tried to present these views without distortion. Where the same views were expressed in several H/FHHs then these have been consolidated into more general statements. All *italicised text in 'quotation marks'* are direct quotes heard during the study. Some of these are attributed to individuals whereas some sentiments were heard repeatedly and so are not attributed but can be read as the views heard directly from several sources.

The main findings from the first Reality Check are presented in two sections; Health and Education.

3.1 Health

Health providers

In all three study districts, the H/FHH in urban and peri-urban locations noted a greater number and diversity of health providers than H/FHH in rural areas (e.g. *'I cannot think of anywhere else to go. It is too far away and too costly so we go to the old homeopath in the market who has looked after our family for years. He looked after my parents and my grandparents and now my family and my grandchildren'* (Woman, rural central). The diversity in the urban and peri-urban locations comprises of a mix of formal and informal, government, non government and private health providers. People living in urban and peri-urban locations identified Government health provision as the District Hospital, at least one Upazila Health Complex, Mother and Child Welfare Clinic and satellite clinics. They invariably mentioned private hospitals which may be either specialist or general, private diagnostic centres, homeopaths, registered and unregistered kobirajs, fakirs and other faith healers.

They also mentioned, but less often, NGO clinics primarily providing mother and child health care but also family primary health care. Many discussed the increase in the number of private hospitals and private diagnostic centres that has occurred over the last five years, '*We never saw anything like this before* (so many private clinics) *but it means some mothers can choose where to go and it is easier to get tests when they need them'* (a dai, urban Central). Whilst rural people are aware of the variety of health service providers, their knowledge and experience of these is limited so they rely on their local health providers to refer them or their family networks in town to advise them on where to go.

Health seeking behaviour shared with us is quite complicated and is shaped by a number of factors. Decisions are influenced by the universally held assumption among the H/FHHs that any health issue which is serious will inevitably result in substantial expense irrespective of the health service provider accessed. The stories of illnesses all indicate that rather than opting for one course or sequential courses of treatment, multiple opinions are sought simultaneously thus muddying the understanding of cause and effect. This strategy is intended to reduce risks and costs but in fact, as the conversations revealed, tends to increase them. For example, if allopathic medicine was being taken and the symptoms did not ease, homeopathic treatment might be sought as well as the services of a fakir. Subsequent choices of health provider are then based on which course of treatment was *perceived* to have brought relief in earlier experiences. *'I had chest pain and had an x-ray. The boro doctor gave me some allopathic medicine, but it made me feel bad. So I changed doctor and went to a homeopath. I feel better now. And the cost is much less.' (Woman, urban South).*

As has been the practice for many years, homeopaths and local pharmacies[4] continue to be the most used health providers by the poor although this may not necessarily be their preference. The H/FHHs generally identified Government hospitals as having the *'best qualified doctors'* but do not use Government facilities primarily because they are *'not for the poor'*. By this they mean that they fear the perceived high costs associated with Government healthcare and worry about being *'cheated by dalals'*. They also feel that the behaviour of the staff who favour better off patients and the inability of Government hospitals to honour the obligations to the poor (e.g. free medicines) means they are not *'good for the poor'*. By contrast, homeopaths and local pharmacies continue to be considered *'poor friendly'* because

- they are open long hours enabling the poor to access services around income earning activities
- they are nearby which reduces transport cost and loss of time
- they are willing to dispense small (affordable) quantities of medicine
- they are willing to extend credit, allow payment by instalments or sometimes waive payment altogether
- it entails little or no waiting time
- they know the patient and the patient knows and trusts them which not only results in personalised service but also facilitates follow up
- follow-up visits can be made at little cost (time and money)
- they take time to explain the diagnosis and course of treatment in ways in which the patient can understand
- may also refer them to a qualified doctor whom they know

Time and cost savings, both direct and minimisation of loss of income earning by the patient or those accompanying the patient, as well as personal relationship are the main basis for use of homeopaths and local pharmacies. Furthermore, there is a widespread belief that homeopathic medicines are *'gentler'* than allopathic ones and are thus preferred for children and women.

By contrast, the perception is that going to a Government facility will *'inevitably'* entail transport costs, long waiting times, *'too brief'* consultations, payments both in the hospital and for *'outside'* tests and *'as hospitals don't have the medicines'* costs for medicines *'from outside'*, repeat visits or costly referrals. It is widely felt that initiating contact will commit the patient to costs over which they have no control. So, a Government facility becomes the choice mostly when the illness or condition is critical and when the inevitability of expense is accepted.

The H/FHHs had very little experience of NGO clinics despite the fact that these all had special programmes for the poor. Like private hospitals, the appearance (smart premises, spacious, clean, uniformed staff, well equipped waiting rooms with TV, water dispensers, reception desk, etc.) often led them to the conclusion that these *'are not for the poor'*. Again there is the fear that entering will commit them to high costs (to maintain these facilities) and non-negotiable referrals for expensive tests. Furthermore, these institutions do not necessarily have the best doctors, as it is felt that these are in the Government hospitals. Our visits to NGO and privately run clinics confirmed that they were mostly staffed by less qualified doctors, student doctors and medical counsellors. Private clinics were only able to offer specialist consultation on Fridays by attracting doctors from Government hospitals, teaching hospitals and private practice to provide services on their day off.

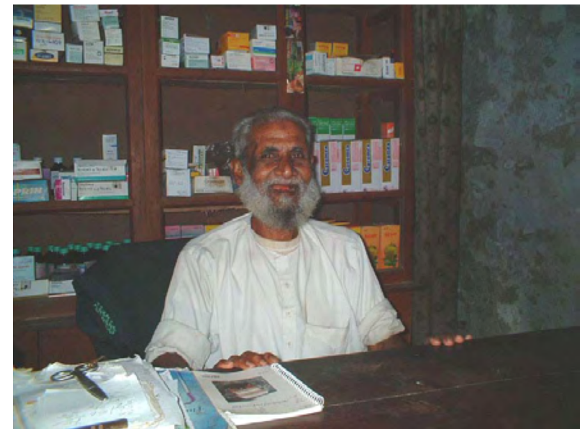
[4] These are basically medicine shops, usually run by staff with little or no pharmaceutical training

Diagnostic centres and pharmacies

The mushrooming of pharmacies and diagnostic centres clustered around government hospitals. These are clearly thriving enterprises used as much by the poor as others.

A typical row of burgeoning private diagnostic centres and pharmacies cashing in on the lack of medicines and equipment in the hospital but *'providing a better 24 hour service'*

The local pharmacy is most used because *'they know us and give us medicines on credit'*. This photo shows how people simply pass the time of day sitting at the pharmacy.



This pharmacist, having given service for nearly 70 years, is the person everyone goes to first for medical consultation. He has advertisements all over the walls of the shop in the market place for private clinics and diagnostic centres. He will also accompany patients if necessary.

People living in poverty say:

Health providers findings

- there is more choice of health providers in urban and peri-urban including note of the recent proliferation of private hospitals and diagnostic centres
- they still prefer homeopaths and local pharmacies to Government or NGO health facilities because they are '*poor friendly*' and save time and expense
- they fear going to a Government or NGO facility as it commits them to high costs out of their control
- Government facilities have the best doctors and are therefore preferred for quality treatment

Special measures for inclusion findings

- they know that hospitals have free medicines for the poor but these are either not available or considered generic and cheap so not worth getting
- they are more inclined to go to the Government hospitals now (since the Caretaker Government) as there are more medicines available
- medicines for diabetes and heart disease are not among those provided free and yet many poor suffer from these health problems
- NGO field workers and trained SBAs now have a commercial orientation and don't serve the poor
- the community clinics which served the poor in the past are closed and should be used again

Special measures for inclusion

Policy dictates that Government hospitals should provide a limited range of free medicines[5]. All the H/FHH knew that there are supposed to be free medicines in hospitals. In the South, H/FHHs felt that provision of free medicines is both a *'poor friendly'* and *'sufficient'* measure for the poor if indeed the supplies could be guaranteed. All the Government hospitals included in this study faced serious supply problems in the recent past that had resulted in a feeling among the H/FHHs that the '*only provision made for the poor*' is denied them. The lack of medicines raises suspicions that '*The Government supply of medicine is sufficient but the hospitals still has insufficient supply. Something is going on that is causing shortage for patients. Someone at the hospital are selling medicines to pharmacies*' (South peri-urban).

There is also criticism that the medicines that are available are the cheapest generic painkillers and antacids[6], '*Cheap white pills that do nothing*' (Man, urban central), '*We can get these cheaply without having to go to the hospital so why waste time going?*' (Woman, peri-urban Central). However, since the take over by the Caretaker Government, many of the H/FHHs say that both the quantity and range of free medicines is improving. To validate this we compared data from the Civil Surgeons office for September 2006 (pre Caretaker Government) and September 2007 (8 months after Caretaker Government take over) in one district which confirmed that out-patient numbers had doubled in district, sadar and upazila hospitals. Patients and medical staff we spoke with attributed this to the availability of free medicines.

Some Government doctors we talked to said they will only prescribe what is available free so that '*the poor don't have to pay*'. Some Government hospital dispensaries told us that they suggest patients go back to the doctor to have prescriptions changed if they do not have it in stock. Whilst this is intended to benefit the poor, it also results in them being prescribed painkillers when antibiotics is what are actually required. These practices were described to us by our H/FHH '*What is the point in going to the hospital if they don't have the medicine I really need?*' (Woman, urban central), '*The medicine I got from the hospital didn't work*' (Girl, peri urban Central).

Whilst there is evidence of an appreciation that free medicines are once more becoming available in Government hospitals as they had been in the past, this is tempered by the fact that out-patient queues are now longer and the range of medicines available under the Essential Drugs Programme is quite limited. 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*'.

The Department of Social Services operates a subsidy programme for the poor but only in Medical College Hospitals and District Hospitals. This facility was only mentioned by our H/FHH in the district in the North. H/FHH indicated that Government policy for provision of health services for the poor was good but that the interpretation of the policy resulted in extra costs, *'It is the local administration which causes the problems'*.

[5] There are 41 essential drugs provided under the Essential Drugs Programme free of cost.

[6] An antacid counteracts stomach acidity, i.e. a stomach acid neutralizer

Government outreach programmes (family planning, immunisation, nutrition) are generally subsidised but often 'service charges' are made. Some H/FHHs shared an unwillingness to participate in the nutrition programme for infants because the nutrition supplement[7] sold by nutrition programme workers had become too expensive. Furthermore, there is a perception that training of Government field staff (e.g. skilled birth attendants - SBAs) leads them to become commercially oriented, *'They have a big bag and now they think they can charge a lot for their services'*. A doctor also supported this assertion on the basis that bribes are required to be selected for SBA training, suggesting qualification must therefore lead to enhanced income earning opportunities. Similarly, our H/FHHs see the practice of NGO health workers being employed on a commission basis rather than monthly wage (they earn their commission on medicines sold and referrals made) results in a diminished service for the poor who prefer to avoid the pressure to buy medicines and cost implications of referral.

It is very difficult to get to hospitals early in the morning. These two photos illustrate just one journey that community members have to make in the South.

Community Clinics usually located in the heart of the community are in poor condition and remain mostly locked and largely unused except for monthly immunisation and nutrition clinics. Our H/FHHs highlighted this waste of resources and the need for more local level health service provision.

Despite claims by NGO-run clinics to have special programmes for the poor, our H/FHHs are generally not aware of these. The clinic staff themselves told us they recognise that their programmes are limited[8] and they had difficulties deciding who should benefit despite undertaking quite elaborate participatory surveys.

Although prevalent in other districts, there is no mention of any free Friday clinics (often sponsored by the private sector) for the poor in our study areas.

Costs

As mentioned in the discussion on health providers, cost implications are a major concern in decisions about health seeking behaviour. To avoid costs for what are considered minor ailments, our H/FHHs will go without treatment, buy few tablets (often only enough to assuage the symptoms rather than affect a cure), change food habits or delay treatment hoping they will get better. *'Sometime we cannot take the full course of medicines prescribed by the doctor due to financial crisis, as a result we suffer for a longer time'* (Old woman, North peri urban). If they do seek treatment, they will use the health provider who will accept payment in instalments or waive it altogether; these are generally the homeopaths and local pharmacies.

There is a general acceptance that serious or emergency health problems will incur huge costs. They explained that these are usually met by drawing on family or social networks as well as false applications for NGO loans. Very large sums[9] are paid out and often have to be mobilised very quickly. The impact of a health crisis on a poor family is huge; our H/FHHs told of severe indebtedness which necessitated taking children out of school for employment, concern about education costs and raising adequate dowries for their children, reduced food intake, elderly having to continue working and high levels of physical and emotional stress, selling land, etc.

If one arrives in the hospital in the morning, the queues are huge and the system chaotic.

[7] A mix of wheat, rice powder, molasses and other nutrients

[8] Although some promised private sector philanthropy may enable expansion of these special programmes

[9] All team members heard stories of illnesses which cost poor families Tk10,000-Tk50,000

People living in poverty say:

Costs findings

- cost of health is a big problem. Only 'serious' illnesses warrant hospital or clinic visits
- large sums of money have to be mobilised quickly for serious ailments, through family and neighbours and false NGO loans
- diagnostic tests are mostly done in private centres and this is often preferred as it is more efficient use of time than using Government facilities.
- if diagnostic tests are not offered then they feel that that they are getting sub-standard care
- brokers are less active in health facilities since the Caretaker Government
- some government doctors make money by encouraging out of hours consultations and persuading patients to have tests and buy medicines
- with serious illnesses, they take multiple routes towards cure

If one arrives in the afternoon the story is very different.

The high costs associated with serious ailments are not just direct costs but include the need for family members to act as chaperones (for women and children) and attendants (caring for the hospitalised patient) or to provide child care where mothers are ill. This entails loss of income and transport cost, particularly acute in rural areas.

H/FHHs felt that there is increased pressure to have diagnostic tests. This pressure is put on in Government hospitals and NGO clinics. Often these cannot be done at the Government facilities because they do not have the facilities, or equipment is broken or there is insufficient technical staff, so most tests have to be carried out at private diagnostic centres at *'high cost'*. Our H/FHH often told us that they thought there was an *'unholy alliance between the doctor and the diagnostic centres'* and that they suspected this practice of referral for tests was to make money.

The decision to use private diagnostic centres is not always based on the unavailability of Government services but also may be proactively taken by the patient because;

- they are open as much as 24hours
- they provide instant results for most tests
- multiple tests can be done at one time

in contrast to the very short opening times for Government diagnostic facilities, the need to make subsequent visits to get results and attend different tests on different days. H/FHHs felt angry that government doctors expected them to make so may re-visits.

As well as pressure to have diagnostic tests, there is a growing demand for diagnostic tests from patients themselves. It is felt that if a doctor does not refer a patient for tests, then s/he has *'not taken the illness seriously'* and is giving sub-standard care to the poor.

The practice of 'speed money' and dalals acting as brokers in Government health facilities is regarded as less prevalent than it was previously. H/FHHs partly attribute this to the Caretaker Government. Our observations in hospitals supported this assertion as new signs warning people not to take the services of anyone other than medical staff were much in evidence. Both our H/FHHs and medical personnel told us that Rapid Action Battalion (RAB) and other officials make routine surveillance so *'everyone is more alert'*.

Registration fees are being charged in some Government hospitals but not all. There is still evidence of the practice of doctors running out-patient clinics at Government hospitals charging 'unofficial fees' for *'better treatment'* and encouraging them to attend their private chambers. There is a suspicion that when doctors prescribe medicines which can only be obtained outside the hospital or require diagnostic tests which can only be done outside the hospital that s/he is benefiting financially from this. H/FHHs told of requests for multiple diagnostic tests and sometimes repeat tests to substantiate this claim. We observed some diagnostic centres and did meet patients who had been told to get a surprising variety of tests which did not tally with conventional health diagnostic algorithms.

The common practice of getting multiple opinions and seeking help from a variety of health providers simultaneously or sequentially incurs high costs. Many shared stories of the costs incurred. They were frustrated that each time they went to someone new they had to start afresh and have the same tests repeated. It seems records are never passed on (even from UHC to District Hospital) so inevitably diagnostic tests are often repeated and conflicting courses of treatments given. We heard many instances of courses of treatment being cut short because of the cost and even prescriptions being torn up.

Health Facility Functioning

Opening hours for Government hospitals (usually 8:30am till 2:30pm) are criticised everywhere as being both inappropriate and too short by poor people. Where people have to travel long distances it is very difficult to reach the hospital in the morning. Mornings are associated with maximum earning opportunity for many poor (market vending, labouring, rickshaw pulling) and so income loss as a patient or chaperone is more significant than if it was later in the day.

In all instances, availing Government services are associated with long waiting times often as much as four hours. H/FHHs said that they had to get to the health facility early to get registered but then '*just wasted the day waiting'*. The long wait is made worse by inadequate or no seating arrangements, overcrowding, lack of clarity on procedures to see a doctor, lack of access to drinking water, inadequate toilets and no provision for nursing mothers. As mentioned above the improvements in free medicine provision has resulted in the negative consequence of longer waiting times.

The H/FHHs complain of perfunctory consultations with doctors when they finally get to see them. They estimate that they may have about 2-3 minutes. Our analysis of out-patient statistics in one area and observation of numbers of duty doctors confirmed that this estimate is a maximum amount of time rather than average time available for consultations. Patients do not even '*have time to sit*', are physically examined standing up, if at all, and given a prescription (relying only on patients own description of symptoms) often without any explanation of the diagnosis or the nature of the treatment. '*We would feel good if doctors touch the patient's body with sympathy but we hardly ever experience that*', (Man, rural South). Very few H/FHHs could explain what doctors had told them when asked what their diagnosis was.

Our H/FHHs complained about the lack of privacy during consultations at Government facilities. Several doctors sit behind one table (sometimes several to a consulting room, sometimes in the public waiting area) and patients are called up together. This is a particular problem for gynaecological cases. Our observations of out–patient clinics confirmed this. In one health facility the waiting room was commandeered by doctors and patients crowded round tables each with three doctors consulting at the same time.

Our H/FHHs told us about the problems of insufficient beds in hospitals and having to pay bribes or lie on the floor. This was confirmed by our observations at all the Government health facilities we visited where we found overcrowding and patients required to lie on the floor. We noted that diarrhoea patients were required to lie on beds or the floor in corridors as they are not permitted in the wards. Although not from our H/FHHs, these patients and their families told us how embarrassing this was for them. We observed in several instances new construction was in evidence or promised at the UHCs to alleviate these problems.

Our observation though not endorsed by perceptions shared by our H/FHHs is that the functioning of a Government health facility is strongly linked to the attitudes and behaviour of the senior staff rather than the nature of the facilities. For example, one very poorly equipped and old UHC provides excellent service due to the vision and motivation of the senior doctors. Whereas another with better and newer facilities opened late, was dirty and left a dead body on view in the main thoroughfare from 9pm until after 5pm the following day.

Our H/FHHs were of the opinion that the Caretaker Government has had a profound effect on the functioning of Government hospitals. The most obvious of these being cracking down on dalals, ensuring

Since the Caretaker Government....

Many information and monitoring notices are now in evidence on hospital walls, this one lists medicines which are available. However, few patients can read the notice.

The clean sheets and clean wards are said to be because of the checks undertaken by the Caretaker Government.

There are also twice as many people coming to out–patients because free medicines are available.

People living in poverty say:

Health service functioning findings

- the opening hours for Government facility out-patients are too short and too early in the day
- waiting times in Government health facilities are too long and the waiting facilities are poor (lack of seats, toilets, drinking water, lack of information, no facilities for breast feeding etc)
- there is no privacy when talking to the doctor and consultations are too quick, do not include physical examinations and doctors don't explain things sufficiently
- there is often a shortage of beds for in patients and bribes are sometimes required to secure one
- the functioning of Government health facilities have improved since the Caretaker Government; e.g. enhanced punctuality of staff, fewer dalals, less unofficial costs and more

Complaints system findings

- they prefer not to complain in Government health facilities in case this jeopardises future treatment
- complaining to local government officials and hospital staff is pointless because they are not taken seriously as they are poor
- they cannot complain in UHCs about doctors behaviour as there is no one senior to complain to

punctuality, stopping doctors seeing private patients during general clinic hours, curbing *'under the table payments'* to doctors and enhanced supply of medicines. In addition, health staff told us that there has been a difference made by prohibiting pharmaceutical company representatives from making visits to doctors during hospital opening hours and politically sponsored Trade Union activity has been curtailed. We noticed on our visits to Government health facilities that there are many public notices regarding health charges, monitoring data and notices warning people not to use dalals.

Doctors told us that one constraint to providing good service to the poor are the many demands made on Government doctors' time for (generally) project-sponsored training. This *'causes severe staff shortages at times'*. One doctor quipped that it is *'Not good news to get ill in May and June because all the doctors are on training' (Central).*

Our observation and discussions with doctors point to the limitations of the 'one size fits all' policy of construction, equipping and staffing standard of UHC facilities. It seems no regard is given to local catchment size, consideration of the prevalence of other service providers in the area and without consultation with local health professionals let alone communities served. For example, one 'standard UHC' in our study area in the North serves only two villages. In another area, doctors told us that one of two compared standard UHCs (both accessible by our H/FHHs) is *'much better'* because it only serves nine paras and not the twelve served by another one. Another *'runs out of free medicines because it serves a large area'*. Yet another has a fulltime gynaecologist and anaesthetist but no facilities for Caesarean sections. And in another, full-time technicians are posted where there is no functioning equipment (diagnostic labs, X-rays). Although these observations were not made by H/FHHs they explain some of the reasons why they do not go to Government facilities (*'can't get tests done', 'no medicines', 'long waiting times', etc.)* Just one example illustrates how this wasteful allocation does not go unnoticed; *"I know that the UHC has no ambulance but a driver has been posted who is working as house staff of the UHFPO"* (Man, rural North).

Complaints systems

Despite the programmes and literature to the contrary, we did not come across any functioning health watchdog committees in any of the study areas. In one location, an NGO has been active in mobilising people to raise their voice on many issues including health services, but had been threatened by the Thana Nirbahi Officer (Sub-District Administrator) as a result. Having changed its name, the NGO is once again active. In the same location a civil society anti-corruption group had successfully brought about the closure of unregistered pharmacies.

Generally, however, our H/FHHs knew of no formal complaints system operating in the Government health facilities. Our H/FHHs felt that they should not complain for fear of jeopardising treatment in the future and because they would not be taken seriously since they are poor. *'I am not ready to raise complaints in the hospital. If I do so I would not get any service in the future as they will recognise my face'* (Man, rural South). They indicated that they could take complaints to local Government officials but felt there was little use. They could not raise complaints about doctors in UHCs because *'there is nobody senior to complain to'*. Another commented *'If we do not get proper service we don't feel encouraged showing our face there again. But in fact, we cannot act according to our choice, despite our dissatisfaction. Due to lack of money we have to re-visit the place',* (Man, rural South). One patient was told when he complained to hospital staff, *'I am doing a Government job not yours',* suggesting that he did not consider himself as accountable to the patient.

One NGO clinic was operating a simple pictorially based feedback system for patients to describe their satisfaction with services thus demonstrating that a system can be introduced for a largely illiterate client base.

Quality

Quality in health care is defined by our H/FHHs as

- getting cured speedily
- being given respect and attention
- being given time and clear explanations of diagnoses and treatment
- continuity i.e. being able to see the same person on subsequent visits
- not being asked to make frequent return visits or diagnostic tests

Cleanliness and new equipment, for example in many NGO clinics, tends to engender fear that the service will cost a lot and is *'not for the poor'* (meaning someone with dirty clothes and no shoes). As mentioned above, most generally acknowledged that Government hospitals have the *'most qualified'* doctors.

Most of the Government facilities we observed were poorly maintained and not very clean. Toilets were smelly and dirty. Bed sheets were, in most cases, dirty, torn or non-existent. Food and waste medical materials (used bandages, cloths) were under beds in the wards and used syringes and dressings were evident in corridors and outside. A cat wandered unheeded through one ward. Our H/FHHs acknowledged the lack of cleanliness but mostly seemed to accept this rather than complain about it[10]. Cleanliness was not usually among the criteria of healthcare quality. Although one young daughter of a FHH told us that when she grows up she wants to be a doctor *'And make sure the poor have clean sheets and better food in hospital'. And* another recent female surgery patient noted *'The food was awful, it made me sick so they had to come with food from my house. Everything was dirty and smelly. I had no bed so had to stay on the floor. The behaviour of the people there was bad'.*

H/FHHs attribute poor quality in Government hospitals to a lack of supervision. More remote and/or difficult to reach (poor road, riverine access) UHCs are rarely monitored, they felt.

Whilst we did hear examples of rude behaviour of doctors and nurses towards the H/FHHs (in particular being abrupt or disrespectful), we felt this was less than we had heard in similar studies conducted in the 1990s where it was very prevalent. Our H/FHHs seemed to accept that the doctors *'have a lot of people to see and not much time'* and *'don't think the poor will understand'.* Although the speedy disposal of patients in out-patient clinics leads some to *'doubt the diagnosis and the treatment',* the doctors competence is not in question. Young health personnel are particularly liked as they *'give us time and smile'* whereas nurses *'see us with gloomy faces'.* Courtesy and kindness rank high amongst the list of reasons why poor people go to particular service providers. In two hospitals in different districts there was evidence that medical staff either had taken initiatives to help distressed people in their own time (out of hours) or would do so because *'it's the humanitarian thing to do'.* But the perception that doctors are only interested in making money and their own private practice still persists.

People living in poverty say:

Quality Findings

- the courtesy, respect, kindness and being given attention and time by health staff are important criteria of quality of care. Young doctors are better at this than older doctors
- although acknowledging that cleanliness is a problem in Government health facilities this is not a deterrent as they have the best doctors. Ultra clean modern facilities are not for the poor and will cost more money to go there
- poor quality in Government health facilities is due to poor supervision

This sink is in a new District hospital. It is the only washing facility for out-patients and yet it has not been plumbed in.

[10] These comments relate to the idea that the smart places are not for them whereas they do not expect better if they are poor.

Access to information

As indicated above being given adequate information about one's diagnosis and treatment is an element of a patient's assessment of quality of healthcare. However, our H/FHHs felt that Government doctors were the least likely to provide this compared to others. We heard many stories of consultations with doctors which left patients confused. For example M told us that '*My husband had pain in his tooth for a very long time. We finally went to the hospital and paid only Tk6 for registration. The doctor told us there was no serious problem, only a toothache and told him to have a blood test. He was found to have diabetes and heart problems. We paid for medicine outside and now he is better.'* Despite lengthy discussions about the implications of the diabetes and how they coped, M was not able to explain anything. They were just happy that he did not have a toothache anymore. The poor provision of information by Government doctors is explained by some as partly being due to time pressure but others felt that '*doctors are rude*', '*think we are ignorant and can't understand*' and '*don't want to serve the poor*'.

This is a male ward but women have been put here becuase there is no room in the female ward. There are no sheets on the bed and the facilities are spartan.

Government facilities do not have an information desk. The reception area is only for registration and issuing of tickets to see the doctor. Our H/FHHs said that it was not easy to get information in a health facility and there was nobody to ask. They also indicated that in the past that this was one reason it was so easy to fall prey to dalals because they offered to help.

As indicated above, we observed more information boards posted in the Government hospitals compared to recent past. These exhort patients not to use dalals, provide information on pathological tests available and prices, free medicines available and some hospitals have monitoring boards which display key indicators. The last two are supposedly updated daily. In one hospital patients are issued with a patient card on which is printed a reminder that doctors are not permitted to practice privately during hospital out-patient hours but that patients can contact doctors for private consultations after this time. This information not only protects patients but doctors we spoke to felt it eased the issue of having to refuse special treatment for influential people during hospital time too.

This is an example of the poor equipping of hospital laboratories. There is no fridge and only a hand-operated centrifuge.

Unfortunately the lists of pathological tests and medicines available are not readily understood by the average patient and go largely unread and unnoticed. We talked to many waiting patients and asked them about the notices and they could tell us very little. So although this information is available it is not contributing to improved transparency.

Our H/FHHs mostly get information about prices and facilities from each other and local pharmacies. Generally, there seems to be more frequent and more informed sharing of health provider information among the poor in urban and peri-urban locations than in rural locations, where there seems to be an acceptance of limited choice and a reliance on outside connections to manage health seeking arrangements on their behalf in times of crisis. As mentioned above, our H/FHHs felt that they do not get enough information from Government doctors about their diagnosis or the treatment.

This shows the state of the only toilet in a UHC.

Why do some actively opt out?

Some H/FHHs told of times when they actively chose not to seek treatment. This was because of lack of money, fear that once started it would commit them to large expenditures as well as due to poor roads and difficult journeys.

Some older people told us that they opt out because they *'are at the end of their lives anyway'* and see expenditure on their health as a waste of resources. Part of this decision often also involves a traditional faith in local fakirs or kobiraj. Consequently, tabiz and other cures were more in evidence among the elderly adults. Younger adults told us *'The elderly believe in old time cures'*.

Government hospitals are frequently criticised as being *'not for the poor'* and going to hospital is equated with only extremely serious cases and therefore an association with dying. *'If I am going to die anyway, why take me to the hospital?'*

Maternal Health

In all locations in the study mothers and families indicated a preference for home delivery. Unlike the situation for general health where this decision is not so much based on preference but practicalities, with maternal health, this was an expressed preference because the traditional birth attendant (dai):

- is known to them (may have delivered them into the world, has delivered other relatives and knows the family)
- is available 24 hours
- lives close by so can be called at any time
- is kind and considerate and *'like a mother'*, provides reassurance
- can provide help before and after the birth

and because the surroundings for giving birth are familiar, family is around for support and it is traditional[11].

More than one doctor confided their feelings to us that home deliveries should be encouraged as the *'most unhealthy place to have a baby is the Government hospital'*. Our observation of delivery rooms tended to concur with this[12]. Mothers told us that going to a hospital to give birth was *'frightening'* and taking this decision implied there was some risk or something was wrong. Having trust in the people helping in the birth is paramount, they felt. They (particularly male family relatives in the conservative Northern district) are concerned that male doctors would attend the birth.

Traditional birth attendants (dais) are preferred over skilled birth attendants (SBAs) who are perceived as commercial (see 'Special Measures for Inclusion' section above) and often refer late or not at all, *'wanting to make money themselves'*. One SBA commented that this is because they *'feel I will be blamed if the referral results in loss of the baby' (SBA, Central)* and that people believe they are *'making money from the referral' (SBA, Central peri-urban)*. H/FHHs also indicated that they feared that SBAs would insist on referral resulting in the H/FHHs losing control and being committed to subsequent expense.

[11] Young children could describe the arrangements made for a birth and what happens in great detail

[12] E.g. one had not been cleaned two hours after a delivery had taken place, another had a delivery table which was torn and soiled.

People living in poverty say:

Access to information findings

- Government doctors are the least likely compared to other health providers to give information about one's diagnosis and course of treatment
- it is difficult to get information in Government health facilities and this has made them vulnerable to dalals
- cannot read the notices in Government health facilities
- they mostly rely on informal channels (neighbours and family) for information about health services, costs etc. Rural poor rely heavily on their 'more knowledgeable family members in towns'

Maternity findings

- they always prefer home deliveries as it is familiar, reassuring and supportive. Going to a health facility suggests there is something wrong and it is more frightening, unfamiliar and costly
- traditional dais are preferred over SBAs who want to make money
- families take more care about mothers' nutrition than previous generations as they have learned about the importance of this from field health workers
- mothers are expected to do ultrasound tests to be sure the baby is alright
- there is a growing practice of dais giving mothers saline before the birth but it is not known why

H/FHHs themselves spoke of a strong commitment by almost all mothers and their families to ensure that the mother ate well during her pregnancy and a concomitant awareness of the need for immunisation. This, they say, is a major change from their mother's generation. As much as anything this seems to be a way to avoid possible costs at the time of the birth and following the birth and is another demonstration of people needing to *'take control of their own health'*. Most attributed the rise in awareness to the work of roving Government and NGO field health workers and their dedication to promoting behaviour change. Some H/FHHs indicated that since awareness of immunisation and nutrition is now rather good, more attention should be given to identifying 'at risk' mothers and the very poor that still need this kind of counselling.

There is a growing trend to access ultrasound (USG) among our H/FHHs. It seems that mothers are being advised to get this done by medical professionals (Government, NGO and private) to *'check if everything is OK with the baby'* or even '*to check if the baby is alive'*. We met pregnant mothers, who could ill afford this, who had had three or more USGs[13]. They could not explain why and showed us very poor blurred images which they had been assured were healthy babies. Other young mothers who could not afford USGs told us they felt ashamed because it seems like 'we *are not good mothers'*. However, some mothers had asked themselves for USG because they thought the baby was in a different position than previous pregnancies or *'felt different'*. There was some suggestion in an urban location that mothers with girls already were using USG to check if they were carrying boys with the intention of terminating girl pregnancies. Our view of the increased trend to refer mothers for USG is that health providers are making money and enhancing their status by offering modern technology when in fact these are mostly unnecessary.

Home delivery is always preferred

This is baby Parveen, she was born two months ago at home on this bed (below). The Dai lives close by and kept a 'good eye' on the mother as she was nearing delivery. Everyone respects the dai as she is devoted to her work and comes out any time of day or night (Central urban area)

Another increasing trend is the practice of providing saline injections before giving birth. Many of the dais we talked with explained that this was something they had learned recently (and given as evidence of their '*keeping up to date'*) as it helps the mother to push harder and '*gives more pain'* which is '*a good thing'*. Mothers said that they were advised to do this and accepted it. Our medical research team member says that this practice has no merit and has been adopted widely by dais who have heard about this from local pharmacies and feel it gives them more credibility. Basically, she feels the practice is nothing more than another way to make money.

3.2 Primary Education

Primary education providers

Except in the Southern district, there are more schools and more options in urban and peri-urban locations. When asked about the different options for sending their children to primary school our H/FHHs mentioned Government primary schools, registered non-government primary schools (previously or currently NGO run or local initiative schools), non-formal schools and registered and unregistered madrasa. Private schools and coaching centres were also mentioned, particularly in the urban and peri-urban areas. Some H/FHHs were sending their children to these which is contrary to the myth that these are only for the relatively well off. We visited some of these schools and found that they have been set up to provide a genuine alternative to Government primary schools; offering smaller classes, wider curriculum and '*more*

[13] Tk400-600 each

attentive teachers'. Our H/FHHs and other poor parents chose these options instead of paying for extra coaching which they feel is essential to supplement the inadequate teaching at Government primaries.

Private tuition (outside of school time) is prevalent among our H/FHHs and even where not availed it is talked about and seen as a means *'to get on'*. The logic is that a good education is necessary to have *'a better life than the one us parents have'*, a good education cannot be received at a Government school so private tuition is essential. Our H/FHHs told us that tuition is provided by primary school teachers, high school students and some private commercial tutors. Despite the commonly held assertion that private tuition is mostly the domain of primary school teachers (to supplement their meagre salaries) our H/FHHs told us that in fact many children avail tuition from high school students or teachers other than their own.

Madrasas were present in all the locations but as a choice for local children's primary education the madrasa were rarely mentioned except a girls' madrasa in one rural location which was quite well supported. Some H/FHH children attended the madrasa before or after school for religious instruction. The madrasa often provide residential facilities and food and we were told that most of the residential boys are not from the communities. If the madrasa admits day students these are likely to be local boys sent because they are unruly or disruptive at home, to ease the financial burden on the family or *'less often'* for purely religious reasons.

Where BRAC[14] schools were present, they always ranked first as the school of choice among our H/FHHs. Housed in simple structures, our H/FHHs parents liked the fact that they are usually located within the community thus conferring some measure of security for their children, that they teach songs, drama and organise other cultural programmes and, most importantly, their children *'like going there'*. No uniforms are required although many wear them and few other costs are incurred.

Special measures for inclusion

The Government's Primary School stipend programme[15] only operates in rural and peri-urban locations. Some urban H/FHHs questioned this and felt it was unfair. *'Do they think that there are no poor people in the towns?'* In some of our rural H/FHHs, children had been sent to live with them from the urban area specifically to avail stipends. These stipends were then used to pay for private tuition.

The stipend programme is valued by the H/FHHs who benefit from it not just for the money it brings into the family but also for the public acknowledgement that their child is attending school and passing exams. Some teachers, students and some parents indicated that stipend students might also be teased for being poor. Parents will send siblings to different schools if this option is available so that each can avail the full

This dai is surrounded by some of the many children she has brought into the world (North rural area)

Baby Arif wears several tabiz to make sure he grows strong and healthy. *'It worked for his elder sister'*.

This little boy was born in this house on the mud floor in the corner. The mother was happy to have her family around and the dai is her auntie. They put straw on the floor and that is all (Central rural area)

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[14] BRAC works closely with communities particularly in rural areas to establish schools for primary school age children who have never enrolled in school or who have dropped out. Started in 1985, this programme is part of BRAC's Education Programme. Simple one-room buildings are constructed in the community and a local teacher is recruited to provide a four year programme which covers Grades1-5 of the Government programme. The schools are regarded as temporary and have little in the way of furnishings but emphasise play, experiential learning and parental involvement.

[15] The primary school stipend is awarded to 40 per cent of poor children in all rural schools if they meet the minimum criteria for attendance (85 per cent of days) and achievement (marks of 45 percent). The stipend is Tk100 per month and where there is one younger sibling attending the same school (meeting same attendance and achievement criteria) the payment is Tk125.

People living in poverty say:

Primary education findings

- there is more choice of school in urban and peri-urban locations including private schools, which some poor families are prepared to pay for
- BRAC schools, if present, are always preferred

Special measures for inclusion findings

- stipends should be provided in urban areas as well as rural. Some parents are sending their children to live with rural relatives to avail the stipend
- stipends are highly valued for the money (which may be used to pay for coaching) as well as the status
- they suspect corruption because the elite are on the committees, some poor do not get the stipend, non-poor get stipends and deductions are made without explanation
- some children with minor disabilities are excluded from school by their parents who think it is not worth sending them or not encouraged to attend by teachers

stipend[16]. Stipends are so sought after that parents and teachers told us that there is inevitable manipulation and conflict. Teachers said that they feel under pressure managing the stipend programme and begrudge the time spent dealing with complaints and settling disputes.

Our H/FHHs shared examples of what they felt was corrupt practice. We were told that competition to be elected (or more often selected) onto the School Management Committee (SMC) can be fierce as this secures decision making power over allocation of stipend resources. Large sums of money were quoted to us as having passed hands as bribes to entitle a person (*'an elite'* or *'political person'*) to membership of the SMC. It was difficult to know how accurate these stories were and how much is just rumour but the stories were repeated over and over from many different sources. When a SMC is infiltrated, we were told that it *'is easy'* to manipulate the stipend lists in favour of families who may be influential, family or neighbours, or take bribes for inclusion on the list. It was explained to us that vacant spaces on the stipend list (through student drop-out, or failure to meet the ongoing eligibility criteria) are not filled but the money is still *'given out'* and that false names are included in the lists. Some head teachers were implicated in these malpractices, while others were, it was felt, coerced (having little option because they were new or non-local and therefore subject to pressure by local elites). We met with some of these teachers and SMC members and looked at records and visited homes of stipend students and it does seem that our H/FHHs may have grounds for their suspicions.

There also seem to be procedural misunderstandings. Most SMCs and teachers explained to us that they used *merit* as the first criteria to select students for the stipend. Among the best students, they then select those who are *'poor'*. The definition of who qualifies as being poor is extremely vague and most teachers and SMC members we talked to simply said *'We know who is poor'*. This lack of transparency leads to both confusion and discontent among those families who feel that their children meet these criteria but are not selected. There were many stories of families getting stipends that were considered 'well off' and families who deserved stipends not getting them.

Policy states that the stipend payments should be made through a bank official. We only came across this in practice in one location. In all other known cases, the head teacher is making the payments and this is regarded by our H/FHHs as normal practice. Even where the bank official is involved teachers told us that they have to be on hand to interpret and verify guardians' photo ID cards as many use old and faded/unrecognisable photographs. Many H/FHH showed us their ID cards and many would indeed not be recognisable.

H/FHH parents complained not only of a lack of transparency regarding the selection of students to receive the stipend but also about withholding part of stipends. Teachers told us that they deduct pro-rata if days are missed but some parents were unaware that their children had been absent from school. The public nature of the payments leads to many parents saying they felt *'ashamed'* because of stipend deductions and more than one H/FHH told us how they had beaten their child because of deductions, primarily because of the public humiliation. Sometimes, parents complain that no explanation is given for deductions. *"I am a poor widow and sending my son to school depends on the stipend. But I do not know why the stipend amount has decrease this year? I will not be able to continue education of my son if it goes like this."*(Mother, peri-urban North).

[16] Second and third children get a reduced stipend if attending the same school.

The tendency is to suspect malpractice whether this is in fact the case or not. Teachers told us that they hate the fact that they are constantly under suspicion and administering the stipend programme has negatively affected teacher-parent relations. A church school in the Southern district shared with us impressive case files for each child so that progress could be tracked. This simple system of preserving documents, they said, prevented parents accusing them of manipulation. One head master had devised his own system to ensure equity, *'To retain all students in the school I generally distribute the total available stipend amount to more poor students. I also try to fulfil government criteria by manipulating attendance and result sheet. I do this mainly to save this school and continuation of education of poor student. But I will never confess this statement in front of the education department officials'* (rural North).

Apart from the stipend there is little evidence of other programmes for the poor. Our H/FHHs told us of old programmes which made donations of uniforms or books to poor students through local philanthropy but which *'don't happen now'*. Some schools, notably registered non-Government primary schools are seen as being more relaxed about insisting that students wear uniforms and some H/FHHs felt this was to help poor students. However, some teachers told us that they feel that uniforms cost less than the alternative clothes the pupils come to school in and that parents are not really benefited by waiving the uniform regulation.

Private school – small classes and individual attention is what parents look for (Central peri-urban)

None of the madrasa we visited charge fees and are, instead, supported by mostly local donations. They also provide food for all students. It was not clear if attendance by local children is linked to being poor as none of our H/FHHs attended these.

There were many children in our study areas with disabilities and some in our H/FHHs. These included mental retardation, deafness and physical disabilities resulting from rickets and polio. Some had been to or were attending primary school but relatively minor disabilities (e.g. slight deafness or minor mental disability) are used by some parents as reasons not to send the child to school, *'She cannot concentrate and forgets everything so what is the point of sending her?'* (Mother, urban Central, referring to her daughter with moderate learning disabilities). *'Teachers don't have time for children like my son. We will always have to look after him'* (Father, central urban regarding his slightly deaf son). Looking at school surveys carried out by the primary schools in our study areas we found that they either ignore children with disabilities as *'not able to go to school anyway'* (so do not record them in the survey) or only record students with extremely severe disabilities in which case the numbers are very small. Teachers told us that children with disabilities *'cannot keep up'* and did not suggest that they should be included in the class room. Physical disabilities such as paralysis resulting from polio or deformity resulting from rickets are not seen by parents as an impediment to primary education but is for accessing higher education, mostly because of the distances required to travel. Teachers and SMC members at schools where construction was being carried out showed us that the new designs include ramps for wheelchair access (as confirmed in discussions with Local Government Engineers) but no physically disabled children we came across had wheelchairs.

These boys are drawing what they like and don't like about school

Costs

The overwhelming consensus among all our H/FHHs is that *'everyone should go to school'* which contrasts strongly with the prevailing view expressed by many teachers that parents are *ignorant and unaware about education*. Being able to read and write is regarded as conferring status and parents indicated that they want their children to be different from them and that education ensures their future. We found that parents thus make quite considered decisions regarding their

People living in poverty say:

School functioning findings

- most schools suffer shortage of furniture, recreational equipment, and teaching materials, but they like BRAC schools even though the facilities are basic because of the use of recreation and teaching materials
- little notice is given to local needs when designing the school
- there are very few toilets, they are often locked and usually dirty so children have to use toilets at home
- play areas are very important and should be big, well equipped and safe
- teacher shortages and using teachers for other duties is a problem and leaving children on their own in class is not good. Temporary teachers are not known to them
- non government schools are often better functioning than government schools because the teachers are local, care about the children and have taught at the school for many years

children's education and demonstrate a willingness to invest. Even poor parents are prepared to pay for private tuition or private schooling. They indicate this is *'essential for our children to do well'* since they themselves were uneducated and could not help with homework. Children told us that they thought teachers purposely made homework difficult to understand or penalised children who did not have tutors so that their parents felt pressured to pay for tuition. The mushrooming of private coaching centres, particularly in urban areas which promise *better results* are very alluring. On the positive side, parents feel that payment confers the right to make demands of the tutor, coaching centre or private school and they feel that they can insist on quality and teacher's attention.

The exception seems to be with some girls of around 11-12 years, when some parents take them out of school to get married. This is regarded as a declining practice everywhere except in urban areas where, it seems to be increasing partly because the parents fear their daughters becoming sexually active so avoid shame by marrying them off. There are mixed perceptions about dowry implications of educated girls. Some H/FHHs suggest that an educated girl can marry above her class where dowry payments are less demanding than from poor families. Others claim that dowry payments are higher for educated girls.

Our H/FHHs tended to deride the concept that education at Government primary schools is free, although SMC members and teachers always emphasised free education as an advantage of Government schools over others. The costs to maintain a child in primary education are estimated to be between Tk800-1000 per year when all the costs of registration, exam fees, uniform, exercise books and pencils and contributions for 'incidental expenses' incurred by the school are totalled up. The latter is a contentious issue as parents told us they object to paying contributions for electricity, cleaning, sports day, social events and other less explicit costs. They say children come home from school relaying messages about contributions that must be made. They are humiliated in class if they fail to bring them but parents think these demands are too frequent and suspect malpractice.

The shortage of school text books has meant that teachers have requested parents to buy from the market place. H/FHH parents are cross about this as they know that free text books should be available from the school. *"As per government rule we get only 50% of the total books required for the students. The rest we must collect from students who already passed to higher classes. So we collect all books from the students while they sit for final exams"* (Teacher, North). New text books are not supposed to be available on the market but we found plentiful supplies in several locations, although some booksellers indicated to us that *'They were more difficult to get since the Caretaker Government'*.

School functioning

As with the UHCs, Government schools are constructed to standard designs irrespective of the local needs and context. This had led to extremes of gross overcrowding (100 to a class) to minimal usage (10 to a class) observed in our study areas. Many H/FHHs felt this standardisation did not make sense. Teachers and parents complained that there is no consultation over school designs. They told us that Local Government Engineering Department contract the construction work out and there is no way to influence the contractors to make changes. Some new designs do not include provision for any toilet facilities. Discussions with a Thana Engineer suggested that he thought this *'Odd but could not change the design'*.

Generally we were told by H/FHHs and observed first hand that most schools lack sufficient furniture (desks, tables, benches) and educational

materials. Almost no recreational equipment is provided and this was a provision many parents and children felt was *'essential'* for their idea of a *'dream school'*. In explaining their preference for BRAC schools, parents and children usually mentioned recreational activities and visual aids among others. These were rare they felt, in Government schools. We observed that whatever visual aids the school have are often displayed in the teachers' room and dust accumulation on them suggests they are not moved into classrooms when needed as teachers claim. Some church and INGO supported schools are the exception and have equipment and educational aids. Parents and children always pointed out that these were at least part of the reasons for preferring these schools.

Some of the rural schools do not have electricity supply making it hot in the summer and dark during the winter and monsoon. Children told us how uncomfortable it was and how difficult it was to concentrate on lessons. Teachers told us that there is no provision to pay for electricity and so they demand contributions towards the bill from students. Teachers told us that there was no provision to pay for electricity in schools with electrical connections.

Provision of toilets is regarded as a major problem. Some schools have no toilet and others one toilet for as many as 800 pupils. Toilets observed and described by children are in a poor state, *'smell'* and are *'cockroach infested'*. Most are locked so pupils have to ask teachers for the key. Girls' drawings of 'naughty boys' showed them going off to the edge of the play area to climb trees and urinate. Girls told us they go home to use the toilet at home and menstruating girls stay at home because they are *'ashamed'*[17]. Because provision of cleaning staff is not included in the school budget, children (particularly girls) are *'told by our teachers'* to clean the toilets and classrooms. In one case children told us they had to fetch water daily from the stream for the teachers' toilet.

We observed that water supplies in all the primary schools in the study are tubewells. Many of these are not functioning and the problem of lack of drinking water was mentioned by children and parents. Children complained that they had to fetch water from neighbours or the river.

Play areas are considered by parents and children very important in describing an ideal or dream school. They told us (and children drew pictures to show) that the play areas they have at school are mud/earth and many are littered, prone to flooding and get used for other purposes such as grazing, youth cricket or football and gambling. Some are only temporary as they are on cultivatable land. Children showed us what they did not like about their play areas and took photos or drew pictures of nearby rubbish dumps (particularly in urban areas), filthy ditches along the edge of the play area, animal excrement and litter. Many schools we observed did seem to confirm these problems (uneven grounds, located next to ditches, rubbish dumps, rivers and busy roads). The children told us the play areas were too small for so many children and their 'dream' drawings showed plenty of space for girls and boys to play. In the case of one urban Government primary there was no play area at all and it was situated on a busy market road. Some H/FHH children who were pupils of this school said that this was the main reason why they would have preferred to go to the RNGPS in the area which has a play area.

Teachers and parents told us of the problems of staff shortages at many of the Government schools. Children told us they often sit in classrooms

[17] This is not an issue that they or their mothers would share with the school because of the social taboo. If they are stipend students they forfeit attendance days.

People living in poverty say:

Costs findings

- everyone should go to school as it confers status and ensures their children have a better future. They are willing to pay for education if they feel it is good quality and so opt for private schools and coaching if possible
- that Government education is not free. This is a myth as they have to pay for books, uniforms, incidentals and text books. Many of these costs are not made explicit
- taking girls out of school for early marriage is declining except in urban areas because parents are worried about their sexual activity

'There were 49 students in our Class 1 but now we have reached Class 5 and there are only four students. We all liked school in the beginning because we played together, but as we grew up we needed games and equipment to play with. Our school has no sports equipment and no playground- We only have a cultivated field to play in and most of the time we cannot play there. Teachers don't tell us stories, recite poetry or show us magic. In fact they sleep a lot of the time. Our friends spend happy times catching fish while we are at school'. (rural South area)

Fahima is a mother of three. Her elder two children live with her parents in a village some distance away because they cannot afford to pay for their education. Fahima, like so many parents we met, feel that education is very important. In fact, so important that she does not touch her savings in a crisis as they are exclusively for her children's future education. She did not even touch them when she was ill and needed the money but instead sold rice and borrowed from neighbours.

Typically two toilets for one school are standard but they are kept locked - partly to keep them clean and partly to stop outsiders using them.

We met with the Upazila Engineer of the Local Government Engineering Department who explained why a new two-story school extension building (under PEDP-II) had no provision for toilets. He told us this was the mandate from the Department of education. He said *'It is more important that the children have classrooms than toilets and the budget is limited'.*

on their own or are told to play outside when there are no teachers. Sometimes teachers *'run between classes'* to cover more than one class. Children *'put in charge'* of the class did not like this responsibility and one said it meant she could not get on with her work. In rural areas, teachers and parents told us it is difficult to attract teachers to such remote or *'backward'* places. Teachers indicated that the Government's drive to ensure that all primary teachers have Certificates of Education has left many schools temporarily short of teachers[18]. Head teachers complained that they felt that there was little point in this training as *'when they come back they don't do anything differently'*. Some vacancies are filled with deputised teachers but the ones we met were de-motivated (forced to go on deputation), often had long journeys (40 km), have no local knowledge or roots and show little interest in undertaking extra-curricula or after school activities. Parents did not know these deputised teachers. Other reasons for absence are the requirements of Government primary school head teachers to attend many meetings at the Upazila Education Office as well as training courses during term time. One headmistress had only been at school for two days this term due to such commitments.

Teachers and SMC members complained to us that teachers are expected to take on many other duties for which they get no remuneration. These include compiling voter lists[19], birth registration (a new mandate), annual child survey (said to take 15 days), polling officer duties, monitoring immunisation programmes and observation of special days. Some told us that such activities were prioritised by the teachers because they attract public recognition. Nevertheless, it was felt it encroached markedly on the number of pupil contact hours which are low anyway.

Registered non-government primary schools are often preferred by parents over Government schools and one reason is that they are perceived as better functioning even though staff are paid at one third of the rate of Government teachers and resources provided by Government are minimal. Many of these schools we were told were established through local initiatives and the founders were highly motivated. Community and SMCs thus feel a sense of ownership and the most active SMCs were observed in these schools. Teachers told us that whilst they are not happy that they get much less salary than their Government primary school counterparts they regard their teaching as a vocation and a social service to the community. Conversations with them and discussions with the children they teach suggest that many of them are more interested in the quality of education and inclusion issues than their Government counterparts. Many have taught in the same school for decades.

Teachers and SMC members in all areas told us that vandalism and theft of school property is prevalent. Tubewell handles and even flag poles are stolen which makes them reluctant to replace them. One of the reasons toilets are locked is to avoid misuse.

Several schools are located close to busy main roads and parents are very fearful of accidents even to the extent of withdrawing children from school.

The team only came across evidence of the School Level Improvement Programme (SLIP) in one of the nine locations (rural Central). Here teachers and SMC members had just received training[20] but were somewhat uncertain how the scheme would work in practice. Their initial

[18] One we visited had half its staff on Certificate of Education training
[19] This year assisting with provision of ID cards
[20] Within the previous fortnight

reaction was that the amount of money which might be granted was *'too little to do what needs to be done'* (SMC member)[21]. *'What we would really like here is to employ some young people to help teach but I don't think that is permitted'* (Teacher). We went through the twenty indicators (targets) which the SLIP hopes to achieve with teachers in one school and which were handed out in the training. One indicator states '40 students per class' and the teachers said that this was impossible as they always had more and how would the SLIP money alleviate overcrowding? They had also been told that the SLIP grant was to *'make the school more attractive so children would be encouraged to come'*. The teachers of one school commented that this was not the problem *'The children come, they even bring their younger brothers and sisters as there is no one at home but we only have two teachers out of four here as the head is always out on business. Both of us are deputised and do not live nearby. How can we manage four classes and we do not know the area? SLIP will not help this.'*

Quality

It was difficult to understand what parents regarded as good quality. They often compared the quality now with what had existed when they were at school and mostly noted new construction and more teachers as improvements. A common indicator of improved quality in parents and teachers' eyes was the award of scholarships to the school, either if it had never got them before or the numbers of scholarships it achieved were increasing.

The presence of a 'good' school in the community seems to contribute enormously to people's perception of quality, becoming a benchmark against which other schools are compared. Since BRAC schools are regarded widely as *'good'*, their presence in a community extends parents' definition of what is 'good' to include:

- opportunity for children to play
- opportunity for children to learn through play, songs, drama
- enthusiasm and attentiveness of the teacher
- a de-emphasising of physical resources since these schools run with minimal physical resources

'*When students in Government schools are learning their ABCs, students in the NGO schools can already read'* (parent peri-urban South).

All Government primary teachers in our study areas were said to arrive late (up to an hour) and many left early. This was considered *'normal'* and parents told us they did not *'hurry to get their children there on time'* (Central). We accompanied children to school and frequently found the schools locked long after sessions should have started. Children told us that teachers take time out of lessons to answer their mobile phones, for gossiping with other teachers, smoking, eating and napping. Some parents and children suggest that this is intentional so that little is achieved in class thus putting pressure on for private tuition.

Beatings were mentioned in all schools except in BRAC schools (in fact this was cited as a reason for liking BRAC schools '*teachers don't beat us*'). All Government primary teachers, we were told, carry a stick[22] but not all of them use it. Children demonstrated through dramas how beatings were carried out, mostly involving using the stick across the palm. They get beaten like this for not doing their homework, poor work or for '*fighting with others'* but also sometimes for not bringing the financial contributions they have been told to bring. Parents told us that they think children should be beaten for naughtiness but not for *'things*

[21] They indicated that although Tk20,000 was the maximum per year only Tk6000 could be awarded at a time.

[22] The stick was much in evidence on teachers desks in all Government schools we visited and some but not all RNGPS

Importance of play

All three study teams were struck by the emphasis given by parents and children to the importance of children's play. When asked what made a good school, time and again the provision of a large play ground and play equipment featured first on the list.

Children in the slum (above) find little space to play and really wanted the school to have a good place to play whereas those in this rural village had plenty of places to play (South) (Although rural locations don't always allow this)

Two brothers drew their dream school and the one they don't like. As they explained their pictures they emphasised the play ground and play equipment.

they cannot help' (e.g. not bringing contributions, not doing homework because they have no light, poor work because the teacher has not helped them to understand). Children told us that it was mostly older teachers who mete out corporal punishment and shout at them. But at the same time many of these older teachers seem highly respected by parents because they understand the locality and are more like a *'friend'*. Even one who resigned over a severe beating incident is still highly regarded in the community as he follows up on children who are not doing so well in school. The new generation of teachers are more qualified, it is acknowledged, but they have lost this personal touch and local 'rooted-ness'.

Parents and children told us that teachers give special emphasis to scholarship students to the detriment of others. Scholarship students sit at the front of the class, have more desk space and often have special classes conducted by the head teacher. As mentioned above, school quality is often equated to the number of scholarships won by its students which promotes this grooming. Non scholarship children told us they felt excluded and ignored. We saw scholarship children being taught separately in a small group while other children were left unsupervised in their classrooms.

Example of Scholarship
Children in Class 5 may sit the scholarship exam to secondary school which is awarded for the first three of secondary (Class 6-8). Children at Government primary schools; registered primary schools and community schools are eligible to appear in the scholarship examination. Students of unregistered primary schools generally enrol their name through other registered primary schools. A maximum of 30% students of class 5 can appear in the scholarship examination.

The exam fee is Tk60 to register and a further Tk15 for each of four model tests which are not mandatory. There is a quota for scholarships related to the population size of the Upazila. Scholarships are of two types: talent pool for students getting more than 85% marks (Tk175 per month) and General grade scholarship (Tk150 per month). In each Union or municipality ward one boy and one girl usually get the general scholarship.

'We like our girls to go to the Madrasa because they can play freely there' (Central rural area)

'The children have so much fun at the local BRAC school' (Parent). *'We are sad today because school is closed'* (Girls attending BRAC school). As they did not go to school that day they spent most of the afternoon singing the songs and performing the dances they had learned and practicing them over and over when they made a mistake. Parents were so delighted in their confidence and skills. (Peri-urban Central)

'Our teachers use pictures even to explain maths', 'We like the Missionary School because they have sports, drama and picnics.' (Parents and children, rural South)

'After 23 years we held our first ever sports day at the school this year. This is so important for children and we need to do more things like this'. (Teacher, peri-urban Central GPS)

'I play games with my daughter, who is three, which I learnt when I was at the BRAC school. She learns a lot through this play and will be ready to do well at school. She loves to sing and dance for us. I wish there was a BRAC school for her to go to here' (Young mother, rural Central)

Poor quality text books were in evidence in many schools and school bags. Children explained to us that they had to reuse text books from previous years and they were already in poor condition and with pages missing when they got them. Many text books are designed so that the student writes in them. The answers are already filled in on old text books and children say they *'don't like that'*.

Similar to health facilities, our H/FHHs did not relate school functioning and quality to the adequacy or quality of resources but primarily to the attitude and behaviour of the head teacher. The model school in the Northern district is a particularly good example of this but also a registered non-government primary school in the Central district slum surpasses the Government school, despite much fewer resources solely because of the dedication of its head teacher. Poor quality schools are perceived by parents to be a result of poor supervision.

Complaints system

Similar to the situation for health provision, our H/FHHs knew of no formal system for complaints. Parents fear reprisals if they complain and cannot raise complaints about teachers to their teaching colleagues. Some poor parents felt disrespected by teachers and would not consider complaining, *'How can a poor person complain?'* or *'It is not the role of the poor to complain but of the elite', 'If I talk to the teacher about my*

*son's achievement if he is not doing well I will only be told off. You have to do this and that, you are not supporting your child, that is all they will tell me' (*Father, peri-urban South). Parents felt there were sometimes reasons to complain; teacher's absence, lateness, beatings, *'teachers do not bother if the children play near the school instead of attending class'* and teachers *'do not follow up on home tasks'.*

Our H/FHHs are not sure what the role of the SMC is and some had never heard of it. Even SMC members themselves are not very clear, *'I never knew that I am a member of SMC. So far I can remember the headmistress requested me once but I did not agree'* (SMC member, urban North). *'Why SMC? Our headmaster is enough to run the school. We do not have time to visit school and attend meetings'* (Father, rural North). *'SMC? I don't think the school has one of those. The headmistress makes all the decisions. Certainly I don't know anyone who serves as SMC'* (Man, urban Central).

SMCs and Guardian committees are perceived by parents, and to some extent this is also the view of teachers, to be established to support teachers and school authorities, not as platforms for parents to voice concerns or raise issues, *'The committee always favours the teacher and our complaint is not important'* (peri-urban South). Most SMCs of Government primary schools are comprised of businessmen and aspiring local government representatives and few are parents with children in the school we were told and validated this by meeting many of them. *'I know that people are interested to be members of SMC only to prove their ability and status. But I always put pressure to contribute for the school either in cash or kind'* (Head master, peri urban North). *'People of this area are extremely poor and illiterate. They don't' have time for attending meetings so I have formed SMC by including names of some local influential people and wealthy men mainly to fulfil government demand' (*Head master, rural North). *'We do lobby the parents and spend money to nominate us as SMC member. This is mainly to raise our status in the society and to contest in the local government election. But after being nominated we never look after the school or attend meetings' (*SMC member, peri urban North).

Our discussions with SMC members often revealed a lack of awareness of issues facing the school (e.g. did not know that teachers had left, tubewell not working, text books were in short supply, etc.) and had little interest in its functioning let alone parents concerns. Most of our H/FHHs did not know who was on the SMC and what their function was. In contrast, members of SMCs of registered non government primary schools were either founders and/or parents and are very open to parents' issues and the H/FHHs with children in these schools often knew them and felt they could talk to them if they needed to.

Our H/FHH parents felt there was little value in directing complaints to higher authorities as *'Officers of the education department don't take any action against teachers so there is no point in complaining'.*

Access to information

The most commonly expressed confusions relate to the functioning of the stipend programme as described above. *'Media, mainly the TV is responsible for giving wrong information to the people that every student will get a stipend, which is not true. This message put teachers in a false position. Media must mention the criteria also'* (Headmaster, peri urban North). Parents feel there is a lack of transparency in the selection process and in making payments.

Parents are also frustrated by the constant demands from teachers for money contributions throughout the year and feel it is not clear what all

Discrimination against poorer children

The study team expected to hear stories of teachers being late and less dutiful, but the discrimination against poorer children was more apparent than we might have thought.

The teacher puts the scholarship children at the front. *'She ignores us and gives us purposely difficult homework. Only those who can afford tutors get the homework done and we always get into trouble'. 'She never shows us our exam papers so we do not know why we have done badly. We think that we have not done so badly but she wants us to have tutoring and until we do she will give us bad marks.' 'If we fail to bring money that she demands for various things she scolds us in front of the rest of the class'. 'It is hard for us poor at school'.* (Central rural area)

This boy is a student of Class 1 and very keen to succeed. But *'We do not have electricity at home. We only have two kerosene lamps and one is used by my mother to prepare food and the other is used by my brother and sister for their homework. The light is very bad and my father cannot afford to buy more kerosene so usually only one lamp is allowed. Every day my teacher tells me off for not writing clearly in my copy book. I have asked my father for another lamp. Perhaps he does not have enough money'.* (North rural area)

This little girl has been made captain of the class. She loves school but being captain means she has to look after the class when the teacher is absent, which happens every day for at least two periods. She says this interferes with her own learning and the other children don't like her for reporting misbehaviour.

B dropped out of school because he could never manage to do homework. He asked his father to organise a tutor but his rickshaw-driving father could not afford this. The boy suffered daily beatings and was reprimand in front of the others for not doing his homework. He dropped out against his parents' wishes and now pulls a rickshaw. (Central per-urban area)

these payments are for. They feel suspicious when their children cannot explain what the charges are for.

Poorly performing students and their parents told us that they do not get their exam papers back and do not understand why they failed (some even suspected that they had not actually failed) and so do not know how to improve.

Teacher behaviour

As mentioned above teachers beat and punish children mainly, the children told us, for fighting and poor school work. Poor children feel particularly picked on because they are frequently unable to complete their homework either because they have not been able to understand it, cannot get help at home, have not had time to complete the assignment due to other demands made at home or lack of electric light.

Some teachers, children told us, expect students to carry out errands for them. This includes cleaning the toilets and classrooms but also more directly personal errands like buying biscuits, cold drinks, etc. On visits to schools we observed children doing errands. Class prefects are expected to keep classes in order in the absence of the teacher.

As mentioned above, sleeping, gossiping, eating in class, absenteeism during class hours and chatting on mobile phones by teachers in class are all common behaviours described by children and endorsed by their parents. Children mimed this behaviour for us when asked to dramatise what they liked and disliked about teachers behaviour.

Why some actively opt out?

The economic argument which is popularly perpetuated[23] for opting out of primary school to earn is barely in evidence in our study areas. This is partly because parents regard education and, in particular, the ability to read and write as essential. Whereas parents and grandparents told us that in the past they might have kept children out of school because they could not afford it or needed to involve them in economic activities now they say children don't go to school for a variety of reasons including:

- Boys simply don't want to go to school, prefer idling and playing with their friends, parents feel powerless to persuade them otherwise, *'Boys are very disrespectful nowadays'*. Sometimes parents think their son is going to school when in fact he is playing truant. They wish teachers would let them know if this is happening and feel it is the teacher's responsibility to check they are in school.
- Older role models and siblings are earning good money (e.g. in garment and knitwear factories) without having completed education, so children themselves decide to join them.
- Children told us that if they want to be rickshaw pullers or truck drivers they don't need to read.
- Children with relatively minor physical and mental disabilities are kept out of school because it is considered a waste of money and teachers are too busy with others to give them special attention.
- Much less prevalent than in the past, we were told that sometimes girls are taken out of school for early marriage (now this is more likely to be to pre-empt possible scandal as urban girls in particular may become sexually active than social tradition of the past). Although our general observations were that early marriage is in decline.

[23] and mentioned by many teachers we spoke to. However, out of school children we met were not earning for their families.

The only economic argument came from the frustration that Government primary education was not good enough by itself and that private coaching was needed to supplement it. If the family felt unable to afford this, they may opt out seeing continuation as pointless.

4. Participation, Non–discrimination, Transparency and Accountability

The Swedish Policy for Global Development (PGD) and the Sida Perspectives on Poverty[24] intend that the *poor people's perspectives on development* and the *rights perspective* permeate all development assistance. These two perspectives are underpinned by a further four principles: *Participation, Non-discrimination, Transparency* and *Accountability* (PNTA)[25]. We have therefore used the PNTA framework to analyse our findings from the Reality Check.

4.1 Participation

> *The two perspectives (rights and poor people's perspective on development) are based on the pre-condition that women and men, and girls and boys must be given the opportunity to participate in, and influence, the decision-making process that affect them. Participation at various levels has always been an integrated part of the work of Sida. Mutual understanding and shared methods, however, have not always been easy to find. Sida and many other development actors previously viewed participation as a way or method of satisfying the project objectives, and ensuring sustainable results. A broader approach is becoming apparent at the international scene, as participation is increasingly being viewed 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 that they can demand change and social justice.*
>
> *Like the two perspectives, the goal of development cooperation is based on the view that participation both in decisions that affect private life and the governing of the country is a human right. Participation is also the key to demanding respect for all other rights. Participation thus becomes a core issue in the implementation of the PGD. Participation can be direct or indirect. There should be increased attention paid to the legitimacy and representativeness of those who claim to represent poor individuals and groups. The importance of participation for justice and meaningful conditions relate to all levels of society (both within the development and political processes and in formal and informal networks). Sida can therefore begin to apply the two perspectives by developing an increased understanding of the mechanisms and processes that promote broad-based participation, as well as the development of methods for meaningful and informed participation. In the Paris Declaration on Aid Effectiveness, the partner countries endorse the strengthening of the domestic consultation process, participatory approaches and the involvement of a broad spectrum of participants in the formulation and evaluation of the development efforts, including the macroeconomic processes. (Sida 2006)*

Drop out/opt out?
The study team was struck by the fact that the argument that children need to be economically active and therefore get taken out of school is no longer as strong as it once was. Parents value education highly and will do all they can to keep their children in school.

'Why go to school if I am going to be a rickshaw driver like my father?'

'We just like to idle and pass the day!'

We came across this coaching class in the neighbours' house. The teacher is a student and he takes classes every day. All the students are relatively poor but parents consider this the only way to get on. *'Otherwise better to just drop out'*.

[24] 2002

[25] Proposed in Sida's publication *Current Thinking of the Two Perspectives*

People living in poverty say:

Quality findings

- Government teachers lateness is 'normal' and they waste a lot time gossiping, smoking, eating, on their mobile phones and attending to non school business
- beatings (stick across the palm) are common and acceptable for bad behaviour but not for things the child cannot control (such as not doing homework because they do not have light)
- play is very important for children
- scholarship students are favoured to the detriment of other students
- used text books are often of poor quality with missing pages and written in
- the attitude of the head teacher rather than the facilities can make the greatest difference between good and poor quality education

Complaints system findings

- there is no system for complaints and they fear reprisals or not being taken seriously if they complain.
- they do not know what the role of the SMC or often who belongs to it, they perceive it as promoting the teachers interests and not a body through which to raise complaints

Access to information findings

- there is a lot of mis-information and confusion about the stipend programme
- they feel suspicious about the constant demands for payments throughout the year at government schools for 'incidentals'

Compared to the past when members of the team have been involved in similar work[26], the Study Team noticed a high level of motivation among the F/HHHs to engage in conversations and analyse their situations[27]. On the whole, they have good knowledge of what services there should be as a direct result of an enhanced access to information through television, radio and mobile phone use and exposure to peripatetic service providers who make visits to their communities, although much less about why or how to avail services. The foundations for participation are thus in evidence. However, politics, criminal activity, adherence to traditional power structures[28] and the absence of platforms for people to exercise voice have been a counter-force to active participation. The only platforms we were aware of are occasional parents/guardian meetings at schools but these are always called by the school teachers and are intended to 'motivate parents' or 'provide them with information' (e.g. about stipends, examinations), not platforms where issues of concern to/from the guardians can be raised. There were no examples of platforms for raising concerns in health. These situations perpetuate the top down relationship between service providers and their clients and fuel the discontent that *'Our voices are never heard', 'As poor people we are never taken seriously'*.

In particular, we noted

- Some SMCs (in GPS rather than private or RNGPS) have been co-opted by vested interests either for monetary gain (manipulation of stipends and construction contracts, access to training allowances) and/or political gains. Where this has happened the Guardian Committee is formed with relatives and allies as a supporting body rather than representing the interest of guardians
- No evidence of activity of UP standing committees on education
- A generally strong sense that parents are involved in their children's education and want to be more involved with school
- A general feeling that poor and uneducated parents could not discuss issues with teachers as complaints might jeopardise their children's position (self–exclusion)
- Frustration that there were no higher authorities to complain to about teacher behaviour or school facilities
- Very little evidence of community volunteerism in support of their local schools. Some small efforts apparent in RNGPS but rarely in GPS, include planting vegetable gardens, maintaining the playground, painting
- No evidence of any consultation regarding school construction and renovation under PEPD-2
- Government out-patients sense pressure by doctors not to waste time and feel they cannot discuss their treatment or diagnosis
- There are no simple means to raise issues or complaints at any of the Government health facilities and, as in education, people feel frustrated that there are no higher authorities to complain to about doctors' behaviour and facilities. Complaints are considered risky as one may be refused treatment. In the only case where villagers had made an official complaint about corrupt doctors (rural South) the TNO had made threats to the group leader

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[26] E.g. *Perspectives of the Poor* a report for UNDP, 1992 (PromPT) and other similar studies throughout the early 90s.
[27] We recognise that the extraordinary level of engagement of women and young girls is at least in part because of the immersion process. The study team members spent days and nights with families and built trust that led to animated discussions.
[28] Kabeer, 2002 Citizenship, affiliation and exclusion, perspectives from the south IDS Bulletin 33 (2) describes how the poor see themselves as 'lesser' citizens and accept this inequality with what she refers to as 'absence of question'.

4.2 Non-discrimination

The core of the rights concept is the idea that all individuals have the same value and rights. Non-discrimination thus becomes a fundamental point of departure that prompts Sida to more clearly identify specific categories and groups of poor people as target groups and stakeholders in concrete contributions. Excluded, marginalised and discriminated groups must be given special attention, and must be identified. This requires access to statistical information that highlights the situation for the population in general, as well as for the specific groups. Making poor women, men, girls and boys visible does not only require quantitative statistics, but also needs qualitative information. The qualitative analysis is often based on ethnographic material or methods of data collection that involve poor people, either as the communicators of the information to be analysed, or as data gatherers in a specific area. Qualitative information is valuable to highlight the individual behind the quantitative analysis, and for understanding the social relations, processes and values of a society. (Sida 2006)

The study team was not aware of discrimination on grounds of ethnicity or religion, but despite measures to include the poor, there were many examples of discrimination.

In particular we noted

- Poorer children sat at the back of classrooms in GPS
- Poor children felt they were made to feel different, they were often in trouble because they could not do their homework (home circumstances hinder, no electricity, no private tutors) (mostly GPS)
- Inter-child teasing of students getting stipends (noted in GPS)
- Poorer children asked to do errands/chores for teachers (presumably because parents less likely to complain) (noted in GPS)
- RNGPS more relaxed about school uniform (encouraging inclusion)
- Some inclusion in school of children with physical disabilities (affecting mobility) but not of children with learning disabilities, deafness or poor vision. Very high levels of care and inclusion of children with disabilities in their family homes
- Despite history of discrimination of Hindus in some of our study communities, no discrimination in schools or health facilities
- The poor are particularly vulnerable to exploitation by dalals, health facility staff and facility 'agents' for bribes and persuasion to take alternative services because they are unfamiliar with the procedures, entitlements and are making decisions under duress
- Poor not given beds in hospitals, discharged early, not allowed to use lifts, spoken to rudely and ignored

People living in poverty say:

Actively opt out findings

- some boys refuse to go to school against their parents wishes
- it is possible to get a job in the garment industry without finishing education and some jobs do not require reading and writing skills (e.g. rickshaw and truck driving)
- some children with minor disabilities are kept out of school as they don't get the attention needed and it is a waste of money to send them
- some urban girls are married early to avoid the shame of them becoming sexually active outside marriage

M. had severe stomach pains and went to the UHC. No doctors told him what was wrong but after five days sent him to the District hospital. He thought that because he had not been able to pay the doctors this was why they were not telling him anything. The rickshaw driver persuaded him to go to private clinic instead where it would be *'cheap and good service'*. At the clinic, the staff treated him well but as more and more tests were prescribed the family ran out of money. The Clinic staff forced him to leave realising that he could not pay, so B returned to the UHC but they refused to treat him *'Blamed me for going to the private clinic'*. B mortgaged his last piece of land and took a NGO loan and went back to the private clinic. He is still in pain and now deeply in debt. (South rural area)

During our stay in the village the award of stipends was announced by the school, resulting in a lot of gossip, heated discussion and some confusion among parents. There was confusion regarding the amount of money the stipend gave, since it differed from one year to the other, and between students, but parents had received no explanation as to why this difference was there. One mother was receiving less money than the previous year (Tk100 instead of Tk300). She came back from the meeting, feeling very disappointed and depressed: *'How will I pay for the costs of books and all now? And imagine, I have several children, now grown-ups who have always done well. Now I had to stand there in front of everyone that I know, and find out that my youngest daughter will receive less because of some misbehaviour and I get the blame.'* Her reaction suggests that the 'loss of face' (public humiliation) was as distressing as the loss of income. The mother felt bad for letting her daughter down (she had not supervised her going to school during a period when she stayed with her elder sister). (Extract from field notes South)

4.3 Transparency

> *The right to information is a condition for active participation in the different functions of society. Transparency in society are cornerstones of a just society, and are therefore of central importance to the two perspectives. The reporting of the various measures taken by the state (including local organs) shall be documented, public and accessible to the citizens. Opportunities for citizens to read public documents (e.g. the national budget) should be investigated and strengthened. In order to hold decision-makers at local or central levels accountable, citizens must stay informed. The fight against corruption, too, requires transparency. (Sida 2006)*

Transparency was lacking around awarding educational stipends in all our study areas. People generally knew details of how much the stipend was worth, how it should be paid and the good attendance and exam records needed to get the stipend, but there was very little understanding of who qualifies for the stipend and who does not. Everywhere there were cases where better off families (with relatives abroad, land owned, etc) were getting stipends where needier families could be identified. SMCs and teachers always told us 'We *know who is poor'* but nobody could provide indicators to support this decision making. Parents were also confused why payments seemed to vary from one period to the next. They did not feel they got proper explanations of why this happens. The regulation to make stipend payments through bank representatives was only practiced, it seems, in one location (rural Central).

There is also general lack of transparency about who is selected to stand on SMCs and Guardian Committees. Most parents know very little about these committees, who are on them and what they do.

There are major problems for poor people in understanding diagnosis and courses of treatment. No records are passed between service providers (even within Government) and so patients have to start all over[29] every time they are referred on or self refer.

There is little independent information on what health services are available and general information on common health complaints. Thus patients and caretakers are left with having to rely on rumours and advice of relatives and neighbours.

There are notices in Government health facilities regarding costs (tests, medicines, ambulance) but these frequently use medical terms which are difficult to interpret. Most people we talked to did not pay any attention to these notices as they could not read well. There are more monitoring boards in evidence since the Caretaker Government but although the date is changed daily, little else changes and the general public do not read them[30].

Since the Caretaker Government, there are posters and registration cards entreating patients to avoid dalals and resisting payment of doctors during hospital hours. People are aware that there are more free medicines available in the hospitals.

[29] We only came across one incidence of a patient carrying her test results to another health provider. Otherwise, they all demanded that tests be re-done.

[30] In one District hospital, the study team attracted a crowd around them as they looked at the monitoring board regarding cleanliness, staffing and facilities - nobody was reassured by the board.

4.4 Accountability

One fundamental dimension of a rights perspective is the issue of accountability. People must be able to hold decision-makers accountable. The human rights framework imposes unambiguous responsibility on ratifying states. The obligation for states to fulfill the human rights conventions shall be reviewed and monitored. There must also be judicial methods of complaining of government failures to fulfill their obligations. In cases of decentralisation, the local decision-making bodies are considered part of the state structure, and must therefore satisfy the obligations made by central government regarding human rights, particularly the economic, social and cultural rights as the central government has. (Sida 2006)

Generally, there is an acceptance that education and health facilities for the poor will be basic and even an avoidance of places which '*look too good*' on the assumption that payments will be required at some point. Thus some private schools attracting poor families are in simple buildings but trade on the advantage of better quality teachers and teaching (so families do not have to also pay for tutoring). Some of the NGO clinics with special programmes for the poor are not reaching these.

There was much evidence in GPS of teacher absenteeism, lateness or misuse of contact time but very little means to complain about this. Our study families felt this was due to poor supervision and, in more remote areas, absence of supervision. In GRPS, teachers (often likely to be local) were more diligent and accountable to the community.

We noted a strong sense of change in Government health facilities which people attribute to the Caretaker Government. They feel that there are checks going on and doctors and nurses are more careful, dispensaries are issuing free medicines, there are fewer brokers and less malpractice. Pharmacies, too, are *'being watched'*. Generally our study families approved of this and worried about what would happen with a return to political government. However, any enhanced accountability is upwards as typified by medical staff saying '*We do not work for you but for the Government'*.

Sultana was recently admitted to the Medical College Hospital for surgery. She had been feeling pain in her stomach for some time, but was reluctant to go to the hospital due to lengthy procedures. She explained; '*First I would have to go to the doctor, then take tests, and after waiting I would have to go back to the doctor*'. Instead, Sultana went straight to a private diagnostic centre and asked for an ultrasound. She paid Tk700 for this. The ultrasound revealed she had a tumour, and the doctor at the centre referred her immediately to the Medical College Hospital. She paid Tk12 000 for surgery, and had to spend a month in hospital. (Woman, urban South)

Mr. Malek ended up in deep debt despite selling family assets, after suffering from illness. He has been forced to take a new NGO loan, but feels increasingly depressed since his family is suffering from economic problems that he has incurred on them, and he feels unable to contribute to restoring their previously stable financial position due to continued ill health. (Rural South)

5. Conclusion

This first Reality Check report has provided an initial understanding of the way people living in poverty currently see the provision of primary healthcare and primary education. It has focused on the everyday concerns of ordinary people living in poverty.

In terms of the knowledge generated by the study, we hope that the report makes a two-fold contribution. The first is essentially *complementary* in that the Reality Check report confirms a range of findings that have already been produced by earlier quantitative and qualitative studies on health and education services in Bangladesh.

For example, in relation to health, the study found that local private pharmacies are preferred to Government facilities, that many Government outreach services tend to exclude people living in poverty, and that levels of accountability to service users remains low. In relation to education, the study confirms widely-held views that 'free' primary education carries rather high 'hidden costs' for people living in poverty, that the culture and performance of BRAC schools leads them to be rated

M. collapsed driving his rickshaw a year ago and went to the UHC with pain in his leg and hip. The total cost of treatment came to Tk30,000 and his family was without an income for 4 months. To help pay for this they took two loans from NGOs pretending these were for a new business. But his wife cannot pay back the instalments and has to cut back on food. She feels very stressed going to NGO meetings each week without being able to pay the instalment.

'My husband fell from a tree recently. The local doctor told us to go to the hospital. There were no beds and many patients were lying on the floor. The matron told me to meet one of the male staff who would arrange a bed but he said it would cost me Tk600. So I lay with my husband on the floor. The next day I asked again for a bed. This staff told me he could arrange one for Tk200. I told the doctor and he ordered the duty nurse to provide us with a bed for free but this took another three days. I then realised that the other staff had been asking bribes as there was no official payment for the beds as they had told me. So I complained about him to a nurse. She told me to keep quiet otherwise the staff might create other problems for us. If I had not told the doctor we would never have gotten a bed' (North peri-urban area)

more highly than either Government schools or madrasa, and that parents and pupils feel that they have little say over the quality of educational services.

The report confers on these findings another dimension of credibility, since they were revealed within long-term, detailed conversations which allowed a frank exchange of views in which allowed us to delve beyond the common development myths and the tendency to gather only superficial answers within some forms of conventional monitoring and research.

The second is *supplementary*, in that a number of additional issues or nuances have been accessed during the Reality Checks study that can help to add more detail to the current state of knowledge.

These supplementary findings include the following:

5.1 Health

In addition to the well known reasons for the continuing preference for local homeopaths and local pharmacies, the recent proliferation of private diagnostic centres to which the poor may be referred by the homeopath or 'pharmacist' means that diagnoses obtained from these local health providers can be confirmed without having to take time to go to the Government hospital. In other words, if the medicine provided by the homeopath or local pharmacy is not working then the patient can speedily get a scan, X-ray, blood test, etc. to assess whether the situation is critical. This means people can have more information on which to base their decision to seek Government healthcare which is seen as potentially expensive.

People living in poverty have no doubt that the best doctors are in Government hospitals but unless the hospitals are more poor friendly, i.e. free medicines are available and extended to include more than generic ones, out patient opening hours are more suitable, the risk of dalals is reduced as well as the risk of other unofficial payments (e.g. to secure a bed, better treatment), medical staff are less off hand, information is more readily available and frequency of visits (e.g. for different tests and follow up) can be reduced, they will continue to avoid them.

Mothers prefer to have home births for a whole set of reasons which are not related to poverty or ignorance but more to do with emotional concerns. Going to a hospital for the birth still infers that there is something wrong. There is increasing trend to have ultrasound examinations, many of which seem unnecessary and may be ways to make money and exploit the poor.

There is a perception that the services in Government health facilities may improve as a result of closer supervision by the Caretaker Government.

Increasing perceived commercialisation of community based health services (e.g. NGO field workers, SBAs) has resulted in a loss of trust in these services.

People living in poverty are wary of facilities that 'look too good' because of the perceived cost implications. These may be private, NGO or Government facilities. They continue to accept sub-standard conditions and behaviour and feel unable to voice their complaints.

5.2 Primary Education

Parents are very aware of the advantages of ensuring an education for their children and are mostly committed to doing this. However, they are unhappy that Government schools are not in practice free and that the quality of education provided is poor and has to be supplemented by private coaching if their child is to do well. There seems to be a growing willingness to pay for coaching and stipends are often used for this.

Contrary to popular belief, children who are opting out of school are doing so not because they need to contribute to the household economy, but because the children themselves have low level of motivation. This is particularly true of boys who see little or no benefit from going to school and therefore prefer to play truant.

The operation of the stipend programme, though valued, is regarded with suspicion. This is because people in poverty see that local elites are keen to get involved with its administration, and their experience is that there is very little transparency in the awarding of stipends and in the deductions made for school expenses.

Play is regarded as very important by parents and children alike. BRAC schools are lauded for their emphasis on play. Bigger play grounds and more recreational equipment feature high among the priorities for improving primary schools that are voiced by people in poverty.

Without access to formal systems for complaint, and since they experience off-hand treatment from teachers, parents feel that they cannot influence the quality of education in Government schools. Instead, they are forced to 'put up with' teachers who are late, absent, use class time for their own personal business, leave classes unattended, and with inadequate school equipment and materials because they are not taken seriously.

Both the 'existing' and the 'new' findings have policy implications which readers will need to reflect on further. The study team does not feel that it is the role of the Reality Check to make firm recommendations but instead to let the voices of the poor speak for themselves and influence policy directly.

M's wife became very ill and M rushed her to the UHC. The doctor suggested she be admitted but there were no beds available. Eventually M persuaded the matron to admit her with a bribe. *'She stayed five days during which time I paid Tk4000 for blood tests and X-rays which all had to be done in private diagnostic centres. There was no improvement in her condition so the doctor advised me to take her to the District hospital but nobody told me what was wrong with her, I was just told to go there. I hired a rickshaw van to carry her but on the way the driver tried to convince me not to take her to the District Hospital as the service there is so bad but instead to a private clinic he knew. But I did not have enough money so went to the District hospital where the doctor asked us to do more tests, again at private diagnostic centres. I spent another Tk5000. My wife came home and within a month she died. To look after my young daughter I have given up my office work in Dhaka and now work as a day labourer.'* (Central rural area)

A couple has four children of school going age. They are struggling to make ends meet and the wife says she is always in debt to neighbours, relatives and shops where she buys food on credit. Their eldest daughter goes to a government secondary school and receives a stipend but also plants paddy to help pay towards education costs. Two other children go to the Missionary school because it is free and they get a free meal there. The fourth child goes to a free kindergarten. Even though they are struggling the parents are determined to provide their children with education. The mother said their one wish for the future is to have electricity '*so that the children can do their homework in the evening.*' (Extracts from Field notes South)

Former students told us that teachers did not take their duties seriously; students were sometimes asked to pick lice from their teacher's hair and the school had frequent holidays so the teachers worked less. But now, they say, teachers are taking more responsibility *'They don't spend so much time gossiping with each other or playing snakes and ladder games in the library'*. Their behaviour is generally improving and '*they don't chew betel leaf*' and attend school more regularly. (Field Notes. South)

“This is my dream village where I would like to live!” By Shakin, 9 years.

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

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