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Reality Check Bangladesh 2009

– Listening to Poor People's Realities about Primary Healthcare and Primary Education – Year 3

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Foreword

The challenges and opportunities experienced by people living in poverty can best be identified and expressed by the poor people themselves, those who are confronted with difficult circumstances and realities, sometimes less obvious for the outside observer.

I am convinced that the Reality Check report, now in its third year, is providing those poor and marginalized individuals and households in Bangladesh with new and better opportunities to voice their experiences and concerns in ways that will encourage providers of development aid and national resources to become even more effective in their efforts to reduce and alleviate poverty in Bangladesh.

The Governments of Sweden and Bangladesh signed a five-year agreement on Development Cooperation between the two countries in November 2008. The main share of this cooperation is channelled to the Government's primary health care and primary level of education programmes to ensure equitable and qualitative health care and education for all citizens. Primary Education and health services for all are prerequisites for further strengthening of sustainable democratic processes.

The Reality Check approach is a means to listen to the voices of women and men, boys and girls of different ages and localities but also the voices of grass-root service providers, those working in education and health, which are important and integrated parts of the realities as perceived by the poor. The voices of these different groups will assist in refining the understanding of their challenges and needs and thus their perception of development and change. To understand and learn, we must listen!

This will enable us to improve our understanding of the needs and expectations of poor people and our own contributions to improve their opportunities for change and progress.

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Ambassador

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Summary

The Reality Check report, now in its third year, is concerned with understand the experiences of people living in poverty, and those of local service providers,in relation to the ongoing large-scale investments in improving health and education in Bangladesh. Once again this year the Reality Check teams revisited and lived with a total of 24 households for five days and four nights in nine locations around the country. They listened to and documented people's experiences and perceptions of changing health and education services in each of the localities.

Our findings fall into three main categories: positive changes, less positive changes and 'business as usual'. As in previous years, we found that there had been some important positive changes. For example, in education, the newly-introduced Class 5 public examination system is generally perceived to be an important step forward. In health, some government health facilities, when placed under new and motivated leadership and having filled staff positions that were previously vacanct, are showing signs of improvement in terms of higher standards of cleanliness, organisation and good use of limited resources.

We found this year that the teams' regular annual interactions with our study households have built higher levels of trust and access, with some potentially important new areas of insight emerging. For example, the (ab)use of hospital beds by people seeking legal documentation for compensation cases was one new finding, as was the increased observation of hypertension and possible links with higher salt intake in people's food.

Many of he findings from this year's fieldwork echo many of those previously reported. The general narrative that emerges from the stories people told is one in which both education and health reforms continue to show areas of room for improvement 'on the ground', whether in terms of the delivery of infrastructure and equipment, in the development and deployment of appropriate human resources in service delivery, or in the creation of 'spaces' for poor people to exercise effective demand and voice with which to influence policy and implementation. In both the health and education sectors, non-state service provision is increasing and is generally preferred.

The picture remains one of widespread variations in progress and quality of reforms, with teams noting the very different outcomes in different areas. These differences mainly arise from the specifics of local conditions and leadership. Also particularly noticeable this year was the fragility and 'reversibility' of improvements made on the ground. For example, a well-run hospital that has been improved under one leadership can easily and rapidly revert to being dysfunctional under new leadership or under conditions of increased 'politicisation' through the return of partisan politics.

The general situation in 2009

The unelected military-backed 'caretaker government' formed the political backdrop to last year's Reality Check. The country returned to parliamentary democracy and the Awami League party returned to power with a landslide victory in December 2008. After the initial positive response to the end of the unelected government, people in the communities we report from reported the remergence of negative trends such aspolitical patronage and increasing crime, including extortion, mugging and house thefts.

The severe recession in the global economy during 2009 inevitably impacted negatively on Bangladesh. Although its economy is relatively insulated from the turbulence in global financial markets, there is fear that overseas remittances will be affected. Although there continued to be economic growth during 2009, growth has been slowing. Economic forecasts indicate that GDP growth will fall from almost 6% in the 2008-9 financial year to just over 5% in 2009/10 (EIU Bangladesh Country Report, August 2009). According to our observations of the families we work with, the quantity and quality of household food intake has also declined during the three years that we have been engaged in the study.

Main findings in Health

This year, once again, our informants' experiences and stories confirmed the declining capacity and utilisation of public health services and the increasing use of private providers. Both Upazila Health Complexes (UHCs) and family planning services were seen by our households as unreliable and ultimately as less affordable than private providers. The new government has attempted to re-open the non-functioning Community Clinic system that had first been established by the first Awami League government, but these have few facilities or resources, and are mainly used by people as a collection point for the limited supplies of free drugs that arrive. Staff shortages, malfunctioning of essential equipment and the resumption of levying of unauthorised charges by medical personnel and by informal 'brokers' continue to undermine the effectiveness of many government facilities.

Where we heard more positive stories, such as in better cleanliness in some facilities (as in the South district), and in improvements in hospital food, this was often the result of positive leadership by newly-appointed directors. We also continued to find that people felt unable to complain about the poor services they received fromgovernment health facilities. Most medical professionals were seen by ordinary people as remote, unaccountable figures of authority.

Private for-profit diagnostic centres continue to be preferred by people living in poverty, because they offered a better quality and more responsive service, despite the higher prices they charge. NGO health services are often of good quality, but we found these often monopolised by better-off households. People failed by formal providers end up going to traditional healers, whose services are of variable quality but whose charges are negligible.

This year we became aware of several new trends. The increased use of mobile phones greatly improves the accessibility and effectiveness of traditional birth attendants (TBAs) and enables other local health providers to make referrals. New health line services set up by social

businesses such as Grameen Phone may also have potential, but we found them little used because of their perceived high cost. We also became aware of the public health issue of increasing levels of salt consumption with food, perhaps because of the declining affordability of good quality food. We also noticed increased incidences of public spitting, even by health agency staff as they go about their work and the lack of first aid knowledge.

Since we were returning this year for the third time to the same families, and had built up higher levels of mutual trust and respect, the field teams were this year sometimes able to 'dig a little deeper' than before in their conversations with people and see further in their observations of local realities. This led to some potentially interesting and important new findings. For example, scarce hospital beds were often found to be occupied for weeks at a time by low-priority patients in order for them to secure a certificate from the medical authorities that would allow them to make a legal claim in the courts for compensation in assault or accidental injury cases. In another example, we observed that the work of TBAs – which we often found to be quite positive – was subject to systematic reputational 'smearing' by the spreading of rumours by other medical staff who spoke disparagingly about their competence.

Main findings in Education

We continue to find that low income households remain very positive about the importance of sending their children to school, and that most still seek to do so. The expansion of private and NGO pre-schools which purposely keep fees low to cater to the lower economic segments of society is testament to this huge demand for education. The growth of new private providers, often local philanthropic enterprises motivated as much by ideas of 'giving back to the community' as by profit, is opening up increased choice for parents.

Again, we found that the reasons given for the high incidence of school 'drop-out' differ widely. Teachers still argue that economic or social pressures often lead poor households to withdraw their children from school, but the accounts given by parents and children suggest that it is often the failure of schools to engage the interest of children which remains a more important factor. We also find that NGO schools are more attractive to children due to the increased level of play used in the teaching style. However, these schools areoften disparaged by both public and private teachers as de-emphasising 'serious' learning.

This year, we found less support for the stipend system, and a stated preference for a universal school feeding programme. Stipends are regarded by many people as divisive, inadequate and time consuming to administer. Increased investment in the training of teachers seems to have mixed results: some teachers were dissatisfied with aspects of the training, but felt it gave them more capacity to manage their relationships with their superiors. Long absences from school for training create staffing problems. A few school children said they noticed better teaching and teacher attitudes as a result of training. An important, though not new, problem that emerged this year was the use of teachers' time for non-teaching work requested by the authorities, such as census and polling.

We continued to follow this year the progress of the School Level Improvement Plans (SLIP) initiative, which provides schools with small

direct grants to use on their own priorities to enhance quality of education. The planned SLIP committees did not appear to function very well in any of our areas (either due to lack of a lack of awareness about the scheme, or a failure to build participation, or because they had become politicised). Wherean effective school Principal was in post, we did occasionally observe some positive outcomes. One less positive outcome reported was that knowledge of the programme sometimes discouraged and displaced local philanthropic contributions. Parents remain uninterested or unmotivated to participate in parent teacher associations (which have been largely non-functioning since their introduction as long ago as the early 1980s) and they are normally unwilling to question the authority of teachers. Meanwhile teachers, for their part, generally feel similarly disempowered in relation to the ongoing government education policy and reforms. Some told us that they felt they could contribute some useful ideas from their experience but that they have niether the confidence nor the opportunity to do so.

The introduction of a new Class 5 public examination has been a significant positive change this year, since it offers a more objective means for both government, private and non-governmental schools to prepare and assess pupils prior to moving on the secondary education. Some students told us they felt that it had also made government school teachers 'more serious' about the way they taught. The exam also provides better protection from inconsistent or corrupt activities practised in the past.

Conclusion

The Reality Check findings remain highly relevant to the ongoing health and education sector reforms. Some findings are borne out by other studies and lend further support to them, while other findings may still require further investigation and validation within ongoing monitoring and research in the two sector programmes.

Either way, the aim of the Reality Check is to try to prompt action within the programmes that can improve the quality of life of people in Bangladesh.

The report concludes with a discussion of trends and themes that arise from the findings of the Reality Check 2009 report and identifies five priorities:

1. Addressing people's lack of 'voice'
2. Providing people with better quality information
3. Improving standards and accountability
4. Helping people respond to wider changes and needs
5. Responding more effectively to basic public health issues

In short, the Reality Check 2009 report confirms the continuing importance of putting people living in poverty at the centre of efforts to improve health and education services. It highlights the continuing need for policy makers and front line staff to improve grassroots consultation and better understood local need and demand, and to encourage greater participation and voice.

The report also argues that programme performance will improve if more consideration is given to the views of local level service providers themselves, and if more opportunities can be provided for ordinary people to constructively questioning of received wisdoms among health and education professionals, staff and managers

Acknowledgements

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

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

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

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

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

Britta Nordström, Monica Malakar and Khaled Syed from the Swedish Embassy in Bangladesh provide valuable on-going support and direction. The Bangladesh Reference Group, comprising representatives from the Bangladesh Government Ministries of Health and Education and development partners based in Dhaka, provides advice and highlights issues in need of special focus.

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

It is our sincere 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.

Introduction

Background to the 5 year Reality Check Initiative

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

The Reality Check builds on the traditions of *listening studies*, which have the purpose of *'listening to, trying to understand and convey poor people's reality'*. Listening studies differ from other forms of study in that they give agency[1] to participants, thus offering an opportunity for citizens' voices to be directly linked to policy makers. Efforts are made in the report therefore to present these voices and experiences as accurately as possible.

The Reality Check focuses particularly on primary healthcare and primary education in Bangladesh. These two sectors are supported by large programmes (known as Sector Wide Approaches or SWAps) to which Sweden contributes. Both programmes started with the implementation of interventions in 2005.

SWAp	Period[2]	Number of consortium partners	Total budget
Primary Education Development Programme (PEDP II)	2004–2010	11	US$ 1.8 billion
Health, Nutrition and Population Sector Programme (HNPSP)	2003–2010	18	US$ 3.5 billion

The Reality Check is intended to provide information on how these large-scale investments in policy change and improved programmes are being translated into the experienced reality of people living in poverty. The Reality Check is a five year longitudinal study (2007–2011) where the research team members interact with the same communities

1 Agency is the term used to denote the exertion of power. In a reversal of conventional power dynamics, giving agency to participants privileges their opinions, ideas and insights.

2 Although the official starting dates of PEDP II and HNPSP were 2004 and 2003 respectively, the first activities under these programmes didn't start until 2005.

and households at the same time every year in order to identify changes, and to build an in-depth understanding of lived realities.

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

The study both complements and supplements other forms of study undertaken within the SWAps, but has its own special characteristics.

Box 1: What makes the Reality Check approach different from other studies?

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

a) It is longitudinal; tracking change over five years,
b) It is qualitative (seeks answers to how? and why? rather than what?, when? and how many?) and deliberately explores a range of experiences,
c) It uses informal conversations, not interviews, to put participants at ease and enable greater openness,
d) It includes participants whose voices are less often heard (elderly, infirm, young, persons with disabilities) because it focuses on the whole household and not on forums such as focus group discussions,
e) It uses immersion (staying with families living in poverty) so that the researchers can better understand the context in which conversations are held,
f) It involves shadowing members of the family as they interact with formal and informal service providers or following up on their comments about service providers by having informal chats with them which enables these voices to also be heard.

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

The findings from the Reality Check may confirm those already indicated by other forms of study and thus confer on these another dimension of credibility since they are revealed as a result of in-depth qualitative conversations. The study may also be expected to supplement other forms of study by highlighting information less readily obtained through conventional studies and providing nuanced interpretations of quantitative data. As well as providing a platform for voices of people living in poverty to be directed upwards, there is scope in the future to directly respond to those involved in the study. This downward accountability is expected to be given much attention in the final year of the longitudinal study.

Impact of the 2008 Reality Check Report

Following the publication of the Reality Check Annual Report 2008, the Swedish Embassy and Sida actively sought opportunities to bring the perspectives of people living in poverty highlighted in the study to policy discussions and public debate in Bangladesh.

Inspired by The Reality Check and the success of last year's Exhibition on the Right to Health (October 2008), GTZ and the Swedish

Embassy facilitated a similar Exhibition on the Right to Education. It presented photos and life stories from the 2007 and 2008 Reality Checks as well as cartoons solicited through a nationwide competition. A book of the Exhibition was published. Both the Right to Health and Right to Education exhibitions have been on tour; the former has toured the Chittagong Hill Tracts facilitated by Transparency International Bangladesh and the latter in rickshaw vans around Dhaka, facilitated by CAMPE. Significant news media coverage was generated around both Exhibitions in both the English and Bangla newspapers.

Introduction to the 2009 Reality Check Report

This report presents the findings from the third year of the 5 year Reality Check Initiative. These findings have emerged from field work carried out in October–November, 2009 and from subsequent inter-team dialogue and analysis. The Reality Check is designed to create a longitudinal study, presented systematically through a coherently organised series of annual reports.

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

The main findings are presented under the headings of Health and Primary Education. The penultimate section looks at the Sida framework of PNTA (participation, non discrimination, transparency and accountability) in terms of governance implications for both the education and health sectors.

Methodology in brief

A full description of the methodology can be found in the 2007 Annual Report.

The 2009 study is the third in a series of five annual studies covered by the Reality Check longitudinal study. What is essentially a *'listening study'* approach was adopted where research teams stay with families living in poverty and conduct conversations with different family members, their neighbours and different local service providers.

The nine locations for the study were the same as those selected in 2007/8 and comprise an urban, peri-urban and rural community in each of the three selected districts (in the North, Central and South of the country). The three communities in each District all relate to the

The kitchen within the house of one of our HHH, showing typical asset ownership (Urban North)

same municipal town with the peri-urban location approximately 8–11km and the rural location at least 32km distant from the town.

Each team member stayed with their own host households for a period of at least four nights and five days in each location. The only exception being the urban locations in the Central and South districts where overcrowding precluded living with the host family. In these situations, the team members spent long days (from early morning until evening) with the family instead. Details of these host households are provided in the 2007 and 2008 Reports. Here we provide a summary of their economic situation over the years (Annex 1).

The team was able to build further on the trust created in previous years to forge deeper relationships which led to more open and candid conversations and debates. This year the team noted the following as important developments in the approach:

- A special focus on the views and experience of adolescents. In previous years teenagers were often out of the house and difficult to include in conversations. Some of the F/HHH children have now reached adolescence and as we are already known to them they were prepared to talk with us. Importantly we included a young man in our team who spent three days in the central urban area talking with adolescent boys in the street.

Team member chatting while helping with the cows (Rural North)

Girls construct diagrams to explain their problems (Urban South)

- Spending more time with our F/HHH than in previous years as the time needed to gather contextual data has diminished. Conversations could be picked up later and subjects were discussed over several consecutive sessions.
- Spending more time accompanying people, e.g. visiting service providers.
- People were keen to volunteer information recognising our interest over the years. People also know that we are independent and this has built trust.
- Families are recognising that we were interested to talk with all members of the family and gave us opportunities and space to do this more this year. This also meant we could spend more time with children without adults around.
- Conversations are more two way building on trust and growing affection. We are more able to talk about sensitive issues.

- Because families and their neighbours have got used to us there is now more opportunity to blend in, observe and even have time on our own (when observations are often made).

This was the second year for the Dhaka based Reference Group. They advise the Reality Check team before the field work highlighting issues that should have a special focus. They also attend a de-briefing following the field work and helped to clarify key issues emerging from this year's work. The overall value of the Reference Group is to ensure the Reality Check is relevant to the needs of those concerned with the sector programmes and to ensure that there is optimal dissemination of, reflection on and use of the findings. Nevertheless, we continue to be careful to ensure that the spirit of the Reality Check is not diluted and the Reference Group were encouraged to endorse the fact that the impetus for the study comes from people living in poverty; it is their priorities, their perspectives and their experiences that we are trying to capture and understand.

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

HHH analysing their family income and expenditure (Urban North)

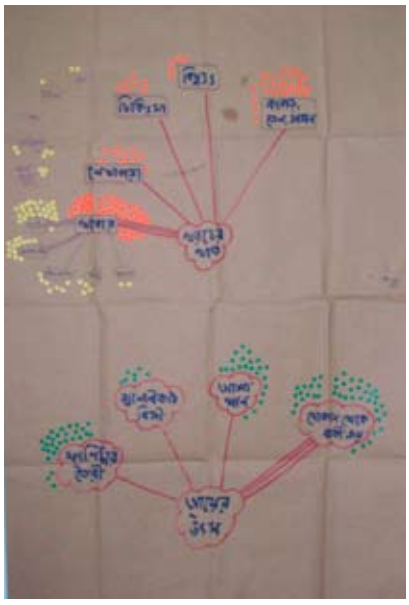


Diagram showing household expenditures (Peri-urban North)

Context

National Context

In the 2008 Report we noted that the repercussions of the global increase in oil prices and food shortages had hit Bangladesh. The situation was further worsened by damage caused by two floods (July and September) and the devastation brought by the 2007 Cyclone Sidr. Nevertheless, GDP reached 6.2%. During 2009 Bangladesh has continued to weather the worst of the global financial crisis and while it was afected its GDP has only dipped a little to a still healthy 5.9%. The World Bank has attributed Bangladesh's ability to withstand the global economic crisis to its low integration with the world economy. Exports grew by 20% in the first part of 2009 but fell to 2.6% in the second half, although the ready made garment sector remained robust. Growth in remittances also slowed from 30.9% to to 15.7% in the second half of 2009. Lower international food and oil prices, combined with a bumper rice crop, helped bring down inflation. In 2009, the World Bank report states that the country's poverty rate (share of population below the upper poverty line) and extreme poverty rate (share below the lower poverty line) are estimated to be 0.5 and 0.4 percentage points higher, respectively, as a result of the crisis. Inflation continues to be high at 8.9% although it has dropped a little since 2008.

Since our report last year national elections took place on December 29th 2008 after two years of emergency rule by the army backed Caretaker Government (CTG). During their term of office, the CTG had launched a broad-based governance reform programme. This included reconstitution of the Election, Anti-corruption, and Public Service Commissions; separation of the Judiciary from the Executive and preparation of credible voter lists. About 87% of the more than 80 million registered voters participated in the elections which were deemed 'free, fair and credible' by international observers. The Awami League-led grand alliance won a landslide victory and took office on January 6th, 2009. Rice prices immediately came down in fulfilment of a key election promise and the first Upazila elections for 18 years were completed in late January.

The final draft of the new Education Policy was submitted to the Prime Minster in September 2009. Public consultation has been undertaken through the Ministry's website where members of the public were invited to post comments and through a series of civil society consultations organised by CAMPE.

District Context

'Rice is the only thing that has gone down in price' (typical comment made in all our areas by low income people). Food prices seem to be a key concern every year in all our locations. This year there was mixed news. Everyone told us that they were pleased that rice prices had gone down as

promised by the current government in their election pledges. At around Tk20/kg,[3] it is now half the price it was last year in some areas (North) though only slightly down in the central area. But the price of other commodities has risen enormously, eroding the gains on rice. Those dependent on rice sales (south and central rural) are finding this low price difficult for them. This is further exacerbated by the resumption of interference by middlemen since the CTG left power. In the rural south area the price obtained (Tk400/maund) did not cover the costs of production. Vegetable prices have doubled in many areas which is good for the F/HHH involved in vegetable selling but most of our F/HHH, as consumers, have found have found this increase very hard. The vegetable price increases are said to be due to artificial hikes created by market syndicates which have returned since the Caretaker Government period finished. Sugar price has doubled (now between Tk55/kg–Tk70/kg) and has meant that producing sweetmeats for sale on the street in the urban north is no longer profitable and so hawkers now buy and sell used resid-

Vegetable prices have increased this year (Urban North)

ual syrup from sweetmeat shops instead. Pulse prices have also increased hugely (from Tk60 to Tk110/kg) and means that our families hardly ever take dahl. Cooking oil has gone up by 10–20% in most places to about Tk70–90/l (although it dropped in central area to the same price) and eggs from Tk4 to Tk6/egg. Our observations suggest that both the quality and quantity of food intake have reduced over the three years we have stayed with our families. Last year eggs occasionally replaced fish but this hardly happens now and most meals comprise large quantities of rice with a handful of vegetables. A doctor in the rural south area told us that he sees more children with low resistance to disease as a result, he feels, of poor and insufficient diet. Some told us the cost of clothes has increased this year; for example a lungi might cost Tk 270 compared to Tk175 last year. These price increases are far in excess of inflation.

Making fuel sticks with cow dung (Rural North)

Fish caught by children supplements the diet. This is for a family of six (Rural Central)

3 The highest price we came across was Tk25/kg in the urban north

Since the new Awami League led government, some restrictions instituted by the CTG to curb corruption and unlawful activities, have been relaxed enabling resumption of previous employment. For example, the transport industry has resumed full operation in the south urban area resulting in an increase in employment opportunities and an increase in income from loading and unloading boats, van transportation. Scrap prices (including metal) have increased slightly and opportunities for selling goods at the nearby market has increased. Although the lifting of restrictions has also meant that the construction industry has picked up in the north urban area, there has been an influx of migrant workers leading to increased competition for work. Rickshaw rents have increased in many areas. Many local poultry businesses were severely affected by the Government's decision to import eggs and several in our study areas were not operating this year. There is a significant trend to seek work outside; for example, in one of our study locations (south peri urban) members of several of our FHH have left for work in Dhaka this year and in another (central peri urban) several FHH women have recently left for overseas employment. Although the global economic climate has also meant that many previously working overseas were made redundant and had to return to Bangladesh.

The increase in food prices has helped to push house rents up in some areas, notably the urban north and urban central where there have been increases of 10–20% this year.

Scrap prices have increased this year

Sorting scrap for re-sale (Urban North)

Many of our study families have expenditures which exceed their incomes and rely on NGO loans to cover the deficit. *'Taking loans has become a practice for any reason'* (peri urban south) typifies what many say to us. People tell us that loans are readily available and none are used for business purposes, even though this is the reason given to justify the loan, it is an *'open secret that it is not being used in this way'*. Although this is not new, the implication we glean from our families is that the scale of loan taking just to ease household cash flow seems to have increased. They also manage temporary loans from neighbours and relatives and make day to day purchases on credit with local shops. The chart (Annex 1) shows how family finance fluctuates from year to year and depends, to a large extent, on what crises they face in the year.

Box 2: The 'roller coaster' of household livelihoods

The wellbeing of our households is precarious and fragile. The fortunes of vulnerable families may fluctuate from year to year, and from season to season, as these stories illustrate. An unexpected crisis can easily plunge a household that is making progress back into debt.

The family's house was destroyed by cyclone Sidr and they are still living in a make-shift home. Other families have managed to re-build but even though this family has taken NGO-loans to but building materials no construction has been possible because an unexpected health crisis occurred. One month ago one of their sons who is a bus driver had a serious bus accident. He is recovering but there is no guarantee he will get his old job back. His treatment has cost the family Tk40,000. The family has now spent all the money previously intended for the building of the house (HHH, peri-urban, South).

Another family is making good progress by increasing their household income. The father works as a van-pusher, delivering goods, and since the new government has lifted restrictions and regulations the transportation of goods has seen a real upturn. They are planning to move to a flat of a higher standard and with more space, and will let their current room out. Every one now seems upbeat about these plans (HHH, urban South).

A third family had finally paid off their loans this year and were feeling positive about the future when the garment factory where the wife works suddenly put all their workers on leave without pay due to financial problems. The wife was the major breadwinner. Her rickshaw driver husband started to make up the deficit by working longer days and the whole family started making baskets but this is intensive work with small profit margins. One day the husband was conned by a customer posing as a policeman into leaving his brand new rented rickshaw to attend to a 'patient at the clinic who was in dire need of assistance'. On his return the rickshaw had been stolen. The man who rented him the rickshaw does not believe his story and is demanding that he pays the full cost of replacement. The family is now in a worse situation than last year when they were still heavily indebted (HHH, Central peri-urban).

Many families have taken up basket making this year to weather the storm of factory redundancies
(Peri urban Central)

Few of these shocks this year are due to external factors (such as natural disasters, world food prices etc) but rather relate to extra marital affairs, conflicts, illness and accidents. The wife of one HHH which is struggling to make ends meet shared the following which sums up the feelings of others who suddenly face financial crises; *'In my experience life is going on and on, and there are no big ups and downs. Now it has been quite the same for some a long time … like flat, but suddenly it has taken a plunge down… it is stressful and bad.'* Families living in poverty are vulnerable to economic shocks and when experienced lead to considerable stress and depression.

More women and children working in the fields this year than before (Rural Central)

Typical slum conditions, narrow passages, garbage and water logging (Urban South)

This shopkeeper allows slum dwellers to buy on credit (Urban North)

There are more power cuts reported this year than before, with as many as seven cuts per day in the north urban area. Our F/HHH here sat in the dark most evenings because they cannot afford kerosene lamp oil. In the central area there was daily load shedding for about two to three hours but there was much appreciation of the new electricity connections in the urban south area.

There are many examples of a decline in law and order this year. In particular, there is a return to politicised resource capture and extortion this year following a relative respite from these activities in the previous two years under the CTG. Some told us that these *'bad elements'... 'need to make up for lost earnings'* over the CTG period and are now particularly aggressive. In the rural north area the waterbody used for common fishing resources has been captured by the UP chairperson (supposedly 'leased') and fishing is now banned. In the urban north, touts have resumed charging street sellers daily tolls which in addition to cutting into profits also means that the street sellers feel harassed. The distribution of welfare provisions (old age, vulnerable group development (VGD) cards etc) has reverted to distribution through political patronage and others fear the politicisation of the local shalish dispute resolution process further compromising access to justice. There are politicised land disputes in the north peri urban area and in the urban south some seizure of land has taken place. There is more of a general reluctance to discuss politics this year compared to previous years and prevalent feelings of disenchantment.

There is noticeably more distrust in general and fear about crime this year. People told us that there has been an increase in theft and mugging. For example, one potato businessman (central peri urban) told us of his recent hold up at midnight in Dhaka which was harrowing as he and his workers were threatened with machetes and guns. A rickshaw was stolen from one of our HHH while we were staying with him (central peri urban). Security lights have been installed outside

houses in the rural central area as there have been more house thefts. People told us that it is hard to run a business nowadays because of the high incidence of theft, interception and protection money demands which have reappeared after a two year lull. People attribute this disintegration to the end of the CTG, in particular to the return of politicisation. Associated with this change, people told us of the control of local markets, increased availability of drugs leading to more addiction and increased levels of gambling. In the north urban rickshaw licence owners are more reluctant to rent out their rickshaws for fear of theft, forfeiting Tk600 per month income. In the central urban area, people were concerned about the increase in th drugs trade. Teenage boys told us that street drugs (heroin, phensidyl, marijuana) are readily available again and they say that about one in four of them takes marijuana regularly and all knew of several heroin addicts. One of our FHH is in fact a heroin addict and he has been able to feed his addiction easily this year and has consequently deteriorated rapidly, sleeping most of the day and getting up to ply his rickshaw just long enough to make enough money for his next 'fix'. The ready availability of heroin this year was mentioned by other families also and noted as a reason why crime has increased.

FHH are still re-building their house after Cyclone Sidr (Peri-urban South).

Recovery from the aftermath of Cyclone Sidr in the south continues, but the capability of families to take on additional loans and freedom from other crises (e.g. accidents, medical costs) affects the speed of recovery. Pan (betel nut) cultivation, in particular, has been difficult to re-start because it incurs high start up costs and families involved in this prioritised re-building thei houses. After the initial relief period post Sidr there has been no further sustained rehabilitation efforts by outside agencies. Many members of F/HHHs have moved to Dhaka to work although this is because of the lack of local work opportunities rather than any link with Sidr. Job opportunities have emerged because of the large-scale investments in new infrastructure in these areas. Many people have been employed in construction for foreign bridge contractors relatively locally and this is seen as an important opportunity as they have gained skills which enable them to chase similar work in Dhaka and Chittagong. Some younger members of families have been sent to live with relatives either to pursue education or to ease economic difficulties. The local waterways have abundant fish this year which some attribute to the aftermath of Sidr.

This bridge was completed last year and attributed to the CTG (South Rural)

In both the central and south areas there is a new problem with *'digital time'*. This is the term used to refer to the new daylight saving initiative introduced by the Government in the summer. It was decided by the Government that clocks would be put forward one hour but this has caused enormous confusion. Whenever people talk about time they confirm it in both *'old time'* and *'digital time'*. Everyone maintains their watches and mobile phone clocks on *'old time'*. Teachers in our rural central area told us that children are late for school because they have not adjusted to *'digital time'* so in one Government Primary School (GPS) they do not take the roll call until 10.30 am (an hour after official start of school). The daughter of one of our HHH told us excitedly that school was now shorter since digital time as they started later but thought they still finished at the old time! A Family Welfare Visitor (FWV) tried to explain to us why only three patients had arrived at the Family Welfare Centre (FWC) by 11.30 am, *'people have not adjusted to digital time and women are busy with cooking before this'*. People keep their watches on old time as they were informed that the change would only be in force for three months and they did not feel it was worthwhile to make the adjustment. This policy seems to have added a new layer to the struggles poor people face with managing their everyday lives. This period has now been extended and people are confused.

We observed more home owned TVs and more computer shops since last year.

Box 3: Social impacts of new technology

On the main road just outside the village there are several new shops. All the shops now have satellite connections and they have TVs switched on all the time. Boys of all ages are attracted by this. Local adults told us they thought this was bad: it hampers children's school work and distracts them. Several mothers comment on the new TV connections and say it has become a big problem. When children go to school they pass by the shop. They stop walking and start watching TV, and become late for school. Children volunteer to run errands to the shops, because they will get a chance to watch TV. They go out and then they do not come back. There is also a new computer shop in this row of shops. Some of the boys 'hanging out' there say computers are useful since they help people with their writing. You can also create pictures and download music, they say. They told us also that some adolescent boys download porn movies and video games for their mobile phones (field notes, rural South).

We also observed that mobile phone ownership and use has increased considerably in all our study areas *'Viruser moto chore geche'* (It has spread like a virus).

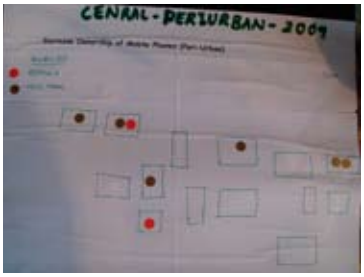
Box 4: The rise of mobile phones

We observed that the use of mobile phones has increased substantially since last year. Their ring-tones are heard from the early morning until late at night. Boys are always playing music loudly on their phones. During some conversations with boys, it was difficult to get their attention because they kept playing phone games while talking to us. When asked if we could see their videos and photos on their mobiles, the boys refused and hid them. Older boys spend a lot of money on their phones, people said. They make phone calls at midnight, download porn, music and video games. One boy also gave an example of how it can be used to harass girls: a boy took a picture of a girl as she was walking to school and then manipulated the photo to suggest that the girl was having an affair with another boy. This was then used to blackmail both the girl and the boy with threats of exposure within the community and to the police if they did not respond to his demands for money. The plan did not succeed and the boy fled to Dhaka (extracts from field notes, South rural). Similar stories of phone harassment were heard in the central study area.

Two women have a lively discussion about the youth of today and swiftly move to the problem of mobile phones which they call a 'communicable disease'. Both mothers have suffered financially due to pressure from their sons to purchase mobiles. 'My son is unemployed and he spends Tk10-15 almost every day. This is an additional cost for my family, for what purpose? Nothing!' The other woman added that she had heard how one parent had had to sell a goat to buy a phone for their non-earning son. 'It has become a competitive game' she added, 'and nowadays even parents sometimes see the phone as a symbol of family status. There are some boys who take money out of their father's pocket without asking. So, they are learning how to steal!' The women also gave examples of how some teenage boys now share less of their daily incomes with their parents since they spend money on their mobiles. Furthermore, they are concerned that boys and girls start romantic liaisons over the phone leads them to fall in love at best or may lead to harassment (extracts from field notes South rural).

The grandson (Class 6) of a widow (FHH) made constant demands for a mobile phone. The grandmother has no regular income and survives with contributions from some rich people. When the grandmother asked why he needed a mobile phone he explained that many of his friends have mobile phones and he needed to contact them to discuss homework and to collect other education related information (North peri-urban).

The number of mobile phones users has increased compared to last year in rural north. Adolescents are using this phone to listen to music which they download in the Upazila town. Some of them use mobiles for romantic liaisons. There is no electricity in the village so people go to the town to charge their mobile phone by incurring costs of Tk20 for transport and Tk10 for charging phone. Mobile phones are important for collecting information about remittance sent by their relatives living abroad. But owning a mobile phone is also a sign of social status. Since most people are illiterate they use symbols for saving phone numbers of others (North rural).



Increase in mobile phones (Peri-urban Central).

HH expenditure on mobiles amount to about 3–5% of monthly income, which is twice what is spent on electricity and often similar to recurrent costs of sending one child to school. In the rural north, people need to go to the central market place to charge their mobile phones as the village has no electricity. This costs a minimum of Tk20 alternate days. People feel that the mushrooming of mobiles has both pros and cons (see Table 2).

Table 2: The pros and cons of mobile phones from the perspectives of poor people

Pros	Cons
Work: in contact for day labour opportunities, job seeking , accessing market prices	Time wasting and costly
Remittance , receiving remittance information	Clandestine love affairs
Advice: health advice (formal or informal), other expert advice	Harassment over the phone- extortion and threats
Referral; local health service providers can manage referrals	Uploading porn
Family contact: with members working overseas or working away.	Increasing mobile theft
Contacting police	
Job creation- secondhand sales and mobile repair	
Recreation- games and music	

Everyone uses mobile phones, even the grandmother (Rural Central)

Old mobile phones also make good toys (Urban North)

Adolescents

The team made a special effort this year to include the voices of adolescents, which had been weak in previous years. These youngsters have much to contribute; providing insights into drop-out from primary school, understanding their aspirations and how this affects younger siblings still in school, sharing their experience of health services and articulating their special needs. We included a additional team member, a young man, who spent three days in the central urban area hanging out with adolescent boys. The insights from this together with the rest of the team members' efforts to include adolescent boys and girls inform the following section and sections on drop-outs later in the report.

Boys love to 'hang around' (Urban Central)

Adolescents and sexual health

Adolescent knowledge of sexual health is limited. Adolescent boys had heard about AIDS but knew very little about it. They had information about condoms from the TV but knew nothing about STDs. Their information on masturbation and nocturnal emissions was limited and had been gleaned mostly from Madrasa teachings and each other. Many of the adolescent boys said that there should be sex education in schools but not counselling *'as students would not want to talk about personal things with their teachers'* (boy, 15). Those who had learned some human biology at school said that this was not able to answer their questions. Girls told us that leaving reproductive health education until class 8 as intended in the Government curriculum was too late as many drop out before this. Medicine shop owners provide some information to boys but mostly they told us that adolescents are too shy to ask. Although when we asked one medicine shop owner in the peri urban south he said that teenagers do not ask for contraceptives but then smiled knowingly. Another said *'they don't come here with those sort of diseases (STDs), they get treatment from local health providers. They go somewhere to keep it secret'*. The main source of information for boys seems to be sister-in-laws.

Box 5: Who do you talk to?

J (20 unemployed) says there is no one to give advice about life and they have to rely on friends to discuss about emotions and life issues. 'We should be able to discuss all things with our parents. We should not have shyness. But we don't. There is a communication gap between parents and children and both are responsible for this'. Others tell us how important it is to have a sister-in-law as she is someone in whom they can confide in. S (15) says he can tell his sister-in-law things which he cannot tell his parents or elder brother. Others say they 'feel lucky for that '(having a sister-in-law to talk to about sexual matters and emotions). M (15) discusses things with his friends but cannot 'get solutions this way' (Central urban).

Despite the fact that we reported last year that many marriages in the urban central area were entered into because the girl became pregnant, most of the young men we talked to here felt that pre-marital sex was a 'sin', on both religious and social grounds. The boys said that they have girlfriends and touched and kissed (mostly in the cinema) but would not go beyond this. They admitted to feeling confused as the girls often wear provocative clothes and flirt but then say no to sexual advances. They said that some girls *'run after men with money'* (trapping them by getting pregnant or offering sex to cement the relationship). Girls said of pre-marital sex, *'Where could we go? There is nowhere to hide'* although boys told us it would be possible in hostels. Some boys we spoke with have had pre-marital sex and used condoms (hearing about this from the TV) or knew that the girls were already using contraceptive pills. Three had used prostitutes; two had used condoms and one had not.

Teenagers told us that sexual and relationship counselling centres should be established for girls and boys but some acknowledged that *'this will be a change in tradition and not easy'*. Adolescent boys suggested it should be a permanent centre or 'local club' *'shongho'* with one or two *'boro bhai'* (like our seconded team member who is 23 years old) who can provide informal advice. Such a centre would provide facilities for playing sports (e.g. table tennis, caromb board, cricket, football). It would be somewhere to chat and share cigarettes in a relaxed environment. They said that there used to be many clubs like this in 70s and early 80s.

Box 6: Youth clubs

Many suggested that there should be youth clubs; centres for recreation and conversation. R (19) thinks a club should provide education too. He suggests English classes and computer skills. Counselling could be offered here- 'we should be able to talk about everything here'. 'Boro bhais' should be involved, 'we can talk freely with them' (Central urban).

Girls and boys tend to have friendship groups and these groups would meet together in facilities such as these. School going boys told us that this sort of counselling could be provided in school but would need to ensure privacy.

Pornography is readily available and two of the boys we met in the central urban area run computer shops where other boys (as young as 12) come, usually in groups, to watch pornography *'Ato dekle ki cholbo' (if I worry about the age of the customers I cannot run this shop)* (young computer shop owner). Pornography is also downloaded onto mobile phones. Some boys felt watching pornography was a 'sin' but others felt that this is acceptable.

Adolescents and mental health

There seems to us to be some depression among adolescents and this year in all our study areas nurses told us that there has been an increase in suicide attempts which are brought to Government hospitals. This was the first time we had experienced admission of suicide patients ourselves and it happened in two places.

Box 7: A perceived increase in youth depression and suicide

A is nineteen. Only a year ago his parents were proud of him and every one saw him as a good example of a responsible and well behaved young man with aspirations. This last year he has faced some emotional crises. He was in love with a girl but his parents forbade the marriage and this has led to depression. He has harmed himself by cutting his arms which has left him with deep scars. His business went downhill and he has been forced to abandon his plans to put enough money away to arrange to go to Malaysia, for work. His health has further deteriorated due to alcohol abuse and possibly other drugs. He has also become involved in paid political activism, taking part in large demonstrations together with friends in order to raise money for his addictions (South urban).

Nurses in all the hospitals told us that there had been an increase in cases of attempted suicide this year. Both men and women had been admitted, mostly commonly having taken insecticide. They put this down to the 'love affairs', in particular men returning from abroad to discover that their wives had had affairs and financial troubles, in particular high indebtedness. One nurse attributed the increase to 'modernisation' (extracts from field notes, Central).

A woman was taken into the emergency department while we were visiting the UHC. She had attempted suicide by poisoning and had been rushed to the hospital by her relatives, including her mother and sister. People where shouting, asking for the woman's husband, but he was not present. 'Why has she taken poison?' someone inquired. Her sister replied: 'When her husband came back late, after midnight last night, she asked him what he had been doing out until so late. The husband could not give her a good answer, so he shouted at her. It is not a happy marriage... shouting like this has been going on since the beginning, 12 years ago. How can a wife tolerate this kind of behaviour?' A man standing next to the patient informed us that 'I see seven or eight patients that come in due to poisoning every month, but I haven't seen anyone die yet'. The statistical office reported that on average five or six patients are admitted due to poisoning every month (South rural).

We were walking down the corridor of the Sadar hospital when a commotion broke out. A young man had been brought in having taken pesticide in a suicide attempt. The rumour was that this was result of a failed love affair. The stomach pump was administered as he lay in the corridor (Central urban).

This girls feels depressed that she feels confined to the house in the slum she lives in. This is not always the case in some other slums girls move around easily (Urban North)

These are said to be due to failed love affairs and 'modernisation'. Several of our F/HHH girls are withdrawn and seem depressed. Some talk about wishing that they could move around more and not be restricted to the home. Girls from the slums said they want to get ideas about what life can be like outside of the slum and *'get smart and brave like boys'* (south urban). In the north urban area, adolescent girls have limited scope to go out and mix with others. They complain there is no common safe place to meet and their families restrict their mobility. We came across an apparently successful initiative for peer support for adolescent girls in the South.

Box 8: Peer educator programme

We met an adolescent girl who is working as a peer educator. She has been recruited by an NGO which has given her training on teenage related issues. She is now organising meetings with girls in groups of ten. She invites them to her house where they meet once a month. She teaches the group about such varied topics as dowry, AIDS, early marriage, patriotism, hygiene and sanitation, and how to behave as a responsible citizen. The teenage girl recounted a story that occurred a few months ago of the parents of a boy who was about to get married were set on demanding dowry from the bride. However, the marriage went ahead without any dowry involved (South rural).

But many of the girls in the central urban and peri urban area wander about very freely, are fiesty and confident (even loud and aggressive at times) and mix freely with boys without this kind of support.

Adolescent boys talk about their aspirations and regrets (Urban Central)

Adolescents and resuming education

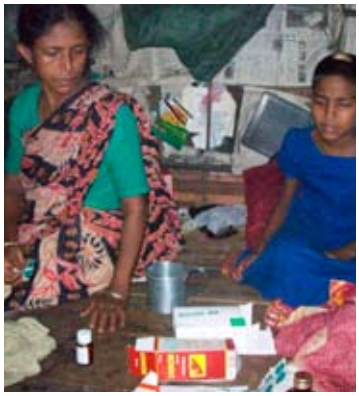
Although in many of our F/HHH families there are determined girls actively pursuing secondary education we have also met girls who have left high school either because they were not doing well, were being teased or for financial reasons. These see their chances of continuing their education as very slim. One girl (south urban) who last year was ambitious and conscientious in high school, told us, *'getting married is the only way to make the teasing go away'* and to make her and her family feel secure from harassment and threats from boys. Another is resigned to getting married because her widowed mother is concerned she *'may fall in love if she goes out to earn'* (north peri-urban). By contrast, a girl (14) who has got married this year to a man working abroad tells us that she wants to build a friendship with him before having sex with him. She only permitted him to visit her daily for the first few months of her marriage. He has returned to work overseas and she has resumed her schooling without consummation of the marriage.

Several adolescents told us how difficult it was to resume schooling after a gap. These gaps may be due to their own decision to drop out or circumstances such as ill health, moving house or natural disasters. They spoke of their embarrassment sharing benches with small children in primary school when they try to resume their schooling. But we also have examples of boys who have missed several years of schooling but are now studying in class 6 or 7 at the age of 17–18 with enthusiasm and commitment not seen when we first engaged with them. However, with the new Class 5 exam, it will be less possible for older children who did not complete primary but who want to resume their education, to enter high school.

Many of the adolescents we talked to are very aware of the job market. They say there is more pressure for girls to get higher qualifications as many jobs in, for example, the garment industry, has SSC as minimum qualifications. Boys tell us it is much easier for them to get work without any qualifications. Nevertheless many of them tell us that in order to get on they need further skills training and seem keen to do this. Computer and English classes were also mentioned by many as essential to get better jobs and access the international job market. But there are almost no opportunities for this and the frustration is epitomized by the comment *'we have taka now* (to pay for classes) *but no chance'*. Evening classes would be ideal and informal environments for learning preferred after so many years out of the formal system.

Main Findings in Health

Healthcare is a major area of expenditure for families living in poverty and, as in previous years we are struck by the careful decisions that are made around seeking and accessing health services. Spending time with our study families in careful analysis, we conclude that they spend between 7–10% of their income on routine medical costs and expect to face huge costs of Tk10,000 and up for any serious illnesses or medical emergencies. As highlighted in our two earlier reports, although Government services are subsidised, they are rarely the preferred service. This year we noted that our F/HHH use of Upazila Health Complexes (UHCs) and government family planning services in our areas is further declining as private providers continue to be preferred. Much of this has to do with the reliability of the services. Where Government services are grossly understaffed, people know that they will have to wait, may be required to make several visits, may find facilities closed and quality compromised so they prefer to buy services from the market. It takes time for people's perception to be changed and even when Government services improve (e.g. Central Sadar Hospital), patients need to be persuaded that adequate provisions will be made and costs will not escalate. However, the mixed fortunes in Government facilities do not build long term confidence in Government services as the next section explains.



This mother tries traditional and conventional medicines to try to cure her daughter (Urban North)

The strict visiting system imposed means that some attendants have to climb the gates to re-enter to look after their relatives. (Urban North)

Government facilities; some get better some get worse

Last year we noted the significant positive changes in the South District hospital with much improved orderliness and cleanliness. We wrote *'there is a new information booth provided for patients at the entrance. All corridors were clean and tidy; with cleaners wet wiping the floors and waste bins placed in*

every corner... The registration counter now opens promptly at 8am. There are guards outside every ward to check visitors. A new system of visitor cards has been introduced' (2008 Report, p.43). Meanwhile, the functioning of the North District hospital had deteriorated (2008 Report, p.45). This year there seems a reversal of fortunes since we found the North District hospital to be thriving. It is noticeably cleaner with teams of active cleaning staff. The out-patients area is well organised and controlled. A strict visiting system is in operation and an information booth similar to the ones we saw in the South last year has been introduced.

We heard that the North District hospital has a new director and can only speculate that these changes are a result of new leadership, although it seems much remains to be done.

Box 9: Dealing with patients in Government hospitals

The outpatient area was less crowded than last year but, as previous years, there is no privacy maintained during consultations. People entered freely into the doctor's consulting room. Hospital staff helped to maintain a relatively orderly queue of patients but this broke down as soon as the staff left and patients crowded into the doctors' chamber. Further problems ensue when patients are referred to another doctor or for pathological tests. Non-availability of staff in the right place, lack of proper information, long waiting times in each department, taking undue advantage by the hospital staff create problems for the patient. Receiving treatment after admission in the hospital is difficult for the poor. It is difficult to get doctors or nurses to pay attention to them. Nurses, ward boys and ayahs treat them rudely if their attendants are perceived to make frequent demands. One attendant of a poor patient told us, 'I requested the doctors and the nurses to check my brother as he was about to collapse due to severe stomach pain. But nobody looked at him.' (Field Notes, North urban District Hospital).

Doctors consulting rooms have two different numbers: one on the top and the other on the middle of the door which confuses patients and makes it difficult for illiterate patients to find their way. The new information booth at the entrance to the hospital helped little in these cases. Though all forms are written in Bangla, most of the time doctors write prescriptions in English. Sometimes they list many numbers of different diagnostic departments on the prescription, which is difficult for anyone to follow let alone those with limited literacy (field notes, North).

Meanwhile, the South District Hospital remains clean and orderly but the visitor card system has been made more complicated and seems to have largely broken down. The cards are transferred between visitors and are used to bring people other than the card holders in so there is little control of the numbers actually entering the wards. There are no guards this year and there is a steady stream of visitors coming and going into the maternity ward.

Box 10: Security problems at hospitals

The North District hospital has introduced the visitor card system we first saw in the south last year. Intended to create more order and security in the hospital, it nevertheless has problems. As every patient requires medicines and other support (supplementary food, drinking water, bandages etc) from outside the hospital they rely on having attendants who can run errands for them. If these attendants cannot have ready access to their relatives, they are hampered in providing for them.

But by contrast I visited the UHC very early in the morning. It was 6:30 a.m. Just at the entrance I found the door of the emergency room open and no one was inside the room. All materials were open and anyone could take it away. No security guard was found on duty. Then I went to the male ward in the first floor. I did not find any nurse on duty and the nurse's room was locked. In the male ward only 8 beds were occupied out of 18, most of them had injuries. I asked one patient what he would do if he needed any attention from a doctor or nurse in the night and he replied "We will have to go to nurse's residence and call her to inform doctor. A doctor might come if there was emergency call.' (North rural).

Doctors are once again arriving late and although the information booth is staffed, up to date information about doctor availability is not maintained. There are now once again many hawkers crowding around the entrance. Progress is fragile; improvements may be introduced and then disappear again within a relatively short space of time.

The Sadar hospital in the North continues to be avoided as *'The district hospital is only 1 kilometre away from the Sadar hospital, so why should I go to the Sadar hospital with less facilities, doctors are not available all the time and anyway they refer cases to the district hospital'* (woman, peri urban north). When we visit we see it is neglected, severely understaffed and underutilised. By contrast, the Sadar hospital in the Central area is now preferred to the District hospital by our urban families and some people from other central areas. This is no doubt in part due to the fact that the hospital is now fully staffed. Like the Central Sadar hospital, the one in the South is also better staffed and is offering a service which is perceived as relatively efficient.

MCWC, recently constructed and well equipped and staffed but no patients (Urban North)

While patients in the district hospital have to lie on mattresses on the floor, (district hospital central), this female ward in the UHC has not been used for weeks.

In previous years the rural North and South UHCs have been quite busy. In the North we reported that *'the lack of choice of alternative service providers means that people are 'bound to use the UHC'* (2008 Report, p.30). This year, however, most of the beds are empty. There were only eight patients in the male ward and six in the female ward. *"Considering the limited medicines available in the UHC our first choice is the pharmacy and its skilled salesman. We get advice from them and they sometimes give us the name of qualified doctors in the town for treatment"* (customer in pharmacy, north rural). The maternity units in two UHC (Central and South) have not been used for weeks. In the one in the South the nurses had to consult the registration book to check when the last birth actually took place and looked a bit embarrassed when they found it was more than two weeks ago. While some MCWCs are active others are idle. Box 11 tells of our experience visiting one in the North where they had not received a patient in days.

Box 11: Visiting an empty MCWC

The MCWC is located in a village, about 15 km to the south of the city. It is well equipped and designated 'women friendly' centre but it is empty on the day that we visit. The centre has modern facilities which include an operating theatre, labour room, post operative facilities, counselling room, necessary human resources, electricity and other facilities for caesarean sections and ligation. The staff quarters were built to accommodate all staff but none of them stay here due to the remoteness of the area. A staff member told us that "this land was acquired by the government for the construction of a FWC but later on with the lobby of a local UP Chairman the facility was upgraded to a MCWC. No publicity was done by the health department and therefore, many people of this district do not know about this facility". He also mentioned that "until 2006 the MCWC was located at the centre of the town and many people visited it during that period and received services. But after shifting over here people do not come because they find it is too far from the town". No pharmacies or restaurants are available in the locality for the patient and their attendants and no regular transport is available to go to the town. When we visited we were greeted with enthusiasm as we were the only people to visit that day (North urban).

This year the Government has instructed that Community Clinics should be re-opened and some have started functioning again.

Box 12: Experience of a Community Clinic

Last year we reported that there was high expectation that the Community Clinic located in the W para would re-open. It finally re-opened fully in July 2009. From October, 2007 during the CTG period it had been ordered to run but no resources were provided. During this time the staff maintained an attendance register which we reviewed. The FWA told us it was falsified just in case someone came to visit. The Clinic has a nine member committee with the land owner as the chair (reported last year to be against the wishes of the community). Other members include two ward members, a school teacher, religious leader and supposedly poor and non poor members of the public. They were supposed to have a one day orientation at the Upazila but only the chair man and staff (FWA, HA, CNP) attended. Apparently nobody else was motivated to go even with the incentive of a 'bag, papers and good lunch'. There has been no formal meeting of this committee yet. The clinic has received only one medicine supply (19 different drugs) from the THFPO (only and not from the Health wing) but this supply was exhausted after 2 months. As soon as news leaked that there were free medicines available a massive queue developed.

In two days the staff just dispensed medicines, including anti-biotics. The opening times are irregular. The FWA does not have key and yet has to staff the clinic on alternate days with the HA. Our observations suggest she rarely fulfils this duty. On the first day there was no service because the FWA was locked out and any way only one patient came. On the second day it was not open until 11.30 am. Inside the clinic there are two rooms, one intended for the HA and one for the FWA. Since they only have one key the second room is used for garbage. People told us that they were initially happy that the clinic has re-opened but disappointed that the medicines ran out so quickly. They have been told that their 'priority is saving mothers and babies' which they interpret as prioritising their SBA work.

A senior health official told a meeting of health staff 'onno shob kichu rubbish, oppekkha korte parbe' (anything else is rubbish and can wait). The CNP (who is employed by VARD since 2004) lives next to the Community Clinic and often opens up (acting as a caretaker) but only works there once per month for EPI and growth monitoring. There is no pushti (nutrition) programme any more. She says 'all mothers know everything so there is no need'. She no longer makes household visits and will sit in her home with her mobile phone ready to contact the FWA or HA if any patients come. One such patient did turn up while we were there requiring a blood pressure check. However as the room was locked the FWA could not get blood pressure equipment. This was exactly the sort of service the Community Clinic should be providing but it failed (Central peri-urban).

In the Upazila in our rural South area there are sixteen community clinics but they do not open everyday as there is a staff shortage so a rotation system has been adopted. Similarly, in the central rural area only twelve out of a potential thirty eight Community clinics have opened because there are only twelve Health Assistants (HAs) to run

them. We visited one model clinic, situated about 10 km from the village in our south rural area. Before the clinic was re-opened the building was renovated. However, there is no electricity, and the sanitary latrine has a faulty design. Members of the community strongly protested to the engineer when the toilet was first installed because they thought it far too close to a pond but the engineer paid no attention. The clinic in the rural North is open but not yet fully functioning. The access to this building is very difficult and this too was raised as a problem by members of the community when it was first constructed (see photo).

The Community Clinics seem to have mostly only had a single consignment of drugs and these were soon exhausted. For example the clinic in rural south received medicines in August 2009 and these were all finished within two months. The same was said of the central peri-urban and rural community clinics. They also lack other resources such as bandages, cotton wool or a blood pressure machine. The clinic in the rural south sees only about ten patients per day. Usually, patients are pregnant woman or woman seeking family planning advice, and children who are brought in for vaccination. Some elderly women come for free calcium and iron tablets that they have been prescribed by doctors. Talking to some women in the village, they agree that the opening hours of the clinics are good, but for them to feel really positive about it they would like it to have medicines and doctors. Other villagers say they have seen staff coming and going, sometimes opening the clinic, but they do not know what kind of services they provide.

Patients waiting in the newly re-opened Community Clinic (Rural South)

The community clinic will re-open very soon but the access over a ditch and with a steep slope is very difficult for ill patients (Rural North)

Staff of the Community Clinics do not themselves seem very happy about the re-opening. They complain that it is an added burden on top of their other duties. For example an FWA attends the clinic (central rural) along with the HA for 5 hours a day three days a week. Only the HA has access to medicines and the FWA feels it is a waste of time her sitting at the clinic *'it only extends my working day'*. This FWA also attended during a vaccination day and did virtually nothing (referred one patient to purchase oral pills form outside) but the HA insisted she was present. Although the nutrition programme has finished in this area and it is generally redundant there are a few mothers who are still at

risk. When one young mother came for a vaccination while we were at the clinic, there was no opportunity available for the FWA or Health Assistant (HA) to provide her with food supplements.

Staffing issues in Government services

'We do the best we can with the manpower shortage' (RMO, District Hospital, Central)

Box 13: Serious staff shortages in Government District Hospitals

The RMO told us that there are only 14 doctors effectively on staff where they are supposed to have 48. This District hospital only has one general surgeon and one orthopaedic surgeon. It only has 12 out of 18 medical officers. Worse, only 25 out of 50 nurses are appointed (although the RMO painted a more bleak picture saying that only 12 nurses out of a sanctioned 60 are currently working) which is even less than last year. Nurses told us that the main problem at this hospital is the staff shortage and the practice of employing doctors' assistants on short placements. These positions are often vacant and as a result nurses have to assist doctors. 'Why do they build a hospital like this if there is not enough people to staff it?' (nurse) And yet patient numbers are increasing; in-patients by 14%, outpatients have increased by 9% and emergencies by 11% compared to last year. There are beds on the floor in some wards. The hospital is on the main road and access is considered very good (Central).

We observed some of the problems associated with under-staffing ourselves. One nurse was alone in charge of two 25 bed wards with only one cleaner to help. As we spoke to her, an old man came to her in much distress suffering an asthma attack. She could not find any medicine in her cupboard for him and so went to find another patient to take back some medicine she had given them. She came back and checked the old man's records where nothing had been recorded there about him having asthma. She had to leave the ward to find a doctor to check this out, leaving the ward without supervision (Central District hospital).

Two male patients had been admitted on Thursday afternoon. For both of them this was the first time that they had been in this hospital. However neither was seen by a doctor until Saturday (more than 48 hours after admission). One was a member of the BDR and had suspected malaria. He would not have come here if he had had a choice but the BDR requires all personnel to attend Government facilities. The other was a very poor elderly man with heart problems. He spent the first two days in hospital in a state of fear because nobody saw to him (Central district hospital).

The theatre technician at the MCWC has been working here many years and is nearing retirement. He feels extremely overworked because of the shortage of staff - he frequently works 12 hours a day and then continues to be on call, particularly as he live close by (Central).

While we are at the Diagnostic Centre a young woman comes in with a companion. She is sweating profusely, and has to leave the room every now and then to vomit. She is an in-patient at the hospital opposite. Some weeks ago she had a miscarriage and has since then continued to bleed and she has had pain in her abdomen. She was told at the hospital that she would have to wait for nine days before she could have a scan to determine what her problem is. She and her family felt it was far too long to wait. On arrival they handed in a slip with instructions from the doctor about what tests she would need including USG and blood tests (South urban sadar hospital).

Box 14: Staff shortages in Upazila Health Complexes

Last year there were nine out of ten nurses in post but this has dwindled to six as two are on deputation to the District Hospital and one is on six months training. This means that there is only one nurse on duty in any shift (8 pm- 8 am, 8 am- 2pm and 2pm-8 pm) (Central peri-urban).

There are only four doctors including a dentist and two nurses when there should be nine. Two specialist posts have been vacant for years. Sometimes there are no staff on the premises at all (North rural).

The hospital has now four doctors, and the newly appointed UH & FPO states there should be 19 doctors in place. He seems defeatist about the hospital's ability to provide quality care and treatment with such an acute shortage of staff. But they do have 17 nurses (two trainees) to fill 15 positions. The UH & FPO has introduced an emergency-duty schedule that includes all doctors and the dentist. The dentist shows a letter that schedules him to do 24 hours duty as a general doctor for emergency and outdoor patients at the hospital in addition to his normal duty. The dentist shared his worries about this arrangement, 'I will be arrested... if any journalist reports and publishes this information in the daily newspapers. Because, being a dental surgeon I am not supposed to perform duties of a doctor who is treating all types of diseases for out-door patients. Sometimes I have to prescribe medicine for female diseases on behalf of Dr. F who is on leave.' He continues, 'I am always in tension when I do my duties. All patients who have political connections, come in the afternoon. They come with injuries and ask me for treatment and to provide them with a certificate about the injuries. This is required to file a case in the court. You see, if I am called to appear before the court as a witness ... what would happen to me then? Would I be excused?' (South rural).

The UHC has been staffed as a functioning 50 bedded hospital even though it is not operating yet. Thirteen doctors are appointed here of whom four live on site and the rest commute daily from Dhaka. According to the RMO, doctors do not stay long here as they are searching for qualifications and promotion. Nurses told us that they were never sure how many doctors were on staff as ' doctors come and go' (Central rural).

Boxes 13 and 14 provide several examples of severe personnel shortages in Government hospitals. These shortages include the whole range of positions from auxiliary staff such as cleaners, ayahs and ward boys through to senior clinical consultants. Only one facility, the Central Sadar hospital, seemed to be in a better position regarding staffing than last year. The difference between this and understaffed facilities was immediately apparent when we visited finding it clean, relatively well-organised and fully staffed for the first time in many years.

There were, for example, three nurses on duty in the women's ward and they were friendly and told us they enjoy their work since the full complement of staff is now operating.

Box 15: What a difference full staffing makes

The nurse showing us around the general female ward tells us they have seven more doctors as compared to last year. They have a total of 22 doctors, but still require a further 8-10. The hospital is clean and tidy. The man at the registration office points out that patients numbers increased slightly this year (around 300 per day) due to an overall improvement of facilities and 'Go in to this next room and you will find a doctor sitting there! He was not here last year.' We were not allowed in either the female ward or the maternity ward because entry is now restricted, evidence of more care. The peon of the pathology laboratory told us 'Our RMO is very strict, he is so careful that all is done in the right way... he is very serious' (South Sadar hospital).

We arrived unannounced at the Sadar Hospital. It was clean and orderly. As we entered the female ward there were three nurses on duty. They were smiling and friendly (in contrast to the tired and harassed nurse we had encountered in the UHC). They told us that they enjoyed their work now that the hospital was fully staffed. Although there is a shortage of cleaners the nurses felt they were able to do their jobs well and did not have to cover for others. This was the first time in many years that this hospital has been fully staffed (Central Sadar hospital).

While there are staff shortages, we also found staff who remain idle because their skills do not match their posting and others who have been co-opted to work in other areas. In the South peri urban UHC the X-ray technician has not had a functional X-ray machine to work with for eight years. He nevertheless continues to come to work and this year he has been allotted new tasks such as giving the daily patient information sessions on various general health issues.

X ray technician has no work as the X ray machine has not been operating for eight years. This year he has been allotted a new task of giving daily information talks to waiting out-patients.

He is also helping with handling sputum tests and administering treatment at the TB-clinic located in the hospital. He seems very proud and happy about this. The dentist in the South rural UHC has been included in the rota of on-duty doctors and is concerned about this. The extended UHC in the rural Central area is now fully staffed but since it has yet to open, the new staff are largely redundant. A newly appointed anaesthetist is not fully qualified and can only administer local anaesthetics. As a result, even when the new operating theatre is finally open it will be unable to provide the services for which it was designed. An orthopaedic doctor has been posted to the Sadar Hospital in the South area but is not authorised to conduct operations. Nor is it clear when this authorisation might be given.

Senior doctors generally do not attend on weekly holidays (Friday and Saturday), which exacerbates the staff shortage and leaves many patients without care.

Upazila level health staff told us that health extension services are also affected by staff shortages. There is an acute shortage of FWVs in some of our areas which leads to major gaps in service provision. There are some positive stories. In some areas certain services are widely used and in others the need for the services has reduced. For example, universal house to house family planning counselling and nutrition programmes for babies is not needed in the Central area as pointed out by health extension worker in last year's report (2008 Report, p.48). TT immunization coverage for adolescent girls seems to have been very successful everywhere. However, some pockets of need and at risk patients need special attention. The North rural area, as we have reported in past years, is severely neglected in terms of family planning and health extension services. Even in the relatively more sophisticated Central area there are some people in need of special support.

Box 16: The need to target 'at risk' clients

The shortage of FWAs means that there are no home visits in the slum. We met one mother who (unusually in this slum) still holds uninformed attitudes to her pregnancy. She suffered a fall in the fourth month of her pregnancy and had an USG. The baby was fine but the mother failed to eat well. The baby was born at home but is small and weak and not thriving. At one year he looks like 6 months. The mother consults traditional healers for the 'alga'.

The baby has jaundice, mouth sores and suckles poorly. The mother has tried to supplement her dwindling breast milk with formula. She knows nothing about proper weaning. This mother is clearly struggling but there are no health visitors to pick up the problem. Although other mothers in the slum seem much better informed, this story demonstrates that others remain at risk.

In the urban North area, women told us that no government family planning staff visit the area. This is despite the existence of an NGO-run UPHCP satellite clinic which is supposed to open for 4 hours six days a week but was closed when we visited. When it is open it refers patients to the UPHCP static clinic for certain medicines. This operates a strategy of partial filling of prescriptions for subsidised medicines to encourage patients to come back and establish a longer term relationship. But people we spoke were unhappy about this. They found this referral, partial provision and payment for medicines policy burdensome and time wasting, often circumventing this by getting their prescriptions filled by another local NGO clinic for free. One man (FHH) said *"In our slum you can not walk properly as lots of kids are roaming in the lane. So you can realize how unaware we are about small family"*. Although some North slum women use free oral pills from NGO clinics and the UPHCP clinics and sometimes purchase from the local market, they stop taking these if they suffer any side effects. Here very few women know about or use the injectible methods unlike in other areas (even the north peri urban women are better informed and prefer injectibles which they get from the local pharmacy). No men use condoms.

In addition to meeting family planning needs, other government health extension workers are responsible to build health and hygiene awareness. The rural North is the only area where our families continue to use pond and river water for cooking, cleaning and bathing. The

EPI camps work well, this one in the rural north was well attended

six tube-wells in the village are all out of order. Although there are a few latrines these are not installed properly. We did not observe hand-washing as we do in all other areas of the study. Consumption of improperly dried fish seems to cause stomach problems and the incidence of diarrhoea is high. Few vegetables are eaten because they do not grow in the poor soil and market prices are too high. Symptoms of malnutrition are much in evidence. But this community rarely receives any Government health extension services and the nearest FWC is 7 km away.

The lack of information and high incidence of mis-information in the North (urban and rural) suggests a particular need for more counselling and information services not found elsewhere in our study.

Costs

'Going to a Government hospital is as costly as going to a private hospital' (woman south peri urban).

As we have reported in previous years, people feel that wherever one seeks treatment, whether through public, NGO or private providers, then considerable costs will be incurred.

Box 17: First response to casualty

T, is an engaging boy of 6 years old and the son of one of our FHH. On October 17th, 2009, he was pushed by a friend into the pan of oil used by his grandmother to cook pitha on the roadside. His face and neck were severely burned. The resulting commotion quickly created a crowd and a passerby donated Tk200 and a passing policeman Tk500. The family panicked and, it seems, were more concerned about collecting money they assumed would be needed rather than getting the boy to casualty. Neighbours thought that the treatment would cost at least Tk20,000. T was taken to the District hospital. So concerned about accruing costs, the family brought him home against the advice of the hospital. But they had to re-admit the following day in the Sadar hospital when 'we realised it was more serious than we had thought'. We visited him in hospital and the nurses said he would have to stay 10 days 'until the burns are no longer 'wet''. Contrary to the family's fears the treatment provided so far has all been free and they were very pleased. The lack of immediate First Aid, delay in getting the boy to casualty and the initial removal from hospital will all negatively affect the boys recovery (Central urban).

A woman came to the District hospital from a distant Upazila with severe burns over the whole body as a result of an accident with a kerosene lamp. Her husband is now living in Saudi Arabia so she was accompanied by her husband's sister. She was admitted three days ago (Thursday mid night). he ward boy of the hospital claimed Tk1,750 to allocate a bed for the patient but she refused to pay. As a result, the patient did not get a bed and when we met her, she was lying on the floor. She told us that no senior doctor visited her till today (Sunday – so nearly three days since admission). She told us that she now realized that she would not get proper treatment in this hospital and feels she 'might die if she continues staying here'. Finally, she decided to get released from this hospital and go to private clinic (North).

We were visiting the Sadar hospital when we heard screams. A woman with acute acid burns all over her body arrived on a rickshaw. The acid was already striping her skin. The duty doctors immediately told her attendant to douse her in water from the pump. It was a harrowing spectacle and brought crowds out to watch. It was clear that this woman would be severely disfigured if indeed she survived. The severity of the incident might have been reduced if the people had known to wash her down quickly and thoroughly immediately rather than waiting until they go to Casualty (Central urban field notes).

Box 17 describes the panic in a family to arrange funds in the case of an emergency on the assumption that this will be considerable. This means that people tend to delay treatment as long as possible.

Although the official prices displayed for registration and tests in Government facilities remain unchanged over the years of our visits,

the real costs have been rising. Women in the South area explained the common practice of 'specials'. Normally if a patient goes to the out-patients they would not expect to be examined *'the doctor just listens to what you say and prescribes'* (woman, urban south). The doctor does not ask questions or engage with the patient. This is just what those patients who come only to collect free medicines want (see 'free medicines' below). In last year's report we noted that doctors running out-patient clinics complain about this, *'Some women get cross that I want to ask them for their medical history as it wastes their time. They just want me to write a prescription so they can get their medicines for free and quickly'* (2008 Report, p.37). But for those people who do want a proper consultation, this is clearly unacceptable. *'We need treatment which is real not just superficial... if a doctor does not touch the patient it is superficial'* (woman, south urban). Another person said *'once I said* (to the doctor), *please touch the patient and the doctor replied that this would mean a 'special' This means the doctors says 'I have done enough' and if you want more services you will have to come to his private chambers... this is called a 'special'* (young woman, south urban).

Box 18: Government doctors and bribes

Villagers in the South rural area told us that during the CTG period there was no 'under the table' money being charged by Government doctors but that this practice has now re-started. A man with a recent experience told us 'I went to the hospital with my grandson. He had broken his hand. When I come to the hospital now doctors ask me if I want a Tk5 treatment or a Tk50 treatment. The Tk5 treatment, which is just paying for the ticket to get admitted, is not a good treatment. I wanted my grandson to be properly looked at so I went to see the doctor in his private chamber in the evening instead, which cost Tk50.

Another man explained that if you go to see the doctor without a 'registration slip', then it is understood that you expect to pay for a prescription written on the doctors own pad. This type of consultation is, in other words, private with payment made directly to the doctor. Alternatively, even when the doctor looks at the slip and uses the Government prescription pad, if the patient starts to ask too many questions then the doctor will again demand money for this. This practice was described in the North rural area as well; *'if the patient wants a check up and cannot explain their symptoms clearly then they have to pay Tk100. If they say they have a headache they get a prescription for free.'*

In an animated conversation with several men in the market in the South peri-urban area, one man described his experience where a doctor treated patients in the government hospital 'at arms length' but then later seeing the same doctor in his own consulting room giving close attention and care to his other paying patients. He said this proved that doctors were only interested in patients who pay. But a *polli* doctor disagreed with this view and said that all doctors pledge to give all patients appropriate care. A large signboard has now been placed at the main gate of the North rural UHC describing the UHFPO's private practice time. All the doctors here run their own private practice from their residences inside the hospital campus. One patient said, *"I came to the hospital at 11:30 a.m. to consult with doctors but I did not find the doctor. I went to his residence inside the hospital campus and found him busy with consultation. So I consulted with him at his residence where he gave me a prescription with Tk100. I find it cheaper than other doctors doing private practice in their chambers."*

In previous reports we highlighted the high costs of medical treatment for serious conditions (e.g. Report 2008, Box 13). Medical costs can have severe effects on a family in poverty as. As we have seen earlier, medical costs are often the main reason for taking out an NGO loan even if the loan is given for productive purposes. As a wife of a FHH told us, *'Sudden health crisis, that is the main reason for so many (people) always being in a loan cycle…Taking NGO loans has become such a common practice now because they run behind the poor people to distribute loans!'* (south peri urban). For households that have no economic 'buffer' to protect them form the shocks of ill health, getting a loan becomes the first option to try to solve a sudden crisis. Loans may also be taken to compensate for any unexpected fall in household income due to loss of time because of illness.

Box 19: A bus accident results in debt

T. is a bus driver. A couple of months ago he had a bad accident: a head on collision with a truck. The bus turned over, and luckily most passengers escaped without serious injuries. He hurt his foot though, quite badly (a vein was almost cut through). He was taken to the district hospital. They treated his foot but he was not pleased about how he was being treated. He went, on his own initiative, to a government hospital in Dhaka, where they operated on him. He got a very bad infection after the operation, and again on his own initiative transferred to a private clinic in Dhaka. At the private clinic, they cleaned the wounds up and the foot is now healing properly. The total cost for his treatment was Tk40,000. He was compensated Tk2,000 from the company he worked for. The medical costs have meant his father now has to support him, and he has therefore had to stop attempts to re-build his house that was destroyed in the cyclone Sidr two years ago. T's father has taken on several loans and is facing problems repaying them. Although he already has one loan with BRAC he has recently taken another one by going to a BRAC office in another nearby area (South peri urban).

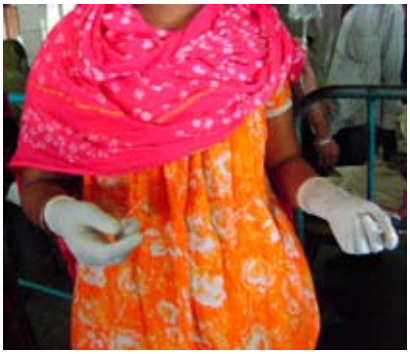
Cleanliness in Government facilities

Several factors conspire to make maintenance of cleanliness standards particularly hard in Government health facilities despite evidence of training this year. These factors include shortage of auxiliary staff, wards over-crowded with visitors and shortage of cleaning materials. Last year we noted that there is no budget for cleaning materials and hospital staff have to raise this money themselves (2008 Report, p.45). We spoke to one cleaner (Central district hospital) who described the difficulties he faces. He spoke both of being directly overworked and also undermined by the lack of discipline in wards where there are too few ayahs/ward boys.

Box 20: Problems for cleaning staff

There are two ayahs and two ward boys but one works in the out patients area so there is only one on each of the three ward shifts. There are three cleaners but one is very old and contributes little and another also works 'downstairs'. This means there is effectively only one cleaner for both wards. The nurses said the lack of cleaning staff is the main problem. As each patient is accompanied by many attendants and has many visitors, the wards can be quite chaotic. These people make a mess and misuse the toilets, including putting waste down the toilets. There are no guards and when staff try to control the visitors, they retort things like, 'This is not your hospital, it is a Government hospital so we have a right to be here'. (Central rural UHC).

Also, many visitors accompany each in-patient and cause disruption to the ward. Officially only one 'attendant' is allowed per patient but we observed and were told that most have many more. These extra people put a strain on the toilets, showers and make a mess by bringing in their own food, spitting, dropping rubbish and sleeping anywhere. The cleaner showed us how the showers are used as toilets partly because people do not know what they are and partly because the toilets are too few. Another cleaner told us that they had received training recently from JICA and described some of the things they do differently as a result, including wearing gloves and boots



A result of training this year: the cleaners now wear gloves and boots (Urban Central)

Cleaners outside the District hospital (Urban South).

Patients and their attendants asked us after we visited the toilets what we thought. When we said they were *'quite clean'*, they retorted *'you should see them at 4 o' clock… they only get cleaned once a day'*. Last year conversations with the nurses of a UHC (Central peri-urban) revealed that they felt that 2008 had been the worst year they had experienced for material supply and maintenance. The situation has not improved during 2009. Still there are no brooms, brushes or buckets. There is no light in the corridor outside the wards and the toilet in the women's ward has been out of order for 5 months so that patients have to use the one attached to the men's ward or walk down the corridor to the gynaecology ward. But even here the wash basins are not in use. The cat we have observed each year wandering through the wards has recently had kittens.

Box 21: Cats in hospitals

Lots of cats were roaming around the beds. One patient complained that cat took away his bread from the cupboard and therefore, he was hungry for the whole morning. (North rural field notes). The cat we have seen every year in the Central peri-urban UHC has had kittens. Cats were spotted for the first time roaming the wards of the central district hospital and in the rural central UHC.

Leadership seems to have an important influence on the cleanliness of hospitals. This was evidenced by the observed improvements last year in the South district hospital and those in the North this year resulting from posting of new directors and the introduction of teams of cleaners.

Food in Government Hospitals

We observed the implementation of the new policy of 'improved diet' for in-patients in the central district hospital where a contract company provides the food. The food was nicely presented on clean plates and looked appetising. One woman told us she thought the food was excellent.

This woman was very happy with the improved food in hospital. She said it was 'delicious' (District Hospital, Central).

Improved food at the district hospital; well presented and appetising (District Hospital Central)

Just below the no spitting sign, there is newly deposited spit on the steps of the sadar hospital (Urban Central)

Nursing and auxiliary staff told us they were pleased with the standard of food. Similarly in the north district hospital we did not hear the complaints about food that we had heard in previous years. By contrast, there was no evidence in the central peri-urban area UHC of an improved diet. Two male patients said that the food was very poor (chapati and poor quality banana for breakfast, rice with either fish or meat for lunch and dinner but with very small pieces of fish/meat). They said it was essential that their family bring in supplementary food. The nurse in charge said that they were provided fish, meat and egg on alternate days but acknowledged these were small portions for young men. Nurses confirmed that the budget had been increased but said it made little difference as food prices have increased too. This same sentiment was shared in the rural central UHC. In the rural south UHC patients told us *'We know that government gives more money for food now but you could not tell really, from the quality of the food'*. One of the patients has food sent to her from her home 3 km away.

Construction and maintenance in Government facilities

We observed that many of the buildings being constructed under the HNPSP programme are delayed and that the construction itself is causing considerable disruption. The MCWC in our Central area has been under construction since our first visit in 2007 and although the third floor extension is now regarded as having reached 'practical completion', it is not yet in use except for occasional training. The UHC extension (central peri-urban) has also reached practical completion but it was promised to be opened two years ago. The temporary entrance is around the back of the building and the grounds are littered with building materials. Medical staff told us they are concerned that the new equipment which has remained unpacked for many months in the unused extension may be getting damp and corroded. Similarly, in the peri-urban UHC in the south new staff quarters and a new extension are being constructed. The two storey extension is completely blocking the entrance and arriving patients are confused and have difficulty find-

Construction at the UHC. Patients trying to find their way in (Peri-urban South).

ing their way. The Central rural UHC was originally constructed in 1972 and since the start of the Reality Check study, the extension to upgrade to a 50 bed facility has been under construction. Last year the 'final completion' work had been stopped three months before our visit. Further work has since been undertaken and the old out-patients area has gone. The extension is supposed to have reached practical completion but it is not yet open. The boundary wall which was cited as the reason for construction delay last year has not been built and animals still graze in the grounds. The RMO said there was 'an official reason' why the building had not been handed over but said he did not know what this was. He speculated that the contractor was in dispute with the DPHE. The nurses told us they hoped that it would be open in January 2010 but the RMO said it was more likely to be a further 3–4 months.

The same basin in the public toilet in the waiting area of the District hospital has a new tap this year but there is still no water connection (from left to right: 2007, 2008 and 2009) (Urban Central)

New equipment has been provided to the operating theatre of the newly-extended UHC in South rural area but it remains closed. Although we were first told that the equipment was not adequate for a 50 bedded hospital, further enquiries revealed that all the necessary equipment has been received but it has not been set up yet. The implication is that there is a problem between the purchasing committee and the installation company resulting in stalemate due to non payment of bribes.

Box 22: Power cuts

We asked the nurse in charge of the maternity ward about the state of equipment. She told us that there was enough and it was all working. But a mother protested she had given birth the night before, in the dark, because none of the spotlights in the delivery room worked! The nurse still maintained however that all was in good order. The woman was upset about the risk she had been subjected to, by having to go through labour and delivery in complete darkness (South urban District Hospital).

We visited the dispensary at the Sadar hospital and as there was a power cut at the time the room was pitch dark. The staff were upset and asked us to come in to take pictures, as evidence, to show to the government that they are suffering: 'Come in here...see the government does not supply anything! It is always a crisis! Yes, we do have a little bit bigger budget now than we had under the CTG... then we could provide 40% of the medicine demand, and now it is maybe 50% or a bit more. But take a picture of this... see! There is no electricity! (South urban sadar hospital).

We have problems with power cuts; it is very common in this area. If it gets black I have to see my patients with the light of my mobile phone. There is a generator but there is no fuel, or there is no budget for fuel. Nobody at higher level is taking any care of this. Every month we write to the Civil Surgeon but so far, no actions have been taken. Our Civil Surgeon is the man who has been here since long... so lets see.' (Dentist, UHC South rural).

The tube-well at the newly opened Community Clinic is not working (Rural South)

Box 22 describes problems associated with frequent electricity cuts.

Equipment in Government hospitals

Table 4: Status of X ray equipment in some Government hospitals

Facility	2007	2008	2009	Comments
District Hospital North	✗	✗	✓	3 X ray machines (USG and CT scans) were not working properly last year, but are all functioning now
District Hospital Central	✗	✗	✓	Finally long awaited X ray is installed but no radiologist and only one technician.
District Hospital South	✓	✓	✓	X ray machine functioning
Sadar Hospital North	✗	✗	✓	Working partly in 2008
Sadar Hospital Central	✓	✓	✓	This X ray was installed in 1985 and is just about kept working under the supervision of a highly motivated technician who says there are lots of technical problems because of its age
Sadar Hospital South	✓	✓	✓	

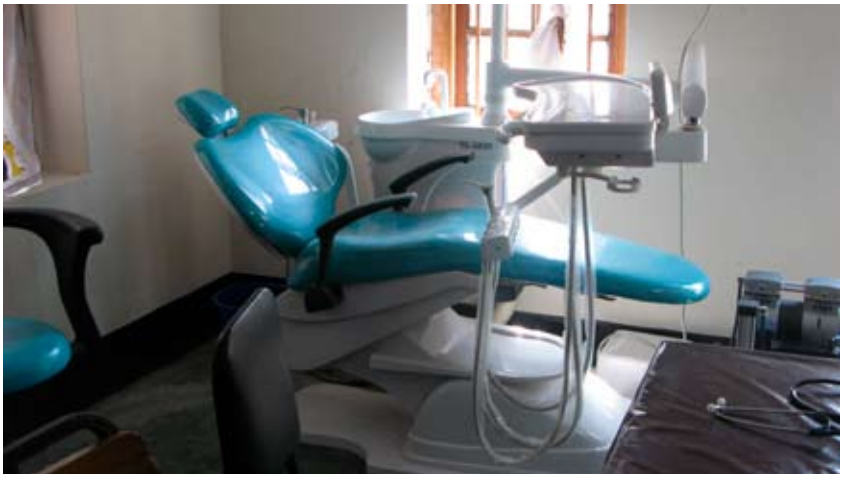
UHC Central peri-urban	×	×	×	X ray machine has never worked over the last 3 years
UHC South peri-urban	×	×	×	Broken for 8 years . Technician now runs patient information sessions
UHC North rural	×	×	×	Continuously out of order, patients always referred to local Diagnostic centre next door
UHC Central rural	×	×	×	X ray is 36 years old ' it is an old lady' and frequently out of order. Even when working the negatives are unreadable. Technician idle most of the time

Table 4 demonstrates the problem with equipment. X-ray facilities are essential medical equipment and yet they are often not working at all or require regular repair. In the South peri- urban hospital they have recently received new equipment due to pressure exerted by the RMO, but the x-ray machine has been broken for eight years and although the RMO continues to try to get it fixed, this has so far proved impossible.

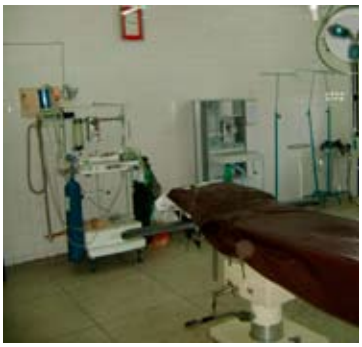
Box 23: Importance of essential equipment

The RMO at the UHC shows us some new equipment. Through putting pressure on higher level officials the UHC has secured equipment for the emergency room with new autoclave to sterilise equipment, an oxygen machine and a suction machine that is used for sucking mucus from babies' lungs/throats. All of this, the RMO points out, is essential for the hospital in order to deal with some of the most common problems that patients face. For example, the fact that they can now deal with babies with pneumonia and/or who have difficulties breathing by using the 'suction machine'. Had they not had this, they would have to send babies to the district hospital, and many babies would not survive such long travel. Hence, a simple machine makes it possible for doctors here to provide essential and life-saving treatment (South peri-urban).

As mentioned above (Construction), equipment may be in place in new facilities but not installed because of payment issues. Similarly we were told that it took three visits to Dhaka to follow up before a UHC got the ambulance it had been promised. Each time they were told that the papers were not in order but the real reason, we were told, is that there was no backing from the local MP, presumably because this decision had become politicised. A UHC dentist told us that although he has adequate equipment he does not have the necessary materials and so has to remove decaying teeth rather than treat them.



New dentist's chair at the UHC (Peri-urban South)



None of this equipment is functioning (District hospital, South)

The operating theatre lights are not working (District hospital, South)

Superb operating theatre facilities at the district hospital but only two surgeons (Urban Central)

New demonstration skeleton helps doctors explain diagnoses (Peri-urban South)

Old but well organised laboratory (Peri-urban South)

The reluctance to complain about poor Government services

As we have reported in previous years, people do not feel able to make formal complaints about Government facilities and services and yet they often have a lot to complain about (e.g. Box 24).

Box 24: Diary of a field team member: How can an illiterate poor person access health services?

Once I had the opportunity to accompany a patient to the district hospital coming from the North rural area. I went to observe how was availing the services and what problems he faced. This is a story of the man.

One of our FHH head is a day labourer and has been suffering with a hernia for the last three years and got treatment in the Upazila Health Complex but was not cured. This year he decided to seek treatment from the district hospital. He started from the village at 5:30 a.m. and arrived at the hospital at 9:00. He registered himself with Tk10 for consulting the doctor in the out patients. At first he was told by the staff to stand in queue number-1. After waiting for an hour he finally entered the doctor's room. The doctor looked at his slip and told him to go room number 2. He came back and stood in queue 2 which took him another 1 hour to consult the doctor. The doctor sent him to the surgical section for consultation. The doctor on duty in the surgical section sent him to another doctor for physical check. The third doctor advised for blood test, X-ray and USG. While coming out from the doctor's room he was caught by a dalal (broker) of a private diagnostic centre. As soon as he looked at me the broker released the patient assuming that I was accompanying the patient. I asked the patient whether he knew this man. He said 'no'.

The doctor had written three different room numbers for the man to go to for further diagnosis and it would have been really difficult for anyone to follow those numbers. It took about half an hour for him to find out the pathological section being an illiterate person and never having visited the district hospital before. The pathology department charges Tk60 for blood test. He had to wait for another half an hour, as the pathologist was not in the laboratory. Then the patient went to the first floor for X-ray. Again it was a big queue and he has to pay Tk170 for X-ray and USG. He was referred to room number 2 for X-ray. It took about one and half hour for his turn to enter in to the X-ray room. Looking at the slip staff inside the room told him to go to room 5. Then the patient could not control his temper and asked the staff why you did not tell me before? It is written room number 2 but you are forcing me to room number 5 after waiting for two hours? However, he then rushed to room number 5 for X-ray so that he would not miss their opening times. It was a room without any privacy. While he was preparing for X-ray a lady patient suddenly entered into the room and found the patient half-naked preparing for the X-ray. She quickly went out from the room. After completion of X-ray he was sent to the USG room where it took about half an hour to perform the USG.

At 4:00 p.m. he came out from the hospital without any diagnostic report. He was advised to collect reports on the following day. He had to spend about Tk900 for transport, food and pathological tests in the district hospital. Next day he went to the hospital to collect the diagnostic reports and consult the doctor. After collecting the reports he contacted with the doctors to know the date of operation. Shockingly, the doctor threw down all his reports and shouted that the date was written on the reverse side of the slip. The doctor told him to come after seven days to get admitted into the hospital for operation.

After ten days I phoned him to know the progress of his treatment. He informed me that he went to the hospital but the duty doctor again told him to come after ten days, as the Eid Ul Azha vacation would start. This was the final straw, he has spent all the money he had managed from the relatives as a loan and it is not possible for him to visit hospital again as no one will give him loan any more for the treatment. (Rural North).

Typical are the comments of a woman in the peri-urban South Area, *'If we feel we have been treated badly or inappropriately at the hospital we come back from the hospital silently and resolve not to go back there again. I would never complain about anything at the hospital'*. We asked a group of men we were chatting with in a pharmacy one evening whether they ever complain about the poor treatment they get at the Government hospital *'No, no this is not at all possible. You would risk being banned; the doctor would remember your face. And not only that doctor; he may say in front of other doctors and staff 'take a look at this person, remember him, he is not to be treated here again' and so they will be prevented from seeking help at the hospital in the future'* (South peri-urban). In the North, the team reports that nobody ever complains about services. For example, in the north rural area people say they do not complain about the fees Government doctors charge 'under the table' because it is still cheaper than going to a private provider.

Box 25: Challenging the doctor

M is a TBA who received some training in 1970 from the Red Crescent. She has been providing TBA services ever since and is frequently consulted and much trusted. She told us the following recent experience. A family in a neighbouring village called for her help with a difficult delivery. After examining the mother she realised the mother was carrying twins. The babies did not seem to be in the proper position so she suggested they go to the UHC. On arrival there was no doctor on duty. M ran to the RMO's residence on campus and explained the situation. The doctor then told M, based only on the verbal information she had provided, that one of the babies must be dead. He suggested a caesarean. But M protested: 'I challenged the doctor and said both babies are alive!' Then they argued about this for some time. Exhausted, M suggested the family take the mother to the district Sadar hospital. M asked the doctor to assist in arranging an ambulance. The doctor did so but asked for Tk1,500. The price was negotiated to Tk1,200. At the Sadar hospital M informed the doctor about the case. It was lunch time and the doctors said they will attend to the case after lunch, in spite of M saying it was urgent. She pleaded: 'Both babies and mother are alive now, if anything happens to them I am telling you then that you have to take that responsibility. So, what will you do?' The doctor maintained they will come back after lunch. M left to get some lunch herself. When she returned the doctors had successfully conducted the delivery: mother and her baby twins were all doing well.

The babies' uncle was very upset about the treatment given and went to visit the doctor in his chambers. This is what he told us. I said, 'Sir, you are an educated person, you have passed medical college. You are supposed to be saving lives. But why did you say the baby was dead and why did you want to cut the child out?' Then Dr A started to shout at me and said 'Do you say that you know more than me? Did you not just cut grass as a young child, or did you study? Are you suggesting I cannot say what is wrong with patients?' I responded: 'Then how come the babies are alive now?!' Dr. A. shouted and said, 'Why do you people come to me? Did I call for you? Oh, you people annoy me!' I said 'You are a doctor, you do your job, and that is why I come to you. Why would anyone else come to you? I see no other reason'. We were shouting, and it attracted people. Many gathered around us. They started to ask the doctor why he did what he did. Then I went back home.

Dalal activity in Government hospitals

The activities of intermediaries or brokers, known as *dalals*, have increased this year. In the Central and North district hospitals we observed a number of well-dressed young men 'assisting' patients with their prescriptions and test requests by directing them to outside Diagnostic Centres. An *ayah* at the UHC (Central peri urban) told us that *dalals* intercept people on the way to the UHC and persuade them to go to private facilities. She said that they used to have at least two births per day here but when we visited there had not been a birth here for a very long time and it was evident that neither the delivery room nor gynaecology ward had been used recently. She put this entirely down to *dalal* activity diverting patients away.

Box 26: Dalals return

While discussing with one male patient in the out patients, who had been referred for some tests, an unknown person took him by his hand and began to tell him where to go for tests. Observing the well dressed study team member and confusing him for another dalal, he freed the patient's hand and excused by saying that 'I thought he was someone I knew.' (North District hospital).

Dalals will sometimes come to the Medical social services department and claim support on behalf of someone else. However, the department feels that they control this misuse because patients must come with a recommendation slip form the doctor. (South urban District hospital).

During a visit to the district hospital a team member was invited to sit down with the male nurse working at the information desk. Discussing the problem of dalals, the nurse said, 'Last year there were only a few of them around, but this year... when a patient is waiting to see a doctor, every patient will be approached by a dalal! This is not good at all. But I cannot do anything... because in some cases for example they are relatives, or have good connections with important administrative staff of the hospital. Sometimes they steal, just take valuables off the patients, but the patient will have no idea of what is going on. So they are getting more in numbers now, and they are behaving worse and worse. You cannot believe that some dalals now take all the money that a patient has... people willingly show all they have, collecting their taka from their pockets, to show this man that they think is going to help them, and then the dalal just takes it all.' While talking, the man suddenly asked our team member to move away a bit and observe. A few steps away was a man who had just spotted a patient with his two companions helping the patient in through the main entrance. The man quickly went to sit with the nurse in the information centre. As the patient approached the centre the man got up and went to talk to them. They engaged in a discussion, and the man started offering his help, guiding the patient and his companions around. The team member returned to the information centre and the nurse told him that this man is a dalal. He is the brother of an important man working at the hospital. He clearly used his connection to convince incoming patients that he belongs to the hospital staff. (South urban).

Other health service providers:

NGO Clinics

NGO clinics are mostly providing maternal and childcare services. Although they all claim to serve the poor, few of our F/HHH use them. As in previous years, there continues to be evidence of clear leakage of special provisions intended for the poor to the less poor (e.g. cards distributed to the non-poor, preference given to family members). Since the programmes are primarily addressing maternal health, they will be discussed in more detail below. Some clinics complement their main focus of maternal health with general primary health provision. For example, a clinic in Central urban area issues family health cards (Tk150) to poor families and charges Tk20 per visit but none of our FHH/HHHs have these cards.

Diagnostic Centres

Although the charges at Diagnostic Centres are generally higher than in Government facilities (see Table 3 for example), people tend to use them.

Table 3: Comparative costs for diagnostic tests in private and government facilities (North)

Types of diagnosis	District Hospital (Tk.)	Private diagnostic centres (Tk.)
X-ray	70	110–150
Blood test	60	100–140
Urine test	60	100–110
USG	110	400–800
C-T scan	3,000–5,000	6,000–9,000

This is because Government hospital equipment is often out of order, waiting time may be very long, opening times may be short and, unlike private facilities, test results are rarely provided on the same day. Even in the South district hospital where all the equipment is in good working order, technicians provide patients with slips to avail tests outside, telling them that there is a waiting list for tests and it will be several days before the test can be done and further days before the results can be provided. The wife in one HHH in the south urban area summed up the sentiments of many others, *'the government hospital is free in name but not in any real sense. They refer us outside for tests and costly medicines. And they also suggest going to a particular diagnostic centre or pharmacy of their choice. It is only when other alternatives fail that you would go to this hospital'*. Another person who frequently uses the Government hospital said *'you always hear from doctors that the machine is not working so you will have to go outside'*.

Requests for USG in pregnancy continue to rise. According to one Diagnostic centre (Central urban) these are mostly self-referrals as people want to know the position and sex of the baby. Three of our FHH in the Central urban area had had recent USGs. One had a transverse lie baby but the other two just wanted to know the sex. A mother remarked; *'But here it is not like India where they kill female babies'*.

Pharmacies and Polli Doctors

Like the Diagnostic centres, the private pharmacies thrive at least in part because of the shortcomings in the Government supply of medicines. *'I have heard that the Government has sent sufficient medicine to each government hospital but it seems poor people don't see the benefit of this as most of the valuable medicines are sold in the market'* (*Fakir*, South peri-urban). Doctors and dispensaries tell us that they get between 40–50% of the medicines they actually need. Government facilities now carry a limited range of medicines and often limit the distribution to eke out supplies for longer. Dispensaries allocate medicines for each day and if this runs out they do not replenish until the following day. A night nurse in a UHC (Central peri-urban) showed us the limited selection of drugs she was allocated for the night shift and in another UHC (South peri-urban) the storeroom is securely locked and only one man has the key. This measure to prevent pilferage has serious repercussions for patients who may be denied medicines on the grounds that they are not available and not necessarily that they are out of stock.

Polli doctor gives time to each patient, knows the family and gives them medicines on credit (Peri-urban North)

Medicine shops also sell on credit (Peri-urban North)

Plastered over the walls of a pharmacy are ads for diagnostic centres and private medical facilities

The wife of a HHH tells us about her family and the decision she makes is typical of many. She feels they are not *'doing very well, is often feeling unwell, sometimes with fever, sometimes with body ache'*. Her husband too suffers continuously from vertigo and feels dizzy. He takes medication from a *polli* doctor (he is himself a *fakir*). They do not go to government hospital unless it is very critical. They trust the local *polli* doctor, who is well established and well liked in the community. This is their first port of call if they face any serious problems. This is well illustrated by the situation in the rural North where the *polli* doctor is regarded as the only source of treatment for the poor as he gives them time and charges low or no fees. He will also sell medicines on credit and will refer patients to senior doctors and specialists if necessary.

The lack of regulation highlighted in the 2008 Report continues to be a matter of concern.

Box 27: Lack of regulation of private health services

This year we included a young man in our urban team to have conversations with adolescent boys. He also posed as a client in seven pharmacies in and around the slum area asking for help for 'his friend with a suspected STD'. The symptoms were diagnosed by the staff of these pharmacies as syphilis or gonorrhoea (although one medicine shop seller did not know about these). Two pharmacies said they would not sell medicines without a prescription, one said they needed to see the 'friend' immediately, one offered to sell medicine for syphilis and the other three all said that they would sell him medicines without prescription if he could supply the name of the medicines (Central urban).

The most popular local polli doctor told us that the paramedics in NGO-S provide medicines without understanding the possible side effects of combining medicines or that same medicines cannot be prescribed for different patients even though they may have the same diseases because of differences in the patient's physical condition. These young paramedics have joined in the job just after completing the training and they do not have any skills in prescribing medicines. (Field notes North peri-urban).

Doctors told us about the medical representatives who visit them regularly to try to build relationships with them. 'The representatives... they consider anything we propose to them. Sometimes they give us lifts to the main road'. They also told us that they had persuaded them to donate Tk4,000 for to operationalise a digital signboard for patients. The representatives from less respected companies are looked down upon by the doctors who scorn their low educational background: 'they are not even qualified; they have something like HSC or a simple BA pass'. If the representatives do not agree to support the requests of the doctors they have no chance to have any influence on what doctors prescribe. 'We know everything'' one doctor said. 'If they don't do this kind of dealings with the doctors they will get no promotion. But we don't prescribe their medicines, we only prescribe those medicines that have been through strict quality controls, from the government'. (Field Notes, South rural).

An owner of a Diagnostic centre (himself a Government UHC laboratory technician) is unhappy about the competitor who operates a thriving business nearby. He claims that the owner is responsible for checking all the tests but has no academic knowledge at all. We asked this man's assistant what qualifications his boss had 'I don't know... maybe he has a degree form Dhaka'. (South rural).

A new roadside pharmacy has opened near to the high school and primary school. Every time we passed it was being minded by a young boy of about 12. We tested his knowledge on drugs by asking him what he would recommend for different ailments. He was surprisingly well informed but it is still of concern that such a young boy should be taking this responsibility. (Central peri-urban).

Traditional healer is treating a patient with oil and holy words (Peri-urban South)

Traditional Healers

Cost is often the main reason why people consult traditional healers. Box 28 describes some of the different traditional healers available. A *fakir* told us *'From my observation it is people who are poor that come to me, and they come because they cannot manage the cost of government hospitals or private clinics. Some of my patients say that the government hospital is in fact not at all free for the poor because of endless malpractice. It is because of these bitter experiences that poor patients choose to come to me. They know that I do not need to be paid. There are some patients who got good results from my treatment; they keep on coming to me even if I don't expect them to come. Others who hear about me from my old patients, they also rush to my house. This is why I find patients standing in front of my house almost every morning.'* (South peri urban)

In addition to cost some ailments are regarded as particularly appropriate for traditional methods of treatment. These include jaundice, weight loss, nightmares, spots and blisters on the body.

Box 28: The work of traditional healers

A fakir told us 'The steps I generally use include giving the patient a tabij with some religious words written inside. I also give the patients water while I read holy words, water for drinking and bathing. I can also give some seeds with holy words that the patient will eat. Sometimes I can rub the skin of the body part with a problem, and at the same time uttering holy words. Some patients, I will ask them to collect water from seven different ponds, in separate locations. Then I take the collected water and add seven pieces of leaves s from a special type of tree, mix it in a pot, stirring it using thorns of a tree and I utter holy words in the name of a Muslim saint and a Hindu Goddess. Then I ask the patient to drink this. (South peri-urban).

For many years a young man from the village has been practising his special powers on patients from the village and further away. Six years ago he had a vision; in a dream he saw 'Monsha', a Hindu goddess that has the shape of a snake. He saw this as a sign that he possessed supernatural powers, similar to the goddess, and moved into a temple. After some time his parents asked him to move back home, where he now lives and works. He treats all kinds of people (Hindu, Muslim, Christian), with all kinds of ailments, such as pneumonia, chronic diseases, infertility, and even tumours. All his patients, he claims, have been cured. However, he never treats patients he feels will die soon. He sees patients four days a week, and seems to be have built a rather good business: he and his parents have recently built a new house with tin sheet (South rural).

The pharmacy owner told us business had been good despite the competition with the new shop. He thinks his service is preferred as he gives patients options. He can give them allopathic medicines, homeopathic medicines, kobiraj treatment or 'fu fu' (spiritual healing). Mostly patients consult him for herbal medicines. He has developed relationships with the private hospitals in the area and readily refers patients to them and the District Hospital (Central peri-urban).

One of our team visited the nationally renowned hujur who lives in the community posing as a patient. She had to wait over two hours and could listen in on the advice provided to other patients as there was no privacy. Most people were consulting him with relationship problems, concern about evil spirits or some chronic illness. The rich clients from Dhaka were given preference, when our team member complained about the long wait she was scolded. When she did get her consultation she kept being diverted so it took 30 minutes to explain her 'problem'. The advice given regarding her 'brother in law's bad behaviour' boiled down to 'people should be more careful about who they marry' and provision of a tabiz for her to wear to control his lifestyle. She asked the cost of consultation and was told it could be what she wanted to pay. She handed over a Tk500 note and said she wanted to pay Tk200 but no change was given. When she requested her change she was scolded again for her rudeness. (South Central).

Medical Representatives

The marketing of medicines by private pharmaceutical companies is quite aggressive and medical representatives constantly approach doctors. During the CTG period there were strict rules preventing visits during consultation periods in Government hospitals but this has been relaxed again and we observed active salesmen in many locations.

Mobile Phone Health Lines

More people are becoming aware about the various mobile phone based health lines this year than before. There are health lines operated by Grameen phone and Banglalink. But many people still consider them to be *'too expensive'* or *'too difficult for them to follow instructions'*. In the South rural area it was the first time that we had heard villagers talking about this new service. Not many of the women had heard of it but several adolescent boys knew about it. A teenager had once tried the health-line number out of curiosity. He was charged Tk17 per minute. Disappointed by the high cost, he commented: *'This is just a business being run by the mobile phone company. When I go to a doctor with a health complaint he never gives much time. But when you call the helpline they give you lots of time! But they just repeat the same thing again and again. They make your call longer so they can make money out of that. This is just a trick by the phone company.'*

Another man (rural Central) told us he had tried the line but having told the telephone operator his symptoms was told they would phone him back. They did not. So he called again but got no satisfaction. He thinks it is too uncertain how much these calls will cost. A third man (rural Central) said he is never ill so has not needed to use the service but he cannot imagine not seeing a doctor even though that might take longer. A teenager said she knew the phone number but has not used it even though she has a reproductive health problem and is very worried about where to get advice (she even has not shared her problem with her mother). A close friend has suggested she phones the village doctor and she thinks she will do this as *'he knows me and I can ask his advice'*. Many have seen the TV advertisements about the health-lines but they assume it will be expensive and is *'just a business'*. When we called the line ourselves we got an immediate answer both times. The operator listened to symptoms and then offered to provide the phone number of a local doctor. The advice provided was very basic and in one case could have been alarmist (suggesting pain in the chest could be heart failure). We also felt that the advice provided was very urban-centric in that they were interested to provide phone numbers of doctors in town and assumed access to other health facilities although we made it clear we were located in a rural environment.

Box 29: The role of mobile phones and health provision

Although none of our F/HHH use the health lines provided by Grameen Phone or Banglalink, the phone is nevertheless very important as this story illustrates:

Two years ago R. had her first cataract operation. This was carried out by a charity organisation, which came with doctors and full equipment on a boat. R was very pleased about the whole experience, and when she started to face problems with her second eye she said firmly she wanted to have it done on the boat. She did not now how to find out when the boat would be around next time though. Thanks to an exchange of mobile numbers within a network of friends she managed to find out that they were coming to her area again. When she arrived at the boat-clinic there was a huge queue! They had specialist doctors there to cater for a range of medical problems, not just eye patients. She paid Tk12 to get admitted. She had the operation and stayed one night. Again, she was very pleased with the service and said 'this is the best the government can do, allowing this sort of thing!' (South urban).

Most TBAs we interact with have mobile phones to keep in touch with their patients and to contact experts for advice and referral. One of our FHH is a TBA and she has her mobile phone tucked into her saree at all times. She constantly takes calls and we observed her giving advice over the phone at all times of day. *Polli* doctors and pharmacists also provide advice over the phone and use the phones to arrange referrals.

Trends in medical conditions

Families and health service providers tell us everywhere of the increase in hypertension and respiratory infections that has occurred over recent years. Gastric problems are prevalent. In urban areas asthma seems to be problematic and increasing. Road accidents and suicide attempts were also noted by nurses in several places. Other accidents, particularly burns are common (see Box 17) and we feel that simple public health messages concerning first response to these sort of incidents would have important impact.

Hypertension

Several of our F/HHHs have high blood pressure. Some put up with it and others take medication. Pharmacies and *polli* doctors confirmed that they see a lot of patients with hypertension these days and whereas in the past, these patients may have been better off people, it is *'now the poor who have these conditions'*. An elderly pharmacist told us that he noticed that people seem to be *'much more stressed these days and suffering from hypertension. There are more quarrels and family tensions than before'* (Central rural). We became aware of a lot of domestic arguments around relationships and money. The former are often related to members of the family feeling 'taken advantage of' (e.g. having to look after elderly parents, grandchildren, mother in law). While living in with our HHH, we often hear raised voices in neighbouring houses and quarrels which escalate to physical assault. People tell us that the involvement of women as protagonists in these situations is more than it used to be.

Box 30: Social and domestic violence

The men's ward in the UHC had only nine patients and seven of these were casualties from fights (head and hand injuries). Two of these men were from the same village where there had been an inter-village dispute over land. They had both been in for 15 days and it was clear that they did not now need to be in hospital (confirmed by the nurse on duty). Nurses told us that most of the cases they receive are casualties resulting from fights. These are just as likely to be women as men as women intervene in quarrels. Often they purposely intervene to strengthen subsequent litigation cases which are more likely to go in their favour if a woman is injured. Nurses told us that domestic violence against women is very rare and they say it is sometimes self inflicted or exaggerated to 'make a point to their husbands'. (Central peri-urban).

We were told 'it used to be bad, but now it is better' about domestic violence against women. Several older women could recount problems that they themselves had encountered as young wives; My husband used to beat me for many many years... but he has stopped now. It is because my children are grown up and they sometimes protest when they see that their mother is being beaten. More than one woman said the very same: the abuse stopped when their children could protest against the beating. Some point out that attitudes towards domestic violence are changing thanks to women friendly laws that the government has implemented. It is being broadcast on TV and radio, and advocated by NGOs. The message in society now, due to these laws, is that violence should not be tolerated. (South urban).

Nurses told us that they see about 5-7 cases of domestic violence a year at the UHC. A significant proportion of these are attacks on men by women. They estimated about 20%. They said that many of the cases of women with injuries were actually made up or 'self inflicted'. 'You are from Bangladesh; you know these things happen here. You know people are always making false cases ' one nurse told our team member.

Where violence does occur, one Principal linked it with the prevalence of NGO credit: This is sometimes due to women's linkage with NGOs. Since NGOs are giving loans to women, men may not react when the weekly payment is due. Women are not passive... she gets angry and active and tells the husband about this. She is stressed, but her husband may not care. This makes the wife even more angry and rude and then a quarrel starts. And this chaotic scenario is there when the children are at home, it is not a good environment and students cannot read.' (Principal GPS, South peri-urban).

Some of us noted that the food we are eating with our families has been getting saltier over the years. For example, one team member observed large quantities of salt being added to the water in which rice is boiled (a practice which is not typical in Bangladesh). Whenever food is served, as much as a tablespoonful of salt is placed on the side of the each person's dish. The vegetables and curry are very salty. In one family, the young girl of five screams in complaint if her mother does not put a large mound of salt on her plate when she is eating (Central peri-urban). We feel that there may be a link between the changing pattern of salt consumption and the incidence of hypertension and related high blood pressure problems. We asked the opinion of a Dhaka-based research doctor and he confirmed that he too was aware that salt consumption has increased alarmingly. There is some speculation that this might be due to an over zealous response to the promotion of iodised salt. Alternatively, more salt may be being used to flavour the relatively bland, cheap rice and vegetable meals which are taken these days instead of the tastier dahl and curries eaten formerly.

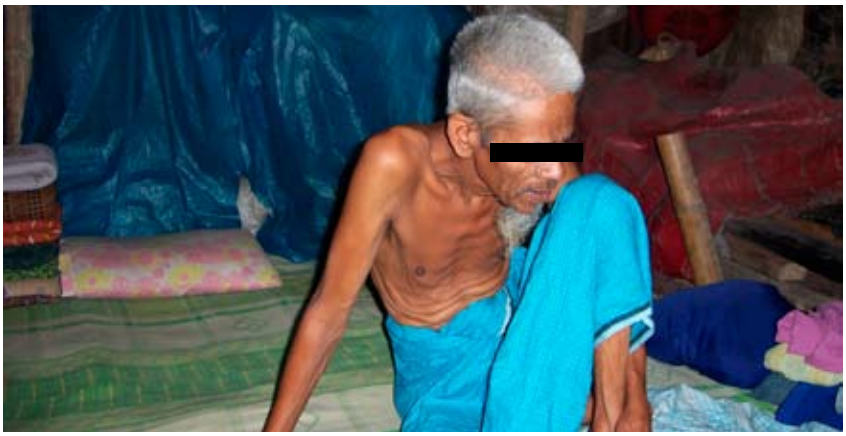
Eating rice with salt only (Rural North)

TB

The apparent spike in TB cases observed last year (particularly in the central area) by the medical professionals we spoke to, seems to have improved a little this year. But we have noted a discrepancy between the statistics provided by a DOTS clinic and the incidence reported by Diagnostic Centres in one area. The former says they conduct about 3–5 tests per day but only find about 4–5 positive cases per month. Whereas just one (of many) of the Diagnostic Centres just outside the hospital where the DOTS centre is located says they test at least 20 cases per month and all are positive. They refer them to the DOTS centre for treatment. Since the numbers recorded in the DOTS centre do not appear to take into account these referrals it is difficult to follow the real statistics. Furthermore, there are some patients who never take up the referrals and self medicate. This Diagnostic Centre said only one patient came back for a test after re-occurrence of TB.

In the South urban area, people told us that TB was more common these days. One woman told of her experience with her children with TB saying that the treatment was very good and better than one gets with other illnesses. Others shared stories of long treatment but eventual cure, although one of our FHH young mothers who has since moved out of the slum and diagnosed last year with TB apparently is suffering a relapse.

A tablespoon of salt is loaded onto each plate as they serve dinner in one of our HHH (Rural Central)



This elderly man continues to suffer from TB (Urban North)

Box 31: Updating last year's TB stories

C whose case was presented in last years report (2008 Report Box 17, p.46) still has TB. She suffers from night fevers and still feels weak. She eventually went back to the District Hospital but as she had lost her DOTS card the doctors refused to treat her. After much pleading, they eventually agreed to give her medication (three packs) but she has stopped taking these tablets again because, as before, they make her feel unwell and unable to work. Her son in law is much better and is now able to work full time again (although his wife says he is still ill and does have to take time off). He is no longer taking the full medication (but his analysis of his expenditure shows he still spends a lot of money on medication). His doctor has recently transferred to Dhaka and so he sees him only once a month for a check up and buys the medication he still requires directly from the doctors house in the slum. He is very grateful that his employer has been so understanding about the illness and has kept his job open for him (he has worked there for more than 22 years, since he was an orphaned boy) and feels this is unusual. The third case we presented last year is E. She has now moved to Dhaka to work in a garments factory. Her mother in law told us that she is still unwell (Central urban).

One of our FHH was suffering from TB last year. His symptoms have developed into 'hip TB' and because the BRAC policy precludes extensive medical treatment (beyond 6 months) he has been denied further treatment. He is a farmer and the pain, fever and fatigue have made it very difficult for him to work but he has not sought further treatment. He is the only bread winner and feels he should carry on trying to work. This year his wife has developed a fever for more than 7 months. Although blood tests indicate TB and kidney infection (as interpreted by our team member who is a doctor), she has been told it is rheumatic fever. The wife says her symptoms are like her husbands and the three anti-biotics prescribed have not cleared it up. There are two issues here: i. The lack of long term treatment for a TB patient whose symptoms persist and ii. The lack of interest in the history by the MBBS who might have identified the high risk of TB in the wife. (Central rural).

Box 32: The problem of Diabetes

An elderly lady (75) who has been suffering from diabetes for about five years told us about her situation. 'Initially I was loosing weight and facing problems with blurred vision. My elder son took me to the local doctor (diploma) and diabetes was identified when my blood sugar was tested. The doctor advised me to go to the Diabetic hospital in the town. I consulted another doctor in a commercial diagnostic centre at the town instead of going to the Diabetic Association and my blood sugar was found to be 23. Then the doctor advised me to take insulin every morning. Initially I took insulin for 2 months buying from the local market but later on I stopped it as it is very expensive for me. My elder son could not afford to buy insulin for me with his little income. I heard that the Diabetic Association gives insulin free to poor people. But I have no idea where the Diabetic Association hospital is or anything about it. None of my family members have time to accompany me. After stopping injecting insulin my blood sugar is increasing and I am loosing eye sight gradually. I don't know what my blood sugar is now. May be I will die without any treatment'. (North peri-urban).

Casualties

This is the third year we have been visiting government hospitals, each year it has always concerned us that many casualties seem to spend inordinately long periods in hospital. We regularly see patients sitting on their beds, bright and seemingly well. They have minor bruising or the remnants of a black eye, simple fractures, cuts which seem to have largely healed. This year we decided to investigate this further. Most of these patients said they were well enough to go home. Nurses generally concurred. So why were they not going home? Then we came across a young woman who had just been admitted. She told us she had been beaten by her aunt. She showed us her back and there was little evidence of a real problem. The husband said he did not know why they were there really but his father had told them to admit her into the hospital and to stay there while he *'sorted things out'*. We spoke to the nurses. They said there was no reason for this woman to be in hospital and

then a ward boy said *'we get this all the time- it is so they can file a case. They can prove grievous injury if the victim is hospitalised for 20 days.'* We have since checked the law on this and indeed Section 320 of the Penal Code defines grievous injury in a number of ways but includes the provision for *'any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain or unable to follow his ordinary pursuits'*. If a doctor cannot be persuaded to certify grievous injury then collecting a discharge notice following 20 days of hospitalisation can be used instead (if not in court at least in the local *shalish*). We asked hospital staff how frequently this occurs and they said it is frequent. We asked how this impacted on bed occupancy and they said it can be a problem when they are overcrowded, for example when there is a diarrhoea or typhoid outbreak but if the beds are not in demand they accept this. Furthermore it keeps the patient numbers up (which may be important in underutilised hospitals). Subsequent conversations with other casualty cases in various government hospitals confirmed that many were locked into litigation cases. Private hospitals turn away casualties like these not wishing to get involved in litigation cases. But, of course, if a patient has to spend 20 days in hospital it is unlikely that they will opt for the expense of private care.

Although toilets are not well constructed, over the years we have been visiting more toilets have been erected (Peri-urban Central).

Collecting water is burdensome and sources are not necessarily clean (Peri-urban North).

Hygiene Issues

Living with our F/HHH, we are able to observe that all but the rural North adopt a certain level of hygiene. Although toilets are not well constructed, we observed their regular use, regular hand washing and plate washing immediately before eating. There is no suggestion that children are suffering from worms. However, throat clearing and spitting, even inside the home and beside where we are sitting is common. Potentially unhygienic health practices such as spitting and nose clearing has, from our observations, become more prevalent over the last three years. For example we saw an NGO health visitor spit on the veranda before entering her patient's house and repeat this a further five times inside the house (Central rural). Spitting was raised this year by nurses and cleaners as a problem inside hospital wards. We observed much spitting in corridors and stairways despite new notices banning spitting.

Medical social services provisions

The Department of Social Services is now running a Medical Social Service programme in district hospitals and some Sadar hospitals to provide support to poor in-patients for buying medicines; health aids (such a crutches, wheel chairs, spectacles, etc.) and sometimes transports costs to return home. To avail this support, the patient has to fill up a prescribed form to prove eligibility which must then be approved by the doctor. A poor woman told us, *"It was very difficult to collect and fill up the form, and get it signed by the doctor. My grandson was admitted to the hospital for an operation. The doctor prescribed medicines which costs Tk2,300 but I had no money to buy the medicines. So I went to the office to seek financial help. I could not find out which doctor could approve my application and nobody helped me in the whole process. Finally I could not receive the grant" (North urban).*

This programme is funded by the government, a percentage of registration fees and donations from local philanthropists. In the North, we were told this amounts to Tk700,000 per year, in the South the officer said it was Tk35,000 per month. The Programme Officer in the North District Hospital told us that they get many applications every day for financial help but that they can support only a few of them due to lack of funds. As a result they do not advertise these services widely as they know they will be swamped with requests. Generally the assistance is given in kind rather than cash and seems to range from Tk700–1,000 per patient. In addition to financial help with medicines and transport home, the officers also provide advice, emotional support and clarify instructions given by doctors to the patients. Another woman told us how useful this support would have been if she had got the information in time.

Box 33: Delayed information leads to losing support

One widow (FHH) took her grandson who was suffering from severe pain in the scrotum to the emergency department at the district hospital. He was made ready for operation on the following day. The doctor gave her a prescription to buy medicines from outside, which cost Tk2,300. She had only Tk80 that she needed for transportation, so she asked one pharmacy to sell medicines on credit. The pharmacy owner agreed and the operation was done at noon. On the third day she managed some money from a relative and settled dues with the pharmacy. On the fourth day one person told her that the Medical Social Service (MSS) department supports poor patients with the purchase of medicines if the patient is admitted in the hospital. So she talked with the office and collected a form to apply for financial help. When she went to get a recommendation from the duty doctor, he said that the boy had already been discharged and he would have to come after ten days for removal of the stitches. As the MSS do not provide any support to a discharged patient she could not avail the support. This support would have been a big help for this poor widow if she got the information earlier. She ended up spending about Tk7,200 for this treatment that she obtained by taking loans from different relatives. (North peri-urban).

In the South Sadar hospital, the RMO has taken his own initiative to address the social services department financial deficit. With the help of other staff he is going outside into the community to request donations to look after the patients in the way they are supposed to. So far, his initiative has resulted in an additional Tk30,000 to the Tk1 lakh provided by the government.

Free Medicines at Government Facilities

Last year we noted that *'outpatient numbers are swollen by people who are not really ill. They drop by the hospital while doing their marketing'.* (2008 Report,

p.37). This is confirmed again this year and happens in all our study areas. In the North area, people told us that people who live nearby the district hospital frequently go there not for treatment but just to pick up free medicines and that school children will also pick up medicines on their way to school. The dispensary in the South district hospital is always busy and never has enough stock. Patients complain that, *'I need six tablets but I know I will only get two'*. The newly opened Community Clinics (see above) all seem to have run out of medicines very quickly and staff spoke of being inundated with people who wanted free medicines but who were not necessarily ill. This practice raises concerns about self medication and home storage of medicines beyond *'use by'* dates. In our 2007 report, we noted that some medicines were said to be used for veterinary purposes. This leakage is serious when put into the context of gross under-supply of specialised medicines for in- patients and the ready availability of the kinds of medicines collected free in the open market at relatively affordable prices.

Family Planning and Maternal health

The TBAs we meet in our study areas come across as confident and often take on the role of spokesperson for others. There is obvious affection and respect for these women in the community and among our F/HHH. One woman said *'the dai ma is a reliable friend. As long as there are poor people there will be dai mas'* (South rural). Another remarked, *'Seeking assistance from the dai ma – it saves money and it helps to keep the tension away. I trusted she could do a good job'* (mother of 7 month old, South rural). Many people tell us that there is now much greater awareness about health and nutrition in pregnancy and the need for regular check ups with TBAs or in clinics (mostly NGO).

These days, TBAs carry mobile phones and are generally quick to refer in cases where they feel mothers are at risk.

Box 34: Home births and hospital referrals

The wife of a HHH delivered her first son at home with the support of her mother in law who is a TBA who has had some training from a NGO. Sadly the little boy died recently. She got pregnant a second time and was taken care of by the TBA. Her family planned a home delivery. But when the delivery time came closer the TBA noted that the cervix did not dilate properly and so she referred her to the district hospital where the doctor provided an injection to increase dilation and the mother was able to give birth to her second son without caesarean. The family had to spend Tk3,000 in total for transport, food and some medicines prescribed by the doctor. (North rural).

The two year old boy of one of our HHH had a high fever and was taken to a Kobiraj about 3.5 km away from their residence. The Kobiraj immediately advised them to go to hospital. They went to the UHC where a doctor referred him to the district hospital. But the admission process in the district hospital took much too long and in desperation they took the boy to a private hospital despite the high cost. After struggling for six days the boy died in the private hospital. His father had to sell their 20 decimal of land for Tk50,000 and borrowed from the neighbours to bear all treatment expenses including transport. The family feels that had the response by the district hospital been quicker, the boy's life could have been saved. (North rural).

The two TBAs in the village deliver most of the children (nine in our study area this year). They make sure all the women receive full doses of TT and babies are fully vaccinated at the EPI satellite clinic arranged in an empty room in the primary school once a month. Although pregnant mothers never go to the FWC as it is too far away, they regularly seek advice on the position and size of their babies from the two TBAs (North rural).

The dai ma did her best but had to suggest that D. went to hospital. She accompanied her to a private hospital and explained the history carefully to the staff. D. had to undergo surgery but all ended well with a healthy mother and child. It cost Tk10,000 for the operation and the medication. (South rural).

TBA nurses her grandson whom she delivered (Peri urban North).

Staff nurse shows the limited number and range of medicines she has been allocated for her in patients (Peri-urban Central)

Mother with her new born baby, happy that she was assisted by a TBA (Peri-urban North).

But one less favourable development this year was that we became aware of increasingly negative views of TBAs and their work among medical professionals which our F/HHH feel is unjustified. In conversations in the South urban area people explained that it is more common for women to deliver in private hospitals as, in addition to having more information about these options, there is also an active defamation smearing of TBAs. They say doctors intentionally create fear about what can go wrong in home deliveries. *'There were no Caesareans in the past, now doctors pressure for this unnecessarily. Women get very worried'* (FWV, Central). Nurses at the peri-urban UHC in the South area justified their own private practice activities by painting a nightmarish image of the dai mas. *'They often make big mistakes'*, they tell us *'which means that they jeopardize the lives of mothers and babies.'* They provided us with grizzly examples of dai mas who would in case of a dead baby, *'chop the baby up'* and take out body parts. A conversation with a FWA and ayah in a FWC in the Central peri-urban area further illustrates this:

FWV: TBAs these days engage in malpractice and only chase after money. They do not refer risky cases. Babies die. They are not serious about the mother's health.
Me: So what is different with SBAs?
FWV: They know the theory and modern practice and can identify at-risk mothers.
Me: How were you born?
FWV: TBA
Ayah: TBA
FWV: Actually my mother was a renowned dai and delivered 10,000 (sic) babies all over this area. She never had any deaths and never any problems. She worked up until two months of her death. She had a special gift and was very skilful. Once she saw a hand and was able to quickly turn the baby around. She always knew exactly when a birth would happen.
Ayah: My mother in law was also a very skilful dai. She had the blessings of the Almighty. Families were always pleased to see her.
Me: So why did you say that TBAs were so bad?

They both laughed and continued…

FWV: SBAs do not have the experience but they do have the training. Perhaps it is best that they work together (with TBAs). They should both focus on the birth and not be concerned about who has the training. We always share with TBAs and have a very good relationship. Training and experience is not the issue it is the skill and attention given to the mother.
Me But that is not what you said at the beginning
FWV: No, that is what we are told in training.

We met SBAs and trainee SBAs. Most felt the training they had received was very good but were nervous about the limited practical experience. TBAs told us that they were aware of the training and mostly were interested to update their own knowledge. Several indicated that SBAs have come to them for advice and assistance at births. One TBA in the Central urban area is routinely requested to take trainee SBAs out for practical experience in the slum. She was very concerned by the lack of direct experience they get before being allowed to practice as SBAs.

Box 35: The way TBAs see their work and SBAs

A TBA told us:
'I am a TBA (58 years) and I have six children. My husband was a shopkeeper. Now he can't work due to old age. I migrated from another district where I worked as an apprentice with a nurse and one health visitor of a government hospital. I assisted them in TBA training sessions as well as during delivery for about 5 years and gathered experiences on delivery. Then I began to handle delivery case independently. I performed about 2,000 delivery cases in my 19 years working period. No accident was happened but 15 years ago I had to deal with a complex situation. At that time there was no scope to shift complicated pregnant mother into a hospital due to transport problem. But I was successful and after this incident I started to visit patients and check monthly on regular basis and try to understand the problems. I also make them aware of pre, during and post natal check up. Most of the mothers are so confident on me that they are reluctant to go to the clinic for check up unless they have complication. If it seems to me that patient may face difficulties then I refer them to government hospital and also I accompany with the patient for describing the history to the doctors.

I consider my job to be social work so I never ask money from anyone rather I work free of cost. For the poor patient I ask for soap and blade only. People give me Tk50 to Tk500 with a Saree. At Ramadan I got 14 Sarees that I have distributed to my close relatives. I enjoy this occupation and so I visit neighbouring villages and unions far from my village. Now I am working with BRAC for collecting patient (pregnant mother) and get Tk5 for each patient. I try to make the mothers aware of family planning methods when I visit pregnant women'. (North peri-urban).

Women in the village explain that TBAs do not expect to get any remuneration for their services. Many say that they do this as a religious duty, and some believe that if they can do 101 deliveries successfully, they will get a reward in their after-life. If a TBA hears about a woman about to give birth in the middle of the night, she is held accountable for anything that happens: the TBA cannot deny anyone their help and must immediately rush to assist a woman in need of her help, no matter at what time it happens (Field Notes, South peri-urban).

A Government Health Assistant received six months SBA Training (July - November 2008). She told us, "I performed only one normal delivery after receiving SBA training. I have visited many pregnant mothers and tried to convince them to seek my support for delivery but they do not feel confident on me because I am newly trained and younger. They feel that the local TBA is more skilled, close to them, can give motherly affection and can attend any time of the day and night. Also they are not aware of the benefit of performing delivery by a skilled birth attendant". (North peri-urban).

As reported in the two previous reports there are two sisters in our peri-urban Central area who practice as birth attendants; one is a BRAC *shebika* (trained birth attendant) and the other a FWA who received SBA training. The BRAC *shebika* is mostly interested in her own family's wellbeing and is busy cow rearing. She very rarely makes house-to-house visits (we have never seen her do this in the three years we have observed her). She and her sister defend this by saying if people want family planning supplies, then they can come to her house. They have both become important first line health advisers and actively refer people to private or Government health facilities depending on the ailment. This service is heavily dependent on their mobile phones. There is a strong suspicion in the village that they only work for the money; *'taka chara, shartho chara kono kaj kore na' (without money and benefits she won't work)* and so neighbours assume that they are getting a cut from private hospitals. Rumours abound claiming the SBA earns Tk30–40,000 per month (others even speculated Tk80,000). Indeed her lifestyle has changed significantly over the years we have been visiting. Although a widow, her two eldest boys are all in costly education; the elder one studies in a private university in Dhaka and the other is in the technical college in the district town. She paid the BRAC School to take her youngest son who is 10 years and has role number 31 (there are only supposed to be 30 students). She now has computer in her home on which she watches movies, has had her second house renovated and has purchased two cows which she has given to others to look after. Previ-

ously, she tells us, she had a very difficult life and she regards the SBA training as a *'blessing from Allah to support orphans '* (referring to her widow status). She is providing delivery services outside of her catchment area now and charges for everything she does. The household is managed by her niece who acts like her maid. This year the elderly TBA in the area has died and so the SBA and her sister deliver most of the babies in this para now, charging Tk1,000 for a 'normal' delivery. They are not just operating in the neighbourhood but as far as 10 km away. They routinely give dextrose saline injections *(to give energy)* and syntocinon *(for 'increasing pain')* Actually the latter is for increasing contractions and can be dangerous if these are promoted when there is insufficient dilation. The syntocinon is given as intra muscular injection (although it is generally meant to be in a drip). We spoke to mothers who told us this is common practice and never argue with the advice of the SBA. On our visit to the FWC, by coincidence, we saw this SBA's records where she only claims three births in the last month and all were recorded as 'normal'. All were recorded as having had full ANC and PNC check ups. However, she told our team member that this month she has managed six complications as well as several 'normal' deliveries. This further confirms her commercial and private interest and she is simply not recording these additional deliveries with the FWC.

In last year's report we highlighted the mixed reaction of Government health workers to the upcoming SBA training (2008 Report, p.31, Box 5). Neither have received the training yet. The FWA who was initially quite enthused by the training particularly with the prospect of earning from this skill, does not want to go now because her mother-in-law has had a stroke and husband wants her to look after her. The HA remains reluctant, as she mentioned before, her family is her priority and she does not want to make late night visits for security reasons and because her husband will not allow her to. She feels many SBAs feel the same way and she thinks this training has been 'imposed'.

Although private work has been undertaken surreptitiously before, this year nurses based in hospitals have been given official Government sanction to undertake private work in their own time. This follows pressure from nurses who protested that it was unfair that this right was formerly only granted to doctors. A nurse at the Sadar hospital in Central urban area assists with home births. In the South peri-urban area nurses who had previously said that their hospital duties prevented them from doing private work have now set up a network to provide home birth services privately. They have distributed a shared mobile number and whoever is off duty may respond to calls for home delivery assistance. We asked why they were not promoting hospital delivery. They explained that some families worry about going to hospital where everyone would be strangers. But the main reason, the nurses explained, is religion and families do not want the mother to be looked after by a male doctor. They also say that mothers have little say in where they go. (This completely contradicts our observation and experience with families where nobody has ever raised religion as a reason for not attending hospital and several women we have spoken to have made their own informed decisions about where they want to give birth and how). These nurses say they charge according to the family circumstances which means sometimes they may only get their travel costs paid but other times may get as much as Tk1,000.

A number of mothers from the Central and South area had had Caesarean sections this last year. For example, in the Central rural area, these cases were all late deliveries and the mothers were very aware of their dates and had had USGs to confirm the size and position of their babies. They self referred to private hospitals in the nearby Upazila town as they know that no matter what time they arrive there will always be doctors. One mother explained why she encouraged her daughter to go for a Caesarean, *'I could not stand that my daughter was in pain and risking her life and so I insisted on a CS as soon as possible'*. However, one of our FHH told us she was disappointed that she had had a Caesarean and thinks, in retrospect, that it was probably unnecessary but her mother-in-law influenced this decision and the SBA and dai attending the birth could not persuade her otherwise.

As indicated last year we found that there is a general desire for small families and evidence of regrets among those who have not managed to keep their families small.

Box 36: Regrets about not adopting family planning

I have five children; the oldest is 20 and the youngest is just one year. My wife really would have liked to have a smaller family than this, but despite her wishes I have not agreed to adopt family planning. Instead I rely on Allah's wish. Now my wife's health condition is constantly deteriorating. Since her last birth she has been sick and her health is deteriorating. This year I had to spend around Tk700 for her health. (Fakir, HHH South peri-urban).

As discussed above (Staff shortages) the lack of FWAs in some areas has a serious effect on the provision and continuity of family planning extension services. In the rural south it was noted that the irregular visits to the village means that women cannot rely on them for the free oral contraceptive, Shukhi, but this does not seem to worry them too much *'people are not foolish. If the family planning worker does not come to your house we do not wait for her, we go to the market'* (woman rural South). In the North, visits are so rare that there is little family planning information let alone supplies. Women here did not know about basic things such as the need to take pills every day, inadvisability of starting the pill on the day of the marriage and the purpose of the iron tablets included in the pack. People told us that there is a need for more counselling on different family planning options and women need more information about side effects. A homeopathic doctor in the rural South area thinks that he sees many women with side effects from taking the pill, notably iron deficiency and low blood pressure. He says that many women do not take the iron tablets supplied with the *Sukhi*.

This year we noticed that there seems to be a swing in favour of using injectibles. For example a FHH in the central urban area told us, *'it is very popular and many of my friends are using '*. This preference was also echoed in the Central peri-urban area. The injectibles are available from government and private sources. In the Central peri-urban area injections are arranged in monthly satellite clinics attended by the FWV in eight different locations. Woman in South rural are also moving towards injectibles, *'I don't like Shukhi. Every so often I forget it. It is risky, and I don't like to take the iron tablets given in the packet. It also has side effects. Injection is better for me. Some women say that injection does not suit them, but I have no problem with it. We can get the injection if we go to the hospital but to avoid*

travel costs me and my husband purchase this from the market' (South rural woman). Following purchase, women ask *polli* doctors or pharmacists to administer the injection for them. Some complain of back-ache associated with taking the injection but mostly women think there are fewer side effects than with other family planning methods.

As we found last year, men continue to complain that the family planning information is mostly directed to women. An FWA in the rural South confided that *'I talk with both men and women but I prefer to talk with women. Not because I feel shy … but because all the people I talk to, they know me as I come from this area. Sometimes men that I meet, they make me feel uncomfortable because they ask me irrelevant questions for example they ask me how to use the condom… but this is written on the packet! Sometimes they are interested to know about my personal life and that is embarrassing for me'. A man from the same area feels 'Men are selfish, they do not want to compromise regarding their comfort. So when it comes to birth control methods 90% are used by women, but this is because men want this… Because the health workers only go to women and talk to the men know about this through their wives. So, men think this is a female issue!'*

Condoms are readily available and even used as toys (South Rural)

Box 37: Attitudes of men towards family planning

The attitudes have changed but there are still those who put the entire burden on the women and do not bother about the side effects they may suffer. For example, one woman told us 'After taking Shukhi I became very weak and felt sick. I asked my husband to use condoms instead. But my husband never agreed although I tried hard and long to convince him! In the mean time I have had three babies. You see, this is how irresponsible my husband is! He knows I am dying form taking those medicines but he does not care. He just says this is my business. And he says 'if you can't use anything I have nothing to do'. (South rural).

The homeopathic doctor agrees that men are reluctant to use condoms but says this is also due to low quality ones causing itching. In general men support family planning but leave the decision to the women, not least of all because they know very little about it. Some, however, indicate that they think it is the duty of the woman. One man told us *'I have used condoms for some time – now it is my wife's turn'* (Central urban). Another said *'my father, grandfather and brothers do not use so why should I?'* (Central urban) and he expects the woman to take family planning measures. Some suggest that there should be male FWAs, *'as much as 50% '*(man, South rural).

Box 38: Two brothers with different views about family planning

Two brothers live in a joint HHH family. The elder brother is a farmer and got married in 1998. Both husband and wife are illiterate. His wife gave birth to seven children of which three died due to eclampsia and one drowned in the river this year. Now they have 2 sons and a daughter. All children were delivered at home with the support of their grandmother who is a TBA. The couple do not believe in small families and never used any family planning methods. They consider it as against the will of Allah and a great sin. They never allow the NGO workers to talk them about family planning.

However the younger brother is a Madrasha teacher. He got married in 2005. Both husband and wife planned to keep their family size small within their economic means. His wife decided to take the pill which is collected by her husband from the UHC. She has given birth to two sons. The elder son was born at home with the support of his grandmother (TBA) and second son was born in the district hospital, as she faced some complications. Unfortunately the elder son died in April 2009 due to high fever. Now they are happy with one son and hoping only for one more son or daughter.

Though both the brothers were born and brought up in the same joint family, it seems that the younger brother being educated and exposed to external environment through his job in the Madrasha and his wife also having some education might have made the difference. (North rural).

Vasectomy is still regarded with some suspicion by men. One man was impressed that his father in law had recently had a vasectomy but said *'he should not have had five children in the first place'.*

NGO Support for Maternal Health

The nature of the support provided by NGO clinics is best illustrated by some examples. Very few people in the slum use the services of an NGO clinic located on the edge of the urban Central slum. This Clinic has a new programme that is sponsored by Grameen Phone. It is supposed to be for pregnant women of poor families (defined by their occupation; e.g. wives of rickshaw drivers, day labourers). We found only two women who had benefited from this new programme. One is the wife of a rickshaw puller and had had a still birth previously. She attended the ANC programme and got free iron capsules and folic acid throughout her pregnancy. She gave birth at the Sadar hospital where all the treatment was free and was accompanied there by the TBA to the hospital. The NGO clinic staff visited her after the birth and have indicated that they will give her contraceptive advice soon. This family was very pleased with the services of the NGO clinic but indicated that few people knew about it. In addition to the ANC/PNC care, the Grameen Phone programme also underwrites the costs of a Caesarean section at a private clinic where the mother and child is at risk. This provision amounts to Tk12,000. Although reported otherwise in other parts of the country, we were told that there was no requirement to purchase of a mobile phone to avail this programme and that it is part of a CSR initiative of Grameen Phone.

There is another NGO operating in the Central district town which is providing family planning, menstrual regulation and maternal health services. We found that more women seem to know about the MR services this year than before, though it was not clear if they were using them. The male services have recently been terminated due to lack of funds although their advertising material still suggests that they are offering these. This included sterilisation where their own vehicle collected prospective clients, often referred by FWAs and the FWC on designated days. A FWV (peri-urban) told us that this was an excellent service and men were increasingly motivated for this. The idea of collecting men in groups had helped to allay fears and rumours of the negative side effects were mitigated. She said *'men used to think that vasectomy would make them impotent and not able to be with their wives. They thought it would make them weak and they could not work but now they realise it only takes an hour, it is very easy and does not affect their sex lives. They get Tk1,000, a lungi, medicines and their families are entitled to subsequent free treatment at the clinic if they quote the reference number for the operation.' She also noted that 'some men these days say that it is better that they have the operation rather than their wives as this takes 4–5 days in hospital'.* Considering this reported radical change in attitudes, it therefore seems a pity that this service has been curtailed.

Policy Implications

The aim of the Reality Check is not to present recommendations to policy makers, but instead to suggest issues from the findings that may have potentially useful policy implications.

The first is that attention needs to be given to the problem of improving the regulatory framework for the range of public/private,

formal/informal and governmental/non-governmental providers on which people living in poverty depend, in order to better ensure people's right to health. Quality control is a particular area of challenge. This cannot be simply a 'top down' regulatory initiative, but will benefit from participation by users.

The second area of policy implication is the need for integrated planning and action in health provisioning to tackle the problem of mismatched resources (e.g. good operating theatre but no surgeons). Accepting that many facilities will face resource constraints, there is a need to ensure that solutions are found to ensure as many as possible of such facilities can function optimally. There should be a plan for stepwise holistic improvements which focus on local conditions and needs.

With an improved regulatory framework and more coherent deployment of resources in place, the third important policy implication is the provision of more information for users and providers alike. Even quite senior government health staff are unaware of plans for development of the facilities they are attached to. The Citizens' Charter is not sufficient in providing specific information for particular facilities. The uncertainty around the provision of services and continuation of services leads to disenchantment with Government services.

The fourth area of policy implication is linked to the second and third in that, as an adjunct to information provision and addressing local conditions, there is also a need for awareness raising activities – that could be undertaken by both government and civil society – that can further empower service users to demand a better service culture, particularly from public providers. This would also contribute to the creation of a stronger demand pull to better orient providers towards peoples' needs.

Finally, our findings this year suggest that there is a need for more attention to be given to some simple basic public health messages on issues such as the dangers of excessive salt consumption, the unhygienic nature of public spitting and first aid knowledge. There would be immediate and cost-effective public health gains from such work.

Main Findings in Primary Education

The most important change this year is the introduction of the new Class 5 public examination the purpose of which is to ensure a common standard for completion of the final year of primary education across all primary schools: government, NGO, Madrasa and private. This has had a very significant impact on both students and teachers commitment beyond just Class 5. We also continue to find major differences between 'official' and people's explanations for drop-outs. Teachers continue to explain out of school children as a result of poverty and the ignorance of parents but our interactions suggest strong parental support for education and that dropping out is often the decision of the child him/herself. They do not drop out to get married or to get a job but because they do not like school or are failing.

Girls making biri (local cigarettes) to help pay for their education (Urban South)

Strong motivation for school-going

As we have noted in previous years, parents' motivation for sending children to school is generally strong. Although there are some out of school children notably in the rural North area, most parents are keen for their children to complete at least primary education and that they 'do better than us'. Many drop outs and poorly attending children do so against their parents' wishes and best efforts to encourage them to stay in school (see absenteeism and drop outs below).

This motivation for education is exceptionally strong in the rural South area where families make the education of their children a priority. To cover the costs of education women go out to work, children contribute to their own educational costs through working and parents place their children with relatives for periods to bear the costs. Although this also happens in other areas, the efforts made here are striking because nearly all families are this committed.

School for working children (Urban North)

Education providers

Last year we noted how parents adopt careful strategies to get the best from schools (2008 Report, p.60–61) and that transfer between schools at critical times was important (see 2008 Report, Box 43). As all primary schools (Government, NGO and private) can enter students for the new Class 5 public examination, there is no longer a need to transfer students to government primary schools (GPS) for this final year. Other than this there are few changes in education provision in our areas except the opening of new private primary and pre-schools.

Expansion of Pre-schools

Some GPS schools have opened *'choto one'* classes which are supposed to prepare pre-school children for Class 1. Most schools in our areas say that they neither have the space or staff to be able to manage this despite a Government directive to do this. One Principal (South rural

Even though there are two pre-schools in the area, there are still not enough places so the little girl peeps through the window of the pre-school (Peri-urban Central)

GPS), who is typical of other teachers, told us that she thinks that government schools are best placed to provide early education because they know what skills and competences are needed in Class 1. NGO schools, she feels, do not have the knowledge or understanding and do not therefore gear learning towards the government's curriculum. *'Choto* one' classes we observed tend to be rather formal and basically the same as Class 1.

BRAC pre-school (Peri-urban Central)

Meanwhile, private providers are actively expanding their services in order to provide pre-school education. For example, a private school in the Central peri-urban area has opened a pre-school this year catering to 4 years olds. The atmosphere is informal and the teacher and children sit on carpets on the floor. The Principal tells us that he wants the children to *'learn through play'*. We watch the children arrive and hug the teacher before sitting in a circle and singing some number games. The same school has just opened a 'day care facility' for twenty five of their school children as a result of demands from parents. Children can bring their tiffin and stay from 9am until 5pm. Only a few of the children who avail this service have both parents working. The main reason for this service was in response to requests form parents who cannot supervise homework as the home environment is not conducive. Parents pay an additional Tk350 per term for this.

A new private pre-school, where the Principal wants the children to 'learn through play' (Peri-urban Central).

Box 39: Pre-schools

We often meet the young girls and boys on their ways to and from the school being very cheerful and singing. Parents are generally very happy about the pre-school. They say, for example, that it gives them respite from the children for a while when they can get on with work without being disturbed; that they can use this time to go to the field for work; and that they have noticed that students perform well once they start Class 1 if they have been to pre-school. Parents were also happy that their children learn to sing and recite poems, counting as well as hygiene awareness, things they themselves did not quite think of as important or possible to teach. (South rural).

One of the BRAC feeder schools has recently suffered a rapid turnover of staff and now has a new teacher who has only been there 2 months. We watched her in action and she seemed to lack confidence. She has had no training yet and she seemed unable to use the interactive materials effectively. Despite the affirmation from the BRAC supervisor we met at the Government primary that all pre-schoolers were now catered for, the Principal contradicted him and agreed with us that there were many children who did not go to pre-school and, in particular boys because of the bias in favour of girls. The BRAC supervisor said that all the children at the pre school have to come to the Government primary and the parents are made to pledge that they will not send their children elsewhere. (Central peri-urban).

A student of the village pre-school plays with her book (South Rural)

Choice and competition among schools

With the proliferation of private schools and NGO schools we have noticed a concomitant increase in the 'marketing' of private education services. This is usually carried out through school staff making home visits to persuade parents to send their children to the school. As well as promoting their image, this practice also helps to build good relations with the community. This is an advantage over many of the GPS we visit which seem to have long since abandoned home visits and, with outside teachers, are becoming less embedded in the local community in recent years. However, there is also evidence in several areas of aggressive 'smearing' of the competition and this should be borne in mind when reading comments made in this report by different providers. Madrasas too have been actively canvassing for students (e.g. claiming that if parents place one out of their five children at the Madrasa it will ensure a better afterlife for them (South urban)).

Box 40: When we turn up unannounced at schools

There is a big difference between Government and private sector schools; in all three Government Primary schools, teachers arrive late, there is chaos on our arrival, children pour out of their classes, shout and chatter. When the teachers arrive they seem unable to instil discipline. They always leave their classes to talk with us. There are too few teachers and large numbers of children. In the private school the children remain in their classes, teachers (one in each class!) stay with them and acknowledge us but prioritise the children. (Extract from Central peri-urban field notes).

The dilemma faced by the father in one of our FHH (South peri-urban) is typical in areas where there are a variety of education providers. He has one daughter and two sons and is currently wondering what to do about schools. His son now goes to the local GPS but he has received some pressure from the Madrasa to send him there instead. *'My older daughter is there already, and they will get all subjects there… general and Islamic'*. The Madrasa is more costly than the GPS but the father does not mind since they will get Islamic education in addition to general education. He thinks having all children in the same school would

be good: his older daughter can look after her younger siblings. However, he recently had a visit from the manager of a new private school, which includes both primary and higher education and he has decided to send his children there after all.

NGO schools

We have noted before the recent increase in the number of schools for working children operated by NGOs in the North and in the South urban and peri-urban areas. Last year's report highlighted the practice of double enrolment in these schools as well as the way they may 'poach' children from mainstream education (2008 Report, p.72–73). This year, teachers in one GPS in the South peri-urban area said that as many as 35–40 students have left to go to NGO schools, although some students have returned within 6 months. So common is this that the school has decided not to cut their names from their register so if they come back within a certain time they will be accepted again. Teachers here say that *'the NGO schools attract parents by saying that within three years we will cover the equivalent of five years in GPS.'* Another says *'BRAC is recruiting children from us, and it is making a mess of things, with children being transferred here and there!'* These GPS teachers are jealous of the small class sizes in the NGO schools and feel they too would do better with smaller classes *'how can you do singing with more than 50 students'?* Another GPS Principal (urban South) tells us *'it is easy for NGO schools to create an environment of amusement… but only dancing and laughing does not lead to any learning, does it? Basically, students are not learning anything from their lessons there. The NGOs are not maintaining any norms but they only implement their NGO projects… they violate the rules and they are only doing their business.'* A Principal of a private school in the Central peri-urban area is not very impressed with the BRAC schools as he feels they are more interested in the novelty of singing and dancing and there is little real education *'It keeps people happy but for what? What do they really learn?'*

Singing in an NGO school – some criticise that singing and dancing is not education (Peri-urban North)

The Principal of a new private Kindergarten School (South urban) also shared his thoughts about NGO schools *'Here, parents are looking to get everything for free – tuition, books, and perhaps something extra on top of this. This is because there are so many NGO schools and this has spoilt people and they no*

longer accept the idea that they should pay for good education. They think of cost before they think of quality, and they have no idea what quality in education is. They cannot judge it. For example there is an NGO school here … they give free education, food, and even taka cash for every day their students attend. That is all the parents want to know… Parents do not worry about drop out of these children, they only worry about money… about 'how much money can I get using my son or daughter? The financial ability of families, that is not really the question in relation to education. It is instead the fact that they are not motivated or they don't understand the question of good quality education. For example in the town there are lots of very poor people too but they are different from slum people in that they understand about quality of education'. This comment reinforces the perception that Government schools are not free and suggests it is the incentives provided by the NGOs which alone attract parents. Our observations suggest that a few parents may indeed be attracted to free hand-outs but many more are genuinely concerned about their children going to school as evidenced by double enrolment and efforts to ensure coaching.

Private schools offer small classes and high teacher to student ratios (Peri-urban Central)

Private Schools

We have observed new private schools opening in our study areas. These are mainly aimed at families who are not well off. Fees are kept to a minimum (Tk100–200/month). This means that in many cases it costs the same or only a little more than hiring a private tutor to supplement classes at a GPS. As we have reported in previous years, hiring private tutors is a common practice and regarded as an affordable cost (2007 Report p.34). Nevertheless arrangements for delayed fee payment and subsidised payments are common at private schools For example, one kindergarten Principal said he pleaded to parents not to get upset if he came to personal arrangements with some parents regarding lower tuition fees. He asked them to accept this in solidarity with the less well off, and said it is for the good of the school. Parents apparently accepted this.

The government primary schools here… there is no reading going on there, no education. They only go there, the students, but no one is looking after the children, not even their guardians. But if parents pay for their children's education they get ownership of that education, of that school even – here (referring to new private Kindergarten) they are all members of the school, the parents. And they have meetings

frequently and sometimes even people who don't have children in the school attend. If they pay they can also require us to give good education, because if we charge money for tuition we are compelled to give them this. (Guardian and member of the private school committee, South urban)

Another new Kindergarten school has opened (Urban South)

Several new private schools have opened this year in both the Central and South study areas. The founders we met say that they are primarily driven by commitment to strengthening education in their communities. The new kindergarten established in the South peri-urban area is typical. The young and energetic Founder-Principal has worked abroad as a welder and accumulated sufficient funds to retire and live comfortably on his savings. However, he said he had a *'desire to give something back to my community'* and decided to establish a small school which now caters to about 75 students. He visited eleven kindergarten schools and assessed the level of interest in the community before building the school in 2008. He instigated a rigorous selection process for his six women teachers and enforces a strict code of conduct (no mobile phones, no absences from class). His close contact with the Kindergarten Association ensures that he has access to good resources and advice. Parents are very pleased with the school and the fees of Tk200 per month are manageable. The Principal feels that the quality of education he can provide means that parents make savings as additional private coaching is not needed. He also feels that many parents prefer the formality of his school where children wear uniforms and sit at desks to the system at BRAC schools where children sit on the floor. He also said some parents object to their children having to do chores such as sweeping and collecting water at BRAC schools.

Similarly another young man who runs his own IT company has opened a small school this year in the South urban area. Like the example above, he too wants to give something back to his community. He too has linked to the Kindergarten Association and visited many schools before setting up his. He has recruited friends and family as teachers and recognises that this is not ideal but justifies this as they will understand the low remuneration. One of our HHH in the rural central area has recently enrolled their daughter in a private school. She accepts the cost is going to be around Tk2,000 per year but she and her husband have always said that they only want to have two children and place high value on giving them the best education they can. She was impressed when she visited the school.

Box 41: One parent's view of a 'dream school'

Last year we presented a young mother's (S) views on quality education and her aspirations for her 4 year old daughter (2008 Report Box 24, p.68). She thought they might move house to find the kind of school they wanted where ' they wear good uniform, are disciplined, have teachers who really help the children to understand in a comfortable and good learning environment.' They have in fact built a new house rather than move and have enrolled their daughter in a local private school after all. S had never been to see it so we offered to go with her. When we met back up with her later in the day we asked her what she had thought about the school. She had been so excited she told us, she had phoned her husband who works away to tell him all about it. She liked the 'way of teaching'. She thought the women teachers were very friendly and affectionate, she noted that 'all the teachers were present' and liked the idea that the Principal had told her that the parents are called to discuss their child's progress, particularly if they are failing and she also loved the practice of celebrating with parents after all the exams. She also noticed that the toilet was very clean. Her daughter who accompanied us wants to go to school 'now' and does not want to wait to January! (Start of the new school year) (Central peri-urban).

Students of the new kindergarten (Peri-Urban South).

Impact of new Class 5 public examination

'The new exam will make a big difference' (teacher, GPS, urban Central) *'The best change this year'* (Principal, RNGPS, rural Central) *'This examination will help us to compare teaching standards of different schools and the quality of education'* (parent, North urban).

Our study this year coincided with the build up to the first ever national public examination for the end of primary education (Class 5) and we were able to follow the process of 'model tests' and preparations for this. We also re-visited some areas to talk with students and teachers after the national test which was held between November 22 and November 24, 2009. The examination comprises six subjects (Bangla, English, Maths, Social Science, General Science and Religion) and two examinations of 2 hours each are scheduled each day over the three days. It is compulsory for all students of government, private, NGO and Kindergarten schools to qualify students for entry into higher secondary education. This means there is no separate primary level scholarship examination as before as scholarships will be awarded based on high scores in this examination (understood widely to be 80% +).

Student busy with her homework (Peri-urban North)

Both these boys are in Class 7 and they study every day together (Peri-urban Central)

The introduction of a national examination has had an enormous impact not only on the Class 5 students taking this exam but on education as a whole in all our study areas. Many spoke to us of a new sense of *'seriousness' and 'commitment'* among teachers and students alike. The main benefit perceived is that the standards are set externally making the examination *'more fair'*, credible and nationally recognised. *'This is a good system because the school will not select only the best students for scholarship exam'* (teacher, North urban). *'The exam certificate will have important value, and parents will become more caring, pay more attention to their children and their schooling'* (teachers, South rural). *'It makes everyone the same'* (principal private school peri-urban Central). The principal of a GPS in South urban told us that the exam has led parents to take more care in being supportive of their children and was surprised that, as a result, 62 parents out of 95 attended a recent parents meeting, which had previously been almost unheard of.

In previous years, the only extra tuition officially provided in GPS in our areas was for scholarship students (for free or on payment) not least because school quality was to a large extent assessed by parents, teachers and education authorities on the basis of numbers of scholarships attained each year. Not only did these students receive coaching but also special status such as sitting in the front of class and more attention from the teachers. The introduction of the new public exam for all has radically changed this and free coaching for at least an hour a day was being provided in all GPS and RNGPS schools in all our study areas to all Class 5 students. Some schools even offered extra classes on a Friday (rural North) and in school holidays (peri-urban Central). In some classes, less able students were now sitting at the front rather than the back.

Box 42 gives a few examples of this change in GPS.

Box 42: Impact of the new Public examination.... extra tuition now being provided in Government schools

School A in the Central urban study area was regarded as a failing school with poorly motivated staff who were often late for classes, absent and slept in class. Discipline was slack, children were able to do as they pleased and there was a high level of absenteeism (see Box 36: Same but So Different, 2008 Report, p.84). This year, with basically the same staff and resources, there has been a major transformation. Staff are punctual (they tell us they aware that the TEO might make an unannounced visit) and provide extra lessons before and after school to all the pupils in Class 5 rather than only the best ones which they previously groomed for the scholarship exam. The school is not fully staffed but the principal has organised assistant teachers paid from local donations and deductions from permanent teachers' salaries to cover the extra classes needed to ensure the Class 5 children will be successful in the exam.

The only school (GPS) in the rural North study area has been providing intensive coaching for all their Class 5 students. Classes have been provided between 3:00-4:00pm 6 days a week since January 2009 and there is also optional coaching on Fridays from 2:00-3:00 pm at the teacher's house.

In the rural South, the class 5 exam is greeted with excitement by all. There is a feeling this may change the way students and parents alike approach education; it will make them take it more seriously and in an urban GPS (South) not only are teachers providing extra tuition in their free time to all Class 5 students they have also been tracking students' progress by setting an exam every fortnight.

Box 43: Teachers anxieties around their Class 5 students performance

The teachers in a GPS in our Central peri-urban area have even been providing extra tuition in the school holidays. This is 'because our children are so far behind'. Asked why they were so far behind, the teachers gave five reasons; i. Poor attendance and many children have had big gaps at various times, ii. Teachers are too tired (the school has been under staffed in the past by as much as 50% and they feel that they have not been able to give the children the attention they needed), iii. Half the students come without breakfast resulting in their attention span being impaired, iv. Students are tired (partly because the day is long and partly because they go to bed late and rise early) v. Because of the shortage of teachers, they have to cover other classes.

Box 43 illustrates the kind of anxieties teachers' harbour which has led to the provision of extra classes.

Our own observations indicated that there has been a major shift since last year in the attitudes and behaviour of both school going children and their parents. The introduction of this exam has created a climate of studiousness which we had not observed in previous years. In many houses, children of all ages were seen to be engaged in homework and study.

Evenings were often punctuated with the sounds of children reciting from their text books whereas in previous years they had been playing and watching TV. *'My daughter is so keen to pass the exam; she was pestering me to study with her at midnight last night'* (mother and proprietor of new coaching centre, Central urban).

Parents and private coaches told us that the public exam now means that there is no possibility for teachers *'allowing students to pass'* through improper practices. In the past, teachers said that they used to be under pressure from parents to promote their children to Class 6 even when they had failed Class 5. Children and parents confirmed that it was easy to secure a pass with a bribe. For example, in our Central urban area we were told that *'the parent would be asked to make a 'donation to the school' (of around Tk200) and then they* (the students) *would be promoted but this year they have been told that this will not be possible'*. In our South urban area, a Principal told us that in the past, parents whose children had failed in Class 5 could circumvent the rules by moving their child to a new school and convincing the Principal there that the child was ready to move on to Class 6, and this was simply accepted by the new school. A certificate of pass would then be provided by the new school in order to be able to enrol the student at secondary level.

Private schools welcome the public exam for other reasons too. This will be the first time that their students can sit Government exams without having to be falsely listed by a Government school. For example, one Principal explained what used to happen; *'In the past we could not enter students for the exam ourselves. We had to build a good relation with one of the government schools and then pay to get them to include my students on their registration. For example, last year I paid Tk400 per student to be included in the Class 8 exams. The government school would then get the credit for these students who would have this school name on their certificates.'* He told us with some resentment that last year only three government school children qualified for secondary scholarships but half his students qualified and yet this success was attributed to the GPS. Another private school principal was initially refused to register his ten students for this exam and had to make five visits to the TEO. Finally he sent a letter including Tk400 and the list of names and immediately heard that they had been accepted. The

Even young children spend more time with learning activities at home as a result of the introduction of the Class 5 exam (Peri-urban North).

Secondary school student coaches a boy for the exam (Urban North)

Boy who was not interested last year is now motivated to do homework (Urban North)

Children doing homework in the light of a kerosene lamp (Rural North)

opportunity to register their own candidates in their own right for the public examination will stop the previous practice of transferring girls back into GPS class 5 from these schools in order qualify for female secondary school stipends (This practice was explained in the 2008 Report, p.74).

Students told us that these days *'teachers are more serious'* and *'they tell us we must come on time and every day'* (Central urban). In one Government primary school (Central urban) we heard they are even fining children Tk10 per day for non attendance. A proprietor of a new coaching centre (Central urban) told us that Government teachers *'have started visiting students' homes to see why they are not attending or are not performing well'* a practice which was rare before.

In the run-up to the exam, inevitably there were some concerns voiced particularly among teachers. *'Since this is a public exam it will be a great challenge for our students, more difficult than sitting an exam in the same school competing with a group of students they know'* (teachers, South rural). One concern was the arrangement to have two exams per day (e.g. teachers in rural South expressed concern that this would be *'too much'* for their students) but the comments by children attending a coaching class (Central rural), which are typical of many in other areas, indicated that they *'did not see this as a problem... we have done all the work before so we do not need to revise the night before'*. Following the first day of the model test they said that having two tests in one day was good and *'it will be good that all the exams are finished in three days'*. Although most children in other areas did not seem concerned about taking the exam in unfamiliar surroundings often some distance from their home, those in North urban were *'afraid'* because they *'have never appeared at this type of public exam before'*. In the South rural area there were worries about the arrangements (too many exams in one day, too many students in one place) and that this may negatively effect student achievement particularly disturbing talented students.

Teachers were worried about the standard of the exam being too high. Some feared it might be set at the same standard as the earlier scholarship exams in which case they thought most of their students would not pass. In our rural South area, one school still provides extra tuition for their 'scholarship students' in addition to extra tuition for all. These students were identified at the start of the school year in order to ensure that the school is as successful as possible in the exam. These teachers also worry that there is not enough time in the 2 hour exam to score well.

Some expressed their dissatisfaction with the short time given for preparation for this exam and the lack of information surrounding the arrangements for exams and subsequent procedures. A GPS principal in peri-urban South felt that many of his students' parents were still confused about the exam. When we visited only a fortnight from exam dates, teachers had only just received confirmation of the venues for the exams and Principals were still being called to the Thana Education Offices to check candidate lists. Some private schools had only just had confirmation that their students were accepted to sit the exam.

The model test was hailed everywhere as an important exercise that helped to allay fears associated with the examination. Teachers told us that it built the confidence of children, both in terms of their capabilities in the exam and experience of going to a central (and sometimes

Class 5 students sit the model test (Urban Central).

unfamiliar) location for the exam. In our Central urban area, the children were a little intimidated by the presence of police at the exam centre though. However, students themselves were less concerned about these issues than the teachers, and seemed enthusiastic and positive both before and after the model tests, even when we suggested that it would have been acceptable to have been nervous. Teachers explained this confidence both in terms of *'children these days are more adventurous and less worried about these things'*. But they also suggested that perhaps the children had not recognised the significance of these exams and had inflated notions of their abilities when compared nationally (e.g. children told us the model tests were *'easy'* but teachers said they did not get the marks they had anticipated). Teachers and coaches were very worried about the level of the exam and although somewhat relieved following the model exams, expressed concerns such as *'everyone can pass but it is difficult to score high marks'* (coach rural Central), *'some maths and science teachers (from other sub cluster schools) had complained about the way questions were worded (in the model tests) and although 'these questions were straight forward the children might have been thrown by the unfamiliar language'* (teachers, Central rural). Teachers told us that in the past with final year exams the teachers were always present and could explain things to their students in the exam.

Box 44: Comparison of exam arrangements in 2008 and 2009

The principal of the North urban GPS told us that while earlier they could support the students in understanding the questions and writing answers during the final exams of class 5 under this new system it is not possible for them to do so. The exam will be held in the high school where they will not be allowed to enter and support their students. This change is illustrated by the comparison between arrangements this year and last year in the rural Central study area.

2008: Children who had sat the Class 5 final exam described to us how the English exam was arranged. They were allowed to ask for clarification and the invigilating teachers (from their own and local schools) would tell them the questions in Bangla, sometimes going to their desks and giving hints on how to answer the questions. They put these hints on the blackboard. The children said they were not allowed to copy from each although they are sitting three to a bench. If caught copying they were told to stop writing for 5 minutes and then were allowed to resume. However, they were allowed (even encouraged!) to help each other (as long as they did it quietly!). (From field report Central Rural, 2008).

2009: The exam was conducted at a central venue about 5 km away with about 25 participating schools. The invigilators were not known to the students and their own teachers were not allowed to come with them. Apart from some clarification of the procedures there was no other explanation or help given.

There were complaints that the model exam was organised too close to the actual exam and did not give teachers sufficient time to make good deficiencies highlighted by the model exam.

There were charges made for the model test, ranging from Tk30 to Tk70 and concerns raised about what these covered. The costs associated with the official public exam include the fees and transport. There seems to be quite some variation in fee charges.

Table 5: Different costs associated with the Class 5 exam

	North urban	North peri-urban	North rural	Central peri-urban	Central rural	South urban	South peri-urban	South rural
Exam fee	Tk35	Tk35	Tk35	Tk40	Tk50–70	Tk35	Tk40–60	Tk35–40
Transport	Tk120	–	Tk40	Tk40	Tk 60	–	Tk20–30	Tk60
Total	Tk155	Tk35	Tk75	Tk80	Tk110–130	Tk35	Tk60–90	Tk95–100

The principal of a private school (Central peri-urban) fears it can turn into a *'money making venture'* and already schools are charging administrative costs in addition to the exam fees. In some areas, the transport costs were anticipated as being higher for girls as they need to be accompanied to the exam centre whereas boys can travel together. In the urban North, poorer guardians told us that the transport costs were a problem for them.

There are also concerns about the next steps. This includes some concerns about the marking procedure. For example, GPS teachers (South peri-urban) told us they know that the examination papers will be marked by teachers of a nearby union, but they worry that some students might be known by them and impartiality might be compromised. There is also the widespread concern about what happens to children who do not pass the examination? In the rural North study area, parents shared their worries and asked *'What will happen to the students if they do not qualify? Will the disqualified students be enrolled further in this school or will they be dropped?'* and in the North peri-urban area teachers felt that *'if this school has to enrol them again it will be a big burden.'* They also wondered if students who fail will be frustrated and may discontinue their education, *"This will close the possibility of higher education for the weaker students if they fail to pass the exam."*

Building work on the primary school is causing considerable disturbance

Government school construction

This year we have observed further school construction in all areas except the North. As reported in previous years, construction and handover is always delayed, sometimes for many months and apparently generally due to disputes of some kind or another. The cyclone shelter-cum-school in the South peri-urban area, which had already reached practical completion when we visited in 2008 and which teachers were predicting would open for the new school year in 2009, has still not been handed over. It is not clear whether the contractors, local government or Ministry are to blame for not ensuring that the new building is put to use. The school staff have complained about this to the local authorities and expect that the hand over will take place soon. Two new rooms have recently been constructed under PEDP 2 for the rural South GPS but are also yet to be handed over. The planned date for signing over the new building with the two additional class rooms has passed long ago, but nothing has happened so far and the teachers cannot yet start using it. They are expecting this will happen very soon though, and they look forward to start a new schedule with new timing for the two shifts. However, the two new classrooms built in 2008 at a GPS in our Central rural area which were not handed over due to a dispute over the location of the teachers' toilet (2008 Report, p.82) are now in use but the hand over did not happen until July 2009, six months later than predicted. This school was intended to be a 'pilot' one shift school following construction but only in the last few months have the full complement of four teachers been employed, although one is attending the Certificate in Education training at the moment so they have only three functional teachers. One of these is a student lawyer who told us he has no intention of remaining long at this 'remote school' so we can anticipate that there will be shortages again making the one shift system untenable. The children in this school told us how much they like the new seating arrangements. The tables are arranged around the room so that the children sit opposite each other. They say there is much more room for books *('They don't fall off')*, there is more room to sit and they can work in groups.

In one GPS in our rural Central area, a new storey is being built above the existing classrooms under PEDP 2. This construction, which started in May, 2009, is causing an enormous amount of disruption. The teachers' room has been removed to allow for the stairway and so the teachers share one of the classrooms. Building materials are stored in classrooms and building debris litters the play area, not only taking up the space but posing a safety hazard. The noise of construction has been unbearable at times, affecting the primary school students and the BRAC pre-school students in the adjacent building. The work is also creating a lot of dirt and dust.

Two of the three primary schools in the rural central area have been extended. The thinking behind this is not clear as student numbers are not increasing and lack of staff in both is a major problem which precludes operating the single shift system. Meanwhile schools in the North area seem to be neglected. The RNGPS in the rural north area is operating in a flood shelter which has never been repaired since construction in 2001–2002 and is in a critically deteriorated condition which even last year was considered to be dangerous. Similarly, in the GPS in the peri-urban North area the roof of the veranda is seriously damaged and *'may fall down at any time'*.

New seating arrangement in groups is preferred (Central Rural)

Building materials stored inside the classroom (Central Rural).

School Level Improvement Plans (SLIP)

The SLIP initiative has now been implemented in nearly all our study areas except the rural and peri-urban study areas in the South. It involves the provision of small grants directly to schools and is intended to help develop a local interest in the school. Schools are expected to use the grants in a way which makes the school a more attractive place for children and motivates them to continue in school.

All schools appreciate that the investment decisions can be made locally and that the implementation of much needed repairs and renovation can proceed more quickly.

Table 6: Use of SLIP grants

Location	Amount	Used for	Leveraging?	Comments
GPS CU	Tk10,000 Tk30,000	New teacher's room which eased classroom space shortage, furniture for teacher's room, school benches	An additional Tk55,000 from local donors	Main issue for students is lack of toilets but not addressed
GPS CPU	Tk30,000	New chairs, repairs to benches, cleaning and repair of toilets and septic tank, playfield filling, roof over TW, fans and re-wiring	None – teachers say the community is 'too poor'	
GPS CR	Tk20,000 Tk20,000 (applied for)	New toilet	none	Urgent needs identified in 2007 not met e.g. electricity connection, dangerous veranda & leaking roof
RNGPS CR	Tk20,000 Tk10,000	New toilet, repainting and repair of walls, repair of TW, Sports Day	Has depressed local philanthropy- school seen as having 'own resources'	
GPS SU	Proposed only			Dispute over political appointee during CTG now resolved
GPS SU	Tk10,000	Repairs, replacement of blackboard and fans	none	
GPS NU	Tk10,000 Tk20,000 (not yet received)	Office and classroom floors repaired, repair of windows	Local contractor repaired floors in exchange for storage of building materials in playground	
GPS NPU	Tk10,000 Tk20.000 (not yet received)	Repair of electric wiring and building	none	
GPS NR	Tk10,000	Repair of benches	none	

Table 6 provides some information on how SLIP grants were spent over the last two years. However, in no case are the SLIP committees functioning as planned. For example one Principal (North rural) told us that a SLIP committee had been formed involving students but no students seem to know about this and the Principal could not name all the SLIP members correctly. The decisions are largely made by the Principals, sometimes in consultation with the Thana Education Office and SLIP committees are on paper only. Student involvement as intended in the SLIP policy is non existent and student priorities are not considered. Review of Table 2 reveals a significant amount of investment being made in facilities for teachers or to make their lives easier. Some SLIP committees seem dormant with a number reporting that they had not met recently and were not active in pursuing further grants.

In one school (Central urban) the Principal feels that the SLIP grant has enabled her to leverage further local funds, mostly from SMC

members. She claims that she has raised an additional Tk55,000 in addition to the Tk30,000 provided in two tranches through SLIP. She feels that the directive to seek outside funds which has come from implementation of the SLIP has been very important. She told us that everyone now calls her *'Bhalo madam'* because of the positive changes she has implemented directly and indirectly through SLIP. From further conversations it is clear that the TEO was instrumental in getting things going. He called a meeting with the teachers and the School Management Committee where he emphasised the problems the school was facing and took pledges for help there and then. By contrast, the Principal of a RNGPS (rural Central) indicated that local philanthropy had declined as a result of SLIP as SMC members and others now felt the school *'had its own resources'*.

There is no doubt of the importance of these grants to enable local and appropriate decisions and this is well illustrated by the following two examples; the construction of a roof over the tubewell in one school (GPS peri-urban) to prevent boys climbing the tree above and defecating onto the tube-well platform and purchase of chains and plastic piping to secure the tubewell pump handle and school flagpole in another school (RNGPS central rural) which have been regularly stolen.

The directive issued under the CTG not to include politically affiliated persons in the SLIP committees seems to be ignored now. In one GPS (South urban) the complaint lodged in this respect last year has now been put aside and the committee is convened including the political member.

Stipends and other incentive programmes

'Stipends should be for everyone or no-one' (teacher, GPS Central rural) *'the stipend programme should be stopped'* (Principal GPS, Central rural)

There is a noticeable increase in disenchantment with the primary school stipend programme this year. Whereas last year some teachers were telling us that it was the stipend which keeps children at school (2008 Report, p.67), now most say it makes little difference. For example teachers say that the Tk100 stipend cannot be an incentive since *'parents who are in real need could take their child out of school and easily make Tk300 from a day's fishing'* (South peri-urban). The stipend is increasingly seen as divisive *('it is a major problem to select poor students when basically all are poor'* (GPS teachers peri-urban Central)) and very time consuming to administer.

Box 45: Teachers views of Stipends

Teachers of a GPS (South peri-urban) were very vocal on the issue of stipends which they feel very strongly should be abolished. It creates a 'chaotic situation' every year, and whatever decision they make they can never satisfy all poor families. Furthermore, it is often very hard to find students that fulfil the criteria of being poor, talented and having a good attendance record. The criteria of being 'talented' is, they say, the most difficult one to fulfil. Besides, they feel that parents hardly use the stipend money for educational purposes. 'They buy fish, rice, use it to pay instalment for NGO loans... all kinds of expenses but not often for school related things.' (GPS SMC member).

Teachers of a RNGPS (Central rural) told us that administering the stipend takes two teachers a minimum of 20-21 days per year: 5 days of meetings (selecting students, making lists, etc), 9 days maintaining individual attendance and exam records to satisfy the eligibility criteria, 3 days stipend distribution (when the school has to close) and several days dealing with parent complaints and making house visits.

The Principal of a GPS (Central rural) says he has heard that there will be stipends for 100% of primary school students from January 2010 but he does not support this. There are so many problems associated with administering the stipend currently that 'it should be stopped'. He does not see that it is an incentive and often asks parents if they did not get a stipend would they still send their children to school and all say yes (this is significant since this village was selected by the RC team for being one of the poorest in the District). He says they spend the stipends on the family not on the child. He thinks that the programme is expensive nationally and very time consuming to operate. He would advocate instead some kind of feeding programme or supply of stationery so children did not have to buy from outside.

In the North, the stipend has been withheld for a long time with no payment yet of the second half of the school year. Furthermore many had only received a portion of the first quarter payment. This is probably because their children have not fulfilled the attendance and performance criteria but parents still do not understand this. These parents say they use the money for stationery and school uniform but in other areas teachers say that the money is mostly used *'to repay NGO loans and buy chickens'* (rural Central) or to *'buy fish, rice, use it to pay instalment for NGO loans'* (peri -urban South).

While we were in the field, rumours were circulating in some areas that the primary stipend would not continue from 2010. Rural central parents/guardians had been called for what teachers told them would be the last stipend payment the day before. Parents and teachers did not seem very clear about what would replace the programme. Some teachers speculated that stipends were to be given to everyone.

With the exception of some in the South, parents, students and teachers are all in favour of replacing the stipend programme with a universal feeding programme of some kind. *'A feeding programme would be much better than stipends'* (teachers RNGPS, rural Central). But all make the proviso that this needs to be provided to all students not just the poor, partly to prevent stigmatisation but also to promote socialisation at school and to minimise the administration and conflict created by having to make selections of eligible students.

The villagers in North rural say that they are ready to cook food if the school supplies ingredients. In peri-urban North parents suggested that the food should be provided just before the class is over so that no children would leave school after taking food and without attending classes. Mothers we talked with often indicated that they thought a breakfast programme would be very good at schools. Although some felt that the stipend programme had been good because *'it enabled parents to spend the money on coaching'*, a feeding programme would be better.

They mostly suggest milk, ruti and egg. One mother (rural Central) said it would be much better than the stipend as this *'disappears into household expenses'*. She suggested egg, banana and ruti but insisted it would have to be for all the children. She thought that it should be given after an hour of school (say about 11.30 am) but wondered if children could last that long as they get up early and go to Arabic classes before school. Another advantage would be that the children would get to school on time instead of lingering over the breakfast at home. Children in different areas generally said they would prefer *ruti*, egg, banana and milk to biscuits or *kichuri*.

Last year we reported that teachers and Principals said children come to school hungry (e.g. *'Children come to school complaining about stomach pain. In fact this is not pain but hunger. How can these children pay attention during lessons when they have no energy?'* (Principal GPS peri -urban South) (2008 Report, p.71). This year teachers (GPS, peri-urban Central) noted that at least half their students come to school without breakfast, and felt that a breakfast programme would theoretically be good but these teachers did not see how it would work and feared extra work. Another advantage was noted in the RNGPS in the central rural area as they have a problem with children going home for lunch and not returning. They had had experience of a biscuit programme before and felt that this does not work. Although children are initially enthusiastic, they soon stop eating the same biscuit every day. They felt that first shift children should get breakfast and the second shift should have a midday meal of *ruti* or *kichuri*. They were very concerned about who might arrange such a programme and worried about entailing more work for teachers. They did not think the SMC[4] would organise this without remuneration and the old spirit of volunteerism has gone *('people only do things for money these days', 'people are more interested to take something than to give')*. Teachers from GPS (Central rural) have heard about lunch programmes and one had experienced the 'tiffin programme' in 1993 herself and said it was very good.

Government Teachers; recruitment, quality and training, time

Government Teacher training

The drive to ensure all eligible primary school teachers have Certificate in Education qualifications is still going on. As noted in the last two Reality Check reports, this continues to cause disruption in schools as other teachers have to cover for these absent teachers in training for a complete school year. In the 2008 report we noted that many teachers felt that the training was too long and lacked practical application in the real world (2008 Report, p.78–79). In the South, this year we came across contrasting views on the training. In the rural area recent graduates from the training told us that they think the trainers could have been more friendly and understanding towards them. They also feel they could have used more inspiring and creative presentations during the training sessions. The main advantage of the training was an improved relationship between teachers and the 'authorities' e.g. *'After training we feel that we will not be facing any negative feedback from the authority'*. The training, as they see it, helps them to understand what the authori-

4 The principal said that the only reason the SMC meets is for the good food they get. 'If they get good food then the meeting is good'

ties want and what they favour in terms of teaching approach and reduces the gap between the authorities and practitioners. The peri-urban teachers in the South also feel the training is important as it focuses on teaching in practice, with advice, for example, on how to prepare lessons which is not provided in the short courses. But the Principal of an urban GPS feels that the Certificate in Education training does not include any adaptation to the changed syllabus whereas subject specific training is frequently updated and linked to the current curriculum. Furthermore, the fact that teachers are taken out of school teaching for training for as long as a year is creating great problems through causing long term vacancies at his school.

All teachers in the rural south GPS have recently received new subject-specific training: the headmaster just a month ago and the rest of the teachers in March of this year. The teachers believe the training has been beneficial to them. It has helped them to keep up to date with their knowledge and teaching approach. Peri-urban GPS teachers in the South concur that subject -wise training is important. They feel it is important that teachers teach their own specialist subjects across classes. This also helps when they have to cover for teacher absence as they all know all the classes. In another peri-urban South GPS, the teachers say the training *'is necessary since it covers so many things: arts, physical exercise, culture, and all the rest of the subjects. When a teacher comes back there are some new things introduced in the class, to make things more creative and fun. Something new is happening when a teacher comes back from training'.*

We met the Principal of the GPS (rural Central) for the first time this year. Last year we were told that another teacher had attended Certificate of Education training with him and how this had been good for feeling motivated (Report 2008, p.78). The Principal himself endorsed this but also said it was awkward doing some of the exercises in front of his junior teacher and vice versa. He said that only 30% of the content of the Certificate in Education training was useful and the course could be contracted to about 3 months. Much of the learning is impractical and cannot be applied because there is no time. He thinks the course should be *'I. more practical, II. more livelihoods related, III. should concentrate more on the relationship between the student and the teacher and IV. should have more subject-wise specialisation.'* We asked children in his school, what difference they had noticed in their teachers after training. They giggled and had nothing to say. One boy eventually said that the teachers are 'laughing more' and another said the teacher *'tries harder to help us understand and tries different ways to explain things, using the blackboard more'.*

Women and men teachers

All teachers in the urban GPS in the North are female and many parents feel that female teachers provide a better service saying they are *'more sincere'* than males and provide *'motherly affection'* to the students and they have more patience. However, the female teachers themselves suggested that having at least one male teacher in the team is important for conducting extra curricular activities, e.g. sports and drills. This coincides with the views of a mixed group of teachers at the GPS in the peri-urban North area who say, *'female teachers are good in teaching and take care of children with motherly affection, but male teachers are good in liaising with the community and with other offices'.* Women teachers at the GPS in the Central peri-urban area think that women teachers are better than

men because they *'i. have more patience; ii have more affection for the children and iii. are caring (able to clean children's noses, help them when they vomit etc)'*. Asked what men are better at?, they said that they were needed to *'do the marketing for sub-cluster meetings', 'going outside for administrative tasks'* and *'organising sports'*. Children from this school made drawings for us of the teachers they like and dislike, which often seemed to focus on whether they give punishments or not. The only male teacher here is *'kind'* to students who perform well but beats others so he appears in children's drawings as both the best and the worst. Laziness and absence are also noted as reasons for disliking teachers, irrespective of whether they are male or female. Other reasons to prefer women teachers include that they *'less likely to beat', 'help children understand'* and are less likely to *'spend time outside the school during school-time like men who spend time outside gossiping'* (rural South).

The Principal of a new private school in the rural central area told us he purposely employed eight women out of the total of eleven teachers. He says that they are *'better teachers than men. They are more caring and affectionate.'* However, the following are some notable exceptions. In the Hindu slum in the north, many fathers prefer male teachers because they are hard working and can guide and control students properly. Nevertheless students told us that they prefer female teachers because they are affectionate to them. In the rural North area, parents say they prefer male teachers as it is difficult for a female teacher to attend school in this remote and isolated area in time (considering their household chores and the transport difficulties). They feel male teachers can go everywhere any time when needed. Nevertheless they see an advantage in having at least one female teacher who can look after the girls. Students here, on the other hand, say they prefer female teachers as they do not beat them and help them in understanding the lessons.

But some parents were of the view that *"No matter the teacher is male or female. Everything depends on the attitude, behaviour and affection to the students including quality of teaching"*. Some principals shared a similar view, for example *'there is no difference between male and female teachers. Any difference relates to either the way the headmaster is managing his staff, or to individual differences'* (Principal, GPS urban South).

A woman Principal (peri-urban North) noted the difficulty she has in mixing with the community and encouraging them to take more interest in the school and the SMC *"Being a woman, it is difficult for me to meet with the people in public places like tea stall, vegetable market and convince them to attend meetings"*.

These are drawings of school children depicting teachers they like and dislike

Local teachers

"Teachers should always remain close with the community and follow up children even after the school hours' (parents, rural North).

Four of the eight teachers at the Central peri-urban GPS travel in from the city, a journey which takes an hour each way. This means they are often late and are unwilling to stay late after school. They think that teachers should be recruited from the neighbourhood but there is no Government policy to support this.

Students told us that they really liked the law graduate teacher at the GPS school in the Central rural area who has been teaching here for the last 6 months. He is young and takes time to help them understand things and, because he lodges in a house next to the school, they can go

and see him after school and *'he will explain things'* and *' even if he is busy he will stop for us'*. They said it would be good if the other teachers also lived in the community. Most parents in the rural North area say they prefer local teachers because they reside in the village, and know about the overall conditions of the families of the students and can support students any time. Teachers in our rural North area say that local teachers are good because they know the situation of the community and people's attitude towards education. They can monitor every child and discuss freely with the parents at any time. *"We also know the teacher since their childhood. So we can talk with them freely on any issue. "They can also support us in any social activities"* (parent, rural North). Teachers in a missionary school in the rural South area noted another reason why the community might prefer local teachers as they can monitor their activities and will complain if they are neglecting school duties.

Children on the way to school where their teachers are local and can 'get to the school on time' (Rural North)

Parents in the North urban area told us that it is good to have local teachers so they can attend school in time and can give more time after the school to visiting irregular students, to discuss with the parents, and following up the students through home visits. But one parent contradicted this, *"It is no matter whether a teacher is local or an outsider as long as he or she is dedicated, sincere, committed and punctual to follow up students and discuss with the parents."* But one FHH parent told us that the teacher recruited from outside always leaves school early to reach home in time and no teachers make home visits. Some parents have a different opinion about outside teachers. *"Outside teachers will have an impartial view towards all students. They will not show any favouritism"* (parent, North rural). In the Central peri-urban and rural schools where many teachers travel considerable distances to the schools where they work, they see this as a burden and people in the community commented that they are often late and *'do not make home visits any more.'*

Teacher recruitment

There are staff shortages in many of our GPS and RNGPS schools. This is because some teachers are on Certificate in Education training, some on maternity leave, others have been seconded elsewhere and some remote schools in any case find it difficult to retain teachers. In some cases school requests for more teachers have been turned down by

the Education Office; for example in the urban central GPS there is a need for ten teaching staff as they have adopted a new shift system but they actually have only eight. The school's request for two new teachers was turned down. *'You can employ them but there is no salary to pay them'* (TEO (reported by teachers)). They have therefore decided to employ two additional teachers themselves whom they pay through contributions from the SMC and from deductions to the permanent teachers' salary. This raises Tk1,000 per month per teacher. The intention is to continue to employ these two temporary teachers in the future as teaching assistants after the new positions have been filled. A similar situation was found in the North urban GPS where the Principal has hired a local girl as part time teacher in consultation with the SMC Chairperson to substitute for the teacher who is currently on training. The salary of this part time teacher is Tk800 per month which is paid through community donation.

In adequate remuneration is a big issue for teachers as typified by this quote *'It is our bad luck that we are here as teachers… because our salary is the same as that of a driver in other government departments… this is so unfair! The teaching profession is not good, it gives no prestige!'* (GPS teachers, South peri-urban). Teachers feel pride in their profession but do not feel they are valued. One principal (GPS urban South) told us he *'appreciated that the new recruitment process is aimed at recruiting qualified teachers but the low salary is a considerable obstacle for qualified people to join the teaching profession'*. Although the requirements have become stricter, the salary scale remains the same. He tells us that this means that *'in practice two newly recruited and highly qualified teachers have the same salary as the two teachers at his school who only have SSC pass'*. Like others, he also objects to the present positive discrimination for women which means that requirements for their employment are lower than for men. At present, women need only HSC and men need a Masters degree. Some see this as a cynical way to keep teachers' salaries low.

Box 46: Teacher views on status and salary

A GPS teacher (South peri-urban) with a Masters degree was dissatisfied with his salary and told us the following. His colleagues who followed the conversation agreed:

'How can I create a positive identity and say that being a teacher is a good and honourable profession when I have the same salary as a driver? The government is behaving in unjustly. They are recruiting people with BA degrees and Masters degrees but when they advertise teaching posts in a circular they say that SSC is the minimum qualification required. Before, this was the case only for female teachers but now this is for all. And by doing it is this way they say that they can keep the salary level at a low level, comparable to other jobs with SSC level. They say or think that is OK, so if you happen to have a Masters degree and you cannot find another job with this qualification ... well that is not our fault. That is how the government is reasoning. "Welcome to being a teacher! But you only get a very low salary". These are the mixed messages that the government send s out with their policy and then their behaviour.'

Teachers tell us they will be pleased if the new policy of recruiting only graduates is actually implemented. They feel that it would be better if there is a consistent recruitment process with consistent requirements so there will be no tensions between teachers.

Corruption in the recruitment process still seems to exist despite moves to stamp this out (See Box 46).

Box 47: Experience of teacher recruitment

One of the private tutors we met in the south urban area told us the following story about his recent application for a job as a teacher in a government high school:

I wanted to get a better, more secure job so applied for this. I had to pay Tk70,000 to ensure an interview. I paid Tk30,000 of this amount in advance, and then if I got the job I would pay the rest. But then the interview date was postponed because of some political intervention... the reason for this is not really known to me. I got my Tk30,000 back. But I am still waiting to learn if there will be an interview.

In the North rural area parents said that although they prefer that teachers should be recruited locally, they worry about the influence of political leaders in recruiting teachers. *'Government must recruit teachers from the locality and selection should be fair and unbiased. If they do not find any suitable candidates they should recruit from the neighbouring Upazilas and districts"* (parents rural North). The assumption among parents in the North urban area is that recruitment will once again become politicised following the respite during the Caretaker Government.

Use of Government teachers for non-teaching tasks and impact on contact hours

"We, the government primary school teachers are used by all government departments including local government for non-education related activities. Government never asks private school or Kindergarten school teachers for such activities" (Principal GPS, North urban). *'Whenever any national activities are planned government officials always assign primary school teachers to perform the assignments'* (Acting Principal GPS, North peri-urban)

Concerns are often raised about the demands made of Government teacher's time for activities which are not related to primary schooling. We spent time with teachers in all our study areas trying to understand the nature of these demands and calculate the number of days lost to these activities. The list of regular tasks was rather similar in all areas:

- Updating voter lists – annual (new voters) and when required before national and local elections;
- Manning polling centres for national and local elections;
- Annual child survey;
- National census (every 10 years);
- National Immunization Days (twice per year).

The child survey, which is supposed to take place every January, involves all teachers and is estimated to take 7 days. National census duties also involve all teachers and take about 7–10 days. Immunization takes two days per year.

In addition, teachers have been involved in 'one off' tasks, for some of which they have received modest remuneration e.g.

- Supporting the provision of national ID cards during the Caretaker Government;
- Provision of support post Cyclone Sidr (South 2008);
- Conducting sanitation survey for Unicef (Central 2009).

The voter ID exercise took most teachers between 20– 30 days and the Unicef sanitation survey took all teachers of the Central urban GPS 5–6 days each in addition to 3 days training. For a while teachers were required to register births but this assignment has now, much to teachers' relief, been transferred to the Upazila Parishads.

In addition, teachers complain about the demands to observe a large number of 'special days' each year. They usually have to arrange processions and displays by the students which require preparation. This preparation, together with observance of the actual day, intrudes significantly on student contact time.

Teachers in the North rural area are typical of others we met. They told us that this extra work hampers the teaching and some classes are neglected due to the absence of teachers. Sometimes the school remains closed unofficially if most of the teachers are engaged with external activities. Teachers in the central urban area said these extra tasks are *'bojha'* (a burden).

Table 7: Work in addition to teaching; an example

Central urban GPS teachers provided the following information regarding work they are required to do in addition to teaching. This list does not include observance of National Days and meetings.

When?	What?	Comments
Since 1986, every January	Government's Child Survey	Involves 2 teachers full time for 6 days
2009	Unicef Sanitation survey	Covering whole school catchment area (960 HH) -household survey took 5–6 days for each teacher. They were also provided with 3 days training
Every five years	Election Commission up date of voters list	Takes all teachers 6 days
At national and local election times	Election duty	One day training and one day duty
Since 1986,twice per year	National Immunization Day	Overseeing vitamin A distribution, de-worming and polio vaccination – 2 days per year

Combined with the demands of their own families and expected preparation of lesson plans, they feel severely over-stretched. With teachers in the Central peri-urban GPS, we calculated that there are 275 school days and 75 official days holiday, leaving 15 days unaccounted for.

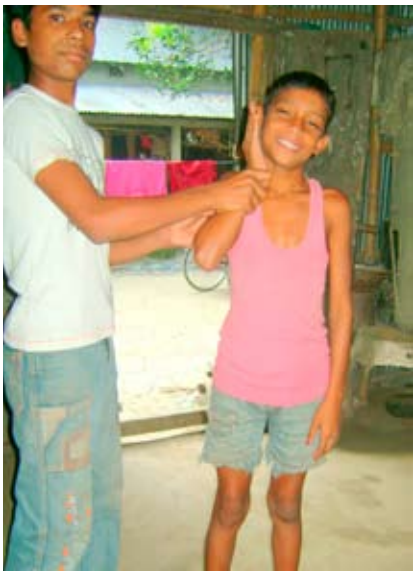
The administration of the stipend system also takes up much teaching time. The teachers at the Central peri urban GPS said it took two teachers six days per year and teachers in a Central rural RNGPS said that they spent 20–21 days in administration of the stipend. Teachers are also expected to attend monthly sub-cluster training and occasional subject based training (4 days) which further reduces contact time.

"The head teacher is always going for meetings with the education officer" (parent, North peri-urban). Principals are often absent when we drop in on schools unannounced and are usually said to have been called away by the Education Office. Principals identified at least 9 days a year spent in official meetings but said they actually were called away much more often.

Then, there are the unexpected stoppages as a result of local politics e.g. *'Today we stood up for three hours, the whole school. We waited for one political leader – he had a programme to come to the school. So there was no studying today* (Boy in class 6, urban South).

Punishment in schools

The Principal of a GPS school in the South urban area says that teachers are now officially instructed not to use physical punishment, *'so nowadays we are not taking any risks'*. But, he says, they are often requested by parents to punish their children if they have been misbehaving. This is reiterated by parents in the rural North area who believe that beating is good for the students, *"How will the student learn if the teachers do not beat them?'*. But teachers in a South peri-urban GPS told us that they do not punish students under a new *'no punishment policy'* as it makes them *'become like stones'* and *'does not make the students become better students'*. In the South rural GPS the teachers say that they also do not use corporal punishment as they believe the best way of behaving towards students is with affection and care so they will feel encouraged to learn.



Boys show how the teacher can make you hit yourself so 'the teachers don't get into trouble because they are not allowed to touch us'

Girl demonstrates the 'chicken' punishment that teachers sometimes make them do (Peri-urban Central)

The move to eliminate corporal punishment has led some teachers and students to feel that classrooms now lack discipline and students are disruptive and unruly.

Box 48: Growing lack of discipline in schools

'In my school there are only boys. Before, boys could be a bit naughty in school but now it is even worse! Boys are naughty all the time! They say silly things to the teachers and then they all get beaten with a stick. All the teachers but one react in this way... and the one who doesn't, he is Hindu, he ignores everyone, just continues the class. Sometimes classes are really disrupted ... it depends on the teacher, when students are loud and so. Once a boy was provoking a teacher and the teacher started to chase him around with the stick in his hand. I have been beaten, but I don't do these things in class now, but it happens even if only one of the boys has been bad.' (Boy, urban South).

Rumana who is in her early twenties and runs the little school in her parents house, is shocked by the attitudes of children towards their parents and teachers nowadays. One of her pupils hit her recently and she was appalled 'this would never have happened when I was young - a pupil hitting his teacher? No'. She thinks that children see adults and youths in the slums who behave badly, are addicts and involved in crime and take these as role models. (Urban central).

GPS teachers told us that since adoption of the 'no punishment policy' in school students 'are becoming more uncontrolled and a bit more wicked and naughty in their behaviour.' (South peri-urban).

One private tutor (urban South) told us that *'nowadays it is more and more common to use punishment that causes children to feel insulted and humiliated, in front of their fellow students. This is a reason for children dropping out, and this did not happen in my youth'.*

Some teachers are finding ways round the new directives prohibiting corporal punishment and the ruling that male teachers must not touch girls.

School Attendance

We noted in previous years that children take days off school for a variety of reasons. This poor attendance can be quite significant, for example in the north urban and peri-urban GPS attendance was only 50–60% on the days we visited this year. Visiting relatives is a common 'acceptable excuse' to take time off school. Typical of many we noted in last year's report was a mother and daughter taking the day off to visit relatives and another saying 'when we go to relatives house for ten days … we just take the children with us' (2008 Report, p.70). This year the same girl (urban Central) who had ambitions to be a doctor (2008 Report, p.70) was absent from school again for two days while we were there as she had gone by herself to visit cousins. We asked her father why he had let her go in term time and he said he wanted to avoid a quarrel and any way had 'nothing to say if his relatives wanted her to stay'. We encouraged children in the Central peri-urban area to analyse their attendance the past week.

It shows a girl returning late after visiting relatives with her family for a few days and feeling too tired to go to school the next day, a seven year old who decided herself to visit relatives without her parents knowledge and two girls who simply decided to skip school to make bangles one day.

One of our team had a chat with a class 5 boy from their HHH who was skipping class, it went as follows:

Me: *"You have to appear at the public exam soon, so, why are you not attending school today?"*
Student: *"I could not sleep last night for enjoying Kali Puja".*
Me: *"Will your teacher reprimand you for not attending school?"*
Student: *"No."*

Boys seem to be particularly erratic in school attendance. In the rural North, it is easy to play in the scrub land or go fishing and nobody will notice or attempt to persuade them to go to school. In other urban and peri urban areas, temptation to watch TV, DVDs and play computer games in shops or simply to 'hang out' with others is very strong.

The lack of tiffin money also affects regular school going.

Mapping school attendance (Peri-urban Central).

Making bangles instead of going to school (Peri-urban Central).

Children call in the local video shop on the way to school (South Urban)

Box 49: Hidden costs of education; demands for pocket money

A boy (aged 10, Class 3) demands tiffin money from his father everyday. If he doesn't get it, he throws a tantrum and breaks household utensils and refuses to go to school. Sometimes his father actually tells him not to go to school as he cannot manage tiffin money (North, peri-urban).

Analysis of school costs with parents in our rural North area indicated that the biggest expense was tiffin money. Children always expect to get some money (Tk2-5) from their parents to buy snacks, ice cream, pickle or chanachure. Sometime they refuse to go to school if they do not get tiffin money. Education expenses here are much lower than in other areas, partly because uniform is optional and there are no private coaches. However costs still amount to Tk440 per year of which as much as Tk350 is for tiffin.

Two sisters (aged 11 and 9) in one of our HHH in the North urban area are studying in class-4 and 3 respectively. They constantly press their father for tiffin money. It is very difficult for their father to give them Tk2-5 each every day as he has no regular income and has now forbade them to go to school. They now attend irregularly. Their elder sister dropped out in Class 4 for this reason.

Last year we told the story of T from the central slum who, at 7 years old, was refusing to go to school. (Box 20, Report 2008). He is now going regularly to the GPS and is much happier but his father says that the boy demands Tk10 every day to go to school. The father sees it as a bribe to get him to go.

As soon as the rickshaw driver father in one of FHH comes home he is beset by his three younger children (aged between 4 and 6), none of whom go to school, who clamber all over him and tug at his sleeves and lunghi. They dive into his shirt pocket and pinch him and punch him until he gives them pocket money from his earnings. They then skip off to the shop and buy ice cream and snacks. (Central peri-urban).

We had an interesting conversation with teachers at a RNGPS (Central rural) where 12% of children registered attend very irregularly. Teachers say that in addition, others also take days off to visit family or the market. Looking through the attendance register it was easy to spot some children who were absent for a week of more at the same time. In one instance it turned out that this was exam time. At first the teachers said that these children were too poor to sit the exam. But when we challenged this since sending them to school was costly anyway, they finally admitted that this was not the reason. For example one particular boy was back at school immediately after the exams were over. This boy and others like him were fearful of failing. This boy said his parents had not bought him the study guide but the Principal said this boy is *'not studious… and his parents have said not to worry as he will repeat the class next year'* (this, of course proves the point that the boy did not avoid the exam for economic reasons). The teachers finally said that the problem was motivating slower learners not poverty as they had implied initially.

School Drop-outs

As in previous years, teachers usually tend to explain the reasons for school drop-out in terms of poverty and parental ignorance. But our experience continues to contradict this assertion. Permanent dropping out of school is rarely a direct consequence of poverty and parents are generally highly motivated to send their children to school.

Box 50: Determination to send children to school despite poverty

The husband of one of our HHH is a day labourer. His wife recently had their fourth child and she is currently at home. The family is poor: there is no furniture in their house. The couple have three school-going daughters. Every morning and evening the wife sits with her daughters and tries to help and encourage them with their home-work. (South rural).

Another of our HHH head is an auto-rickshaw driver (48). Both he and his wife migrated from other districts during their childhood. They have four daughters and a son. Their eldest daughter is reading in Class 10, only son and second daughter are reading in Class 6 and third daughter is in Class 2. The parents believe that mainly education can change their status, so they are more attentive and emphasize their children's education even thought they have limited income. They are both literate. They have to pay Tk200 per month for six months coaching for their elder daughter, who in turn provides coaching for her younger brother and sisters at home. These parents maintain discipline in the family and control their children, so when all neighbouring boys and girls are playing in their own yard these children are doing their homework. The children never take tiffin money. The family buys 24 loose white sheets of paper at a time to make exercise book and save some money. The younger daughter gets a stipend and they use this only for education purposes. They 'never buy any unnecessary things'. They have a dream that all of their children will be educated they will achieve social status as well as earn more money for better life. (North peri-urban).

L is a widow. After her husband died some years ago she was left to look after her family of five without any outside support. But she was determined that her children would be educated. As her children grew up the costs involved in running her family, including all educational costs rose so she convinced her three daughters and one son to join her in share cropping. All her children now work in their field as well as selling manual labour to cover their educational costs. L recently got a job as an ayah in a government office for Tk1,600 per month but works in the field at weekends. This year L says her expenditures have gone up due to her children being promoted to higher classes; her children now read in Class 5, Class 8, SSC and Class 12 but she are still determined to see her children educated. (South rural).

Last year the husband of another HHH was about to move abroad, but was injured and could not go. The family had spent lots of money on an agent to secure both the overseas job and flight tickets and they cannot get this money back. They have also lost the tea stall which was their only income. The family is now facing a difficult financial situation. With no income, and in debt, the family decided to send their son to his grandfather's house in another district. He will be bearing all educational costs for the son until the family has recovered a little financially. (South rural).

The son of one of our FHH repeatedly could not pass his SSC. He took a break from school for a while and cultivated vegetables on some land the family owns. He then resumed his studies and finally after sitting the exam three times he passed. His parents, who had supported him throughout, expressed their relief, 'We are both very keen about our children 's education. But every night I used to cry... why is this happening to me? Why can my son not pass his test? Now, finally I feel free because he has passed.' (Mother, rural South).

'I don't believe that poverty is the only reason preventing parents from sending their children to school. Instead I think it is a poverty in the mind that is mainly responsible for this. I am myself an example. Although I raise four children by myself, and we are living in real poverty, all my children go to school and I strongly believe that I will continue with this.' (Widow, rural South)

In only a very few cases we have come across is poverty the driving factor. In these cases the family is in extreme financial crisis (see Box 51).

Box 51: Drop out stories; very rare cases due to poverty

There are some exceptional cases when families face extreme hardship and children are taken out of school usually as a last resort.

The HHH is a widow living in a house on government khas land. She lost her husband 5 years ago. She studied up to Class five. She has three daughters; the eldest was in Class 6 of the local high school, middle was Class 4 in the government primary school and youngest daughter is in Class 1 in a local Madrasha. This year the eldest daughter has dropped out as her mother could not manage her education expenses despite both being interested to continue her education. They have no earning source and completely depend on family living abroad whom she could not ask for more money to continue her eldest daughter's. (North peri-urban).

One of our FHH in is in extreme debt as a result of being tricked into a life insurance policy which he could not afford. He has taken out NGO loans to service the back payments on annual premiums and as a result has had to take his children out of school even though he regrets this. (North peri-urban).

Boys at a new games shop. We did not notice the so called 'computer game shops' last year. It was raised in several conversations, that boys are highly attracted to them, and that it is being disruptive for school work (Urban South).

There are many other reasons too and the decision to drop out is most often made by the child against their parents' wishes.

Teachers from a GPS (peri-urban and urban south) said that boys are more likely to drop out than girls. Girls, they say are *'more mature' and 'more advanced'* whereas boys are *'naughty and skip school'*. Teachers in other areas tell us that parents are more careful about their daughters because they know that girls are more likely to be successful in higher education than boys. One father (peri urban South) put it this way *'Girls nowadays are more interested in school and in this area there are more girls than boys who go to school and then continue for higher education too. The reason is that education is free for girls, and also that girls are not wicked and naughty like boys. They stay at home and spend less time roaming around outside so they can spend more time on their homework. But boys… they are ruined by bad boys, pressure to do bad things with them. As a result educated girls are now getting married to less educated boys'*. Parents often expect that their sons should go out and earn money as soon as possible. Teachers explain that there is sometimes peer pressure to skip school, perhaps to join with out of school friends. For example in the urban south there is strong pressure to play computer games in one of the nearby shops and *'they get DVDs from somewhere, and hide, watching them secretly at home or from a friend's house.'* (private tutor). In contrast to other areas, in the rural North there are many children who have never been to school and they serve as a distraction to the school going children who want to join them fishing and playing. The resulting poor attendance escalates to a point where the boys are failing and leave school.

Boys prefer to graze their cows than go to school. It is more fun (Rural North)

Fishing (with the school just nearby!) is much more fun than school (Rural North)

Boys tell us it is easier for a boy to drop out because nobody minds them loitering and if they need to earn some pocket money to finance their recreation, there are lots of opportunities. Looking at this another way, several older brothers told us that it is very important for their younger sisters to get an education as the job opportunities are scarce and factory work now requires at least a primary education and often SSC qualifications. There is some concern that dowry demands may be greater from a higher educated girl but there are encouraging signs that things might change.

We talked with a number of older boys in the central urban area about why they dropped out of school.

Table 8: Older boys explain why they dropped out of school (Urban Central)

Age now	Occupation now	Age/class left school	Reason for leaving school
15	Mill worker	11	Didn't like it and wanted freedom. Not for financial reasons
19	Mill worker	9	Did not influence his two friends (above and below) but did not like school
14	Mill worker	10	Didn't like it and wanted freedom. Not for financial reasons
19	Helps uncle - travels	Class 4	Poverty but more importantly he wanted an independent life
13	Tea stall	Class 2	'This is the age for playing. Schooling should not be a priority'
15	Rickshaw puller	Class 2	Father has a big family and although he did not push him to stop school, he felt it was difficult for his rickshaw pulling father to manage. He also wanted to spend time with his friends
13	Mill worker	Class 2	He made his own decision to 'reduce the suffering of his family'. Once he had left school his parents said 'porasuna na korle kam kor' (If you don't study then you must start working)
15	Tea stall	Class 5	He decided to drop out and after loitering for a while his family convinced him that working was better and gave him the capital to start a tea stall
15	Computer shop	15	His parents made the decision because there was a lot of gang violence at the school. His father provided capital to open the computer shop
12	Furniture shop	Class 6	He has been sent to become an apprentice carpenter by his parents. He is motivated for this but regrets leaving school
14	Furniture shop	Class 8	Cousin of boy above - also keen to work but disappointed he could not complete his education
19	Computer shop	SSC failed (15)	Failed the exam and so thought it better to start work

Age now	Occupation now	Age/class left school	Reason for leaving school
20	unemployed	Class 5	Didn't like school
17	Driving school	Class 6 (14)	Didn't like school
?		Class 10	Just as he was about to sit the class 10 exams his father (a government employee) was posted to another town and he could not get admitted to sit the exam. In anger he made his own decision to stop going to school.
19	Driver	Class 5	Wanted to earn for himself and wanted an independent life
18	Works with elder brother	Class 5	His father became very sick when he was in Class 5 and so he left to work with his brother
19	Unemployed	Class 8	He left because he did not have any interest in academic subjects, was not doing well and knew he would not pass Class 8 exams.
14	Audio shop	Class 5	Not because of poverty, he simply did not like school, there was no motivation and he was not doing well. He enjoys spending his own money and being independent of his parents
16	Wants to work abroad	Class 5	Own decision
15	Unemployed	Class 5	He used to go to school in Sylhet. Floods closed the school for 2 months and he lost interest. He was out of school for five years and felt he could not return to schooling. He plans to learn to drive
16	Mill worker	Class 4	No parental pressure to leave school. Entirely his own decision because he did not like it
15	Packing factory	Class 3	He didn't like education. He found work by himself.
12	Bakery	Class 2	More interested in games and sport. He made his own decision to leave school and his parents did not pressure him to work either.

Table 8 presents a summary of these conversations. In most cases the boys made their own decisions to leave school and mostly on the basis of not liking school or failing. Even where economic reasons were given (in two cases only) the boys made their own decisions in order to help their families. Few experienced pressure from families to get jobs although some were given capital to start small businesses or have been absorbed into family business. Many boys told us that they felt they should enjoy 'gap years' – time between school and work when they can become independent and enjoy life. Several emphasised the importance of independence and the good feelings that economic independence brings and were in no hurry to get married and have the burden of their own families.

Punishment is often cited as a reason to leave school (e.g. children in the North urban claimed the maths teacher beat them for not doing homework or not being able to do sums) but as noted in last year's report this may often be an *'acceptable excuse'* to win the support of mothers (2008 Report, p.65). Eve teasing[5] is another *'acceptable excuse'*. While we recognise that this does happen and can be serious, we have found that the incidence and impact is often exaggerated to gain sympathy.

Lack of tiffin money was mentioned as a reason for poor attendance and eventual drop out. Box 49 cites several examples of this and teachers in some areas noted this as a rising trend. Tiffin money may amount to Tk2,500 per year if paid every day and thus constitutes a major cost.

The incentives to continue education are not always there. We noted last year that the lack of job opportunities in the North peri-urban and rural areas and provision jobs for uneducated (e.g. in handicraft centres) as found in the rural South area, suppresses the desire to continue

5 The term used in Bangladesh for the verbal sexual harassment of girls by boys

school (see Box 24, 2008 Report, p.68). The widely felt frustration of poor remuneration despite qualifications is summed up by a private tutor (urban South) *'Look at my brother and I now: I have high education, work as a teacher and earn very little. He quit school early, and he now earns proper money, working.'* Two older brothers in one of our HHH in rural central have well paid jobs in knitting factories and their parents worry that their younger son, who is 12, will see no value in continuing his education. Girls in the South urban area could only name two persons they know from the slum who have passed secondary school. It is perhaps not surprising that aspirations are low, and that parents accept that there is little point in pursuing higher education.

Some note that where the home environment is not conducive to study and where there is no interest and support from parents, then children soon lag behind and failing leads to drop out. Parents tell us that as they have had little or no education it is hard to support homework activities and hiring a private coach is not always an option. Others are busy with work or are too tired.

Box 52: Parents lack of support for children

Although many parents try hard to support their children's schooling there are many reasons why this falls short of what is needed.

Too busy
A is a very busy TBA. She carries her mobile phone tucked into her sari and it rings a lot whenever we are chatting to her. She often excuses herself from our conversations as she has to visit a patient. Her husband used to run a snack shop at the bus station but has now built a little shop at the entrance to their house. He is either there or out buying stocks. There is no one at home to supervise the younger daughter who is struggling at school. Her elder daughter has just been married off, an event arranged in 24 hours as the groom is regarded as a good catch as he works overseas. Anyway this sister was not here much before as she worked 14 hour days at the pharmaceutical factory. The sister in law used to sit with her and help with home work but she now has a new baby and is absorbed with him and her elder child. So the younger daughter wanders from house to house with little or no motivation to do anything. (Central urban).

Too tired
One of our HHH are very keen for their children to get an education. At the moment only one is of school age but the other two will go to school as soon as they are old enough. The mother says she made few decisions when she first got married but since working in the garments factory she is the main decision maker. Her husband hands all his wages from rickshaw pulling over to her and 'she organises the family'. But her elder sister who lives next door is quite different. Her husband who is also a rickshaw driver but much older than our HHH, makes most of the family decisions as his wife is working long hours. He looks after the four younger children while she works and gives in easily to the constant demands for ice cream and sweets. Both parents have been ill in previous years when we visited and have lacked the energy to engage with their children. Now they are much better but the eldest boy refuses to go to school. The younger ones have no interest in school either. The father says he tries to persuade them, but he does not come across as very convincing. The younger sister says they are not very responsible and let the children do as they please. She says 'we can't do anything about this... my sister leaves for work early and there is no supervision. 'They are just like this'. They are just too tired.' (Central peri-urban).

However, drop out from education does not appear to be a problem in the rural South area where there is an exceptionally strong motivation for education which we have noted before as probably due to the strong co-operative and competitive relationships between government,

NGO and missionary schools here and the child sponsorship scheme[6] which operates here.

The drop out statistics can, of course, be misleading in other ways. We have come across many children who have spent many years in school but never pass beyond class 3. There comes a point when they regard themselves as 'too old' and leave school. It is very embarrassing for 'old for year' children to sit cramped into benches intended for much smaller children and to repeat years over and over.

Last year we presented Mita's story (2008 Report, Box 28, p.75). Mita seemed to be a motivated despite having to repeat Year 4 and was earning piece money to contribute to her own education. This year she has left the GPS and through family connections has got admission into class 5 of a girl's school as she failed her year 4 exams at the GPS yet again. Her friends said that she made a lot of fuss with her parents threatening to drop out altogether basically because she was too embarrassed to repeat year 4 again, particularly as her friends had been promoted. A very tall boy in Class 5 (Central rural GPS) faced unkind sniggers from the girls in his class since he was clearly much older than the other students when he admitted to us that he was actually 15. He sneaked away in embarrassment while we were still there.

This girl is very much older than the rest in her NGO class, (Peri-urban Central)

The main reason for drop-out identified by teachers is characterised by comments such as *'poor financial situation, and poor information or understanding by parents/guardians regarding the importance of education'* (Principal, GPS South urban). So why do teachers persist with promoting the idea that poverty and parents are to blame? It takes a while to tease out less glib answers from teachers. The trust we have developed with many teachers over the three years of conversations with them means we are beginning to be able to challenge 'received wisdom' such as this with more confidence. When we share our observations from living with families, teachers agree that mostly parents do want their children to go to school and that those who drop out do so on their own decision and often remain idle for a long time suggesting that they are not contribut-

6 This is run by an International NGO. Through talking to parents we found out that the INGO provides two types of sponsorships; full sponsorship to cover all educational costs except exam fees all the way up to Masters degree or support only for educational materials (stationery items) .

ing to the family economy. Having admitted this, they suggest that school is not really stimulating for the children and not geared to the world of work for the boys. They admit that they rarely follow up failing children and do not spend time trying to motivate them. The first response which blames the ignorance of the parents and their economic situation turns out to be a defensive smokescreen to shift blame away from themselves. The problem seems more to do with what happens in the classroom than the external factors they tend to 'trot out' in their explanations to us.

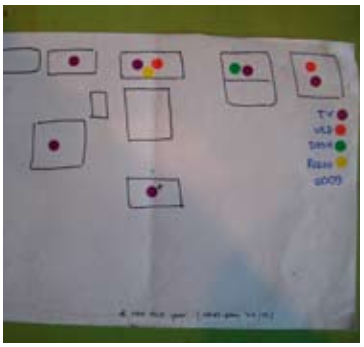
In last year's report we noted that many so-called drop-outs were not drop-outs but were actually school transfers and we commented on the apparent failure of the system to keep track of these movements of children between schools (2008 Report; p.72–73). Teachers told us that children are lured to other schools with promises of incentives. According to teachers, parents are attracted to the idea that NGO schools can provide 5 years of primary education in 3 or 4 years as well as the *'laughing and dancing'* and better teacher to student ratios. But GPS teachers in the rural South also say that students who transfer to NGO schools often come back and they see this as a weakness in the education provided by NGO schools. In the Central peri-urban area, there is a proliferation of new private schools. In fact banners advertising yet another new school went up as we were there. Talking to Principals, it seems there is fierce competition developing including besmirching the reputation of competitors by spreading rumours. Children 'transfer' between these schools even in term time and it is difficult to track drop-out versus movement or change. In the central rural area, some girls are leaving the GPS to attend the girls Madrasa. The main reason seems to be that it provides a safe haven for girls to play and as enrollment has been in decline in recent years, currently the teacher: student ratio is very high.

NGO schools for working children and some BRAC cohort schools continue to include some children who are currently or were enrolled in other schools. This seems to be because the schools have to demonstrate full enrollment and meeting their targets.

But many drop-outs regret not having furthered their education. The time gap that has ensued between leaving school and the present means that there are no opportunities for them to resume schooling- they have missed out and they feel they are now too old to go back to school. Many expressed the need for some kind of continuing education, perhaps in evening schools or based in clubs. As jobs abroad attract many of them, they would particularly like better training in functional use of English language and more knowledge of technical and computing skills opportunities. Most of them said that they were not very interested in girls at the moment and intended to work until their thirties before getting married.

Teasing and harassment

There are mixed experiences of teasing from our study areas. Generally so-called 'eve teasing' does not seem to be the problem it is sometimes claimed to be in the media. Girls told us that it happens but that they manage it and *'if you don't respond to it and encourage it, the boys soon stop '* (girls, 13 Central urban). These same girls went on to explain that their friend who asserts that she is bothered by this actually shouts back at



TV ownership (Rural Central)

School books piled up on the only small table in this HHH (Peri-urban South)

HHH father helps his wife cooking (Rural South)

Father cooks for the family (Peri-urban Central)

boys and *'says rude things'* whereas they have learnt to ignore it. They told us that their friend uses this as an excuse to her father for not going to school.

Teachers in a rural South GPS say that such teasing is not a problem at their school as they have worked on making girls and boys realise they are equals. Girls have learnt ways to deflect the teasing from boys. They gave examples of a Class 5 girl who managed the problem of teasing by a boy herself and of several girls going in a group to talk to the parents of a boy who had been misbehaving towards them.

Home environment and learning

Being part of families for several days we have been able to observe the home environment and what seems to promote and inhibit learning and educational progress. As mentioned above in the Health section, home environments can be quite quarrelsome and may not be very conducive to children learning.

One private tutor (urban South) told us about the family he works for. He takes on most of the responsibility for ensuring school going. He says he constantly has to keep an eye on the boy to ensure he does not sneak off to play computer games in a nearby shop. He says that, *This family is very supportive in attitude, but they could be behaving in a different way – when I am tutoring their children here, in their home there are sometimes lots of people around, and the TV is on, so the children cannot concentrate. It is only because of my contribution and the pressure I put on them that the children are doing well. I talk to their parents and try show them how they could be and should be more supportive. Also if they could move out of the slum that would be even better.'*

One Principal (GPS peri-urban South) purposely does not give students homework on the basis that it is divisive as children from poor homes face difficulties completing homework. These children are less likely to have private tutors to help them and may live in homes characterised by tension and fighting between parents. There are many other disturbances for children at home, the primary one being TV. More families have TVs this year (see diagram) and our observations indicate that it is a common practice to watch TV in the evenings and many watch throughout the day. In slum areas, there is constant street noise.

Many fathers are observed to be more 'hands on' in looking after their children and domestic chores. The photos show a number of examples.

Some families exhibit extraordinary determination to educate their children.

Chores and play

This year we noticed some homework being done, particularly by secondary school boys but primary children (other than class 5) rarely seem to be doing any although they carry their books to and from school daily 'to do homework'. They spend a lot of time playing.

In the Central peri-urban area, girls occasionally help with basket making and, in preparation for Eid, were helping with pitta making but these were regarded as recreational activities rather than chores. We do not observe girls helping with cooking or doing many domestic chores in this village, except the occasional sweeping or clearing cow dung from the yard. Boys will also take care of cows. Parents told us that children are quite reluctant to help and they cannot force them. Children

Girls play inside the home (Peri-urban North)

We did not observe caromb playing by children before in this area (Peri-urban Central)

like to play and there is a noticeable increase in recreational activities this year. We observed many caromb boards and there is a caromb league in most paras. There is also a new football league.

In the north urban area, very few girls support their mothers in cooking, collecting water and washing clothes in the nearby river. Only one boy of Class 4 was seen helping his father in carrying snacks to the market during school hours. Sometime they spend time enjoying in the religious festival with other friends e.g. *Puja* or go to the nearby friend's house to gossip and watch films on the TV. No children are engaged in the household chores that prevent them doing home work or attending school. None of our F/HHH primary school students in the peri-urban North area did home work before going to school or and after coming back from school. Some go to the *Moktab* (learning the Quran) and others play in the courtyard in the early morning until the school starts. Children do not obey their parents and always refuse to do household work. We always found them playing with friends in the fields or going out for catching fish in groups from the low land area and river. Parents do not supervise or motivate their children to do homework. Girls and

Lots of playing with dad (Peri-urban Central)

Father prepares the chicken for dinner (Peri-urban Central)

Every afternoon this mother sits with her children and listens to them read (Urban Central)

Difficult to get enough sleep (Rural Central)

Lots of time to play
(Peri-urban Central)

some boys will help their mothers in cooking, grazing cows and collecting firewood from the bush before school starts. Some parents were happy that the children are catching fish for the family even during school hours. They shout sometime to the children to go to school but children do not care.

Private Coaching

With the exception of the rural North area where there are no persons sufficiently educated to provide, private coaching is still important in all other areas and increasingly provides supplementary income for college students. In the North urban and peri-urban areas the system of 'lodging tutors' still prevails. Government school teachers are less likely to provide private tutoring, particularly as they are currently engaged in extra lessons to prepare Class 5 students for the public exam. The provision of compulsory extra classes in GPS has not had much impact on reducing the need for private coaches though. As parents in the North urban area put it, *'this* (the extra coaching provided at GPS this year) *has become routine work for teachers and they do not monitor or follow up the students individually'*.

More coaching centres have been set up during the year in our study areas (except in the North peri-urban where the only centre has closed because parents could not afford it) but many of these seem to offer little more than homework supervision. In the urban North area, a coaching centre charges Tk200 per shift and provides coaching six days per week. A new coaching centre has opened at the entrance to the central slum and employs four teachers (one from a private school, one from a RNGPS and two honours final students) who get paid Tk1,000 per month for 2 hours per day 6 days a week. It charges Tk200–400 per month depending on 'the capacity to pay of the student'. We were disappointed in our observations of this centre as the quality of teaching was poor and it appeared to be more like a homework centre rather than a centre where children received active tutoring. This is in stark contrast to the informal school run by a student in her parent's front room just around the corner (see Box 53).

Box 53: Variations in private coaching

Last year we noted that a young Open University student had set up a small school in her parent's front room in the Central urban area. Here she 'provides a caring environment for children with learning disabilities' (2008 Report; p.62) as well as others from the slum. This year she is still operating her small school but has not taken on any new children partly because the demands on her pursuing her Open University Degree have increased. She has five Class 1 students and ten Class 4 and 5 students. The children clearly adore her and call her 'auntie'. She sits on the floor with them and helps each one individually. This approach is in stark contrast to the newly opened private coaching centre on the periphery of the slum where pupils sit in regimented rows at crowded desk/benches and the tutor sits at the front, half asleep and is basically supervising homework. R's students told us they love sitting on the floor – 'it is like home' and 'this is what we are used to'. One of her ex students, a girl with learning difficulties, has now been admitted into the RNGPS and passed Class 1. Attending mainstream school has given her more confidence and the teachers we met are delighted with her progress. Whenever we visited her home she is constantly practising her writing and drawing. She has very poor retention skills but nevertheless is doing well. Her mother puts this success down to the year she spent with this tutor. 'I never thought my daughter would be as good as this' she tells us.

The father of one of our FHH in the rural South is a day labourer and share cropper, and himself studied up to Class 5. His wife is a housewife, with some basic education. Their daughter reads in Class 11 and one son in Class 7. The family spends Tk600 per month on private tuition, plus expenses for books, tuition fees, tiffin and transportation. The mother is determined that her children continue even further; *'I will sell our land to support their education'*, she says.

Some coaches are offering 'cut price' coaching for families who find it difficult to pay. For example a coach in the North urban area charges as little as Tk50/month for some children.

Both school K and school C employ young graduates who are either still studying or recently graduated. Both Principals say they are really pleased with these young and enthusiastic teachers. These teachers are motivated and bring new dimensions to the schools. In School C, one has started a scout group on his own initiative. In its first year it has been placed second in the District. In school K another young teacher has started an English Club after school. Another is providing coaching to his class after school free of cost.

Every day this girl sells milk on her way to school (Peri-urban Central)

Government Text books

Availability and condition of text books remains a problem. The government primary school text books arrived in GPS and RNGPS in all our study areas in January and February this year, more or less in time for the new school year. However only 50% new books are supplied as per the Ministry's policy and, as we noted in previous years, the 50% which get passed on to other students are in a very poor state which means sometimes that parents have to replace them by purchasing the books released on to the open market. These books did not reach markets until April. Private schools are also at a disadvantage as they had to wait until April to purchase books from the market. They were also in short supply in some areas and books were consequently being sold in the market above the recommended retail price. The Principal of one private school (Central peri-urban) managed to acquire about 90% of the books he needed.

This girl looks after the shop after school (Rural Central)

Religious Education

Consideration is being given to the teaching of comparative religion in schools. At present, Muslims, Hindus and Christians attend different classes for religious studies where facilities permit. However, the suggestion is that these and other religions should be taught to all students. We talked to teachers, parents and students about these proposals.

Most people were cautiously supportive of this proposal although there was outright opposition among some people in the North study area.

Following the policy to only replace 50% of text books, torn text books like this were distributed again (Urban North)

A typical second-hand book, hardly usable. The father of the boy whose book this is has already had to replace several others (Urban Central)

Box 54: Differing views on teaching comparative religion in schools

North
Most people we spoke to in the urban north area are not happy about the prospect of teaching of different religions in the same class. They explain that this will make children confused about practising their own religion or it may be 'disrespectful to other religions'. Similarly, many parents in the North peri-urban area did not view this idea positively and felt that it should be left until high school level when the 'children will be mature enough to know the practice of different religions'. Younger children, they feel, will get confused if they are taught all religions. The rural North is a very conservative Muslim area and so people do not like the idea of teaching other religions together in the classroom. They feel that this will have negative impact on the children, who are not interested in learning other religions anyway.

South
The Principal of an urban GPS feels that religious education is quite well covered already. For students in Class 3-5 it is compulsory, and this education covers all religions. Although there is no separate subject such as 'religion' for Classes 1 and 2, the syllabus covers the topic anyway. He sees no reason to change.

Central
Teachers (GPS Central peri-urban) were initially very concerned by the suggestion that comparative religions could be taught in schools. At first they were defensive, seeing this as a threat to their own religion. But as the conversation progressed they admitted that this defensiveness stemmed from a lack of knowledge themselves. They preferred the idea that it could be taught as a separate subject in addition to Islam rather than instead. They feared the negative reaction of the community and guardians and felt that the Government would need to do a lot of campaigning to get the community to agree that this was a good idea. They suggested it should be introduced as a seventh optional subject and were not convinced that it should be introduced as early as primary school.

Parents we spoke with in the rural area thought that if schools taught other religions it would be a very good idea. One young mother said that children could then make their parents understand these things too and this would be very good for society. Teachers were also supportive but said it would require a lot of good preparation. One Principal reflected 'I would need to learn a lot and understand the other religions properly before I could teach'. A teacher from another GPS felt that religious education was a very good idea but was concerned that some might feel threatened, particularly the older generation. He himself was aware of other religions and he felt he had benefited personally from this. Students also thought this was a good idea but were surprised when we suggested this might be interesting. 'How can religious study be interesting?' (Boy 12). His friends agreed but they all said that it was very important to understand others beliefs and rituals.

The following sums up their concern *'This will make children confused about practising their own religion'* (Teachers, urban North) but some were a little more positive, *'It is good that children will be able to know about other religions but everything depends on the way of teaching by the teachers and it will require special training for the teachers'* (parents urban North). The main concerns surrounded how the community would see this and the need for careful provision of information (One teacher reminded us of how the scout movement ran into opposition many years ago from communities because its purpose was not well explained). A distinction is made between knowledge and practice and while people generally felt it was good to know about other religions, practice was another issue. It was this point which led some teachers to suggest that it should be taught as a seventh subject in addition to Islamic Studies.

Pocket/tiffin money

We have observed a significant trend in all our study areas towards the demand for and provision of pocket money to children. Box 49 provides some examples. Parent's inability to meet these demands sometimes leads to serious consequences including children throwing angry outbursts and refusing to go to school and parents forbidding them to go to

school because they cannot afford tiffin money. Several children are demanding money for their mobile phones.

Parents interaction with schools

"Nothing will change until a committed teaching team is employed. Nobody will listen to us or give value to our voices" (parents North peri-urban).

We noted last year that many parents feel uncomfortable and embarrassed about interacting with the school because of their own lack of education and feel that the teachers know what is right (2008 Report; p.90). As teachers seem to be making less and less home visits the opportunities for parent- teacher interaction and participation are very limited at best. With the exception of the PTAs in the South rural area and an exceptional turn out for a meeting in South urban GPS recently (see above Impact of Class 5 public examination), parents do not know about or attend PTA meetings called at GPS and RNGPS schools. This is in contrast to the interest shown in such meetings run by private schools. Private school principals regard parent meetings as very important. One shared with us his approach. On the fifth of every month he invites all guardians to explain the educational system he is working with. He serves them a cup of tea and tries to have a discussion.

Some parents feel that they have nothing to contribute to the school, *'Teachers have been appointed to look after school and the students. Why should we be involved in management? We have many other things to do for our survival'* (parent, North rural) and acceptance *'We are fully dependent on the head teacher as this school was established by his initiatives. We have SMC but none attend in the meeting. Head teacher takes all kinds of decisions consulting me'* (SMC Chair North rural GPS). Some teachers are openly hostile to parent's complaints. For example teachers in a GPS (peri-urban Central) said that parents have no business complaining since they do not take any interest in their children's education (no visits to the school, no help with homework, have the TV on when children should be doing homework or sleeping) *'so how could they complain?'*

This boy demands around Tk10 every day from his poor parents for his mobile (Rural South)

Teachers voice

'If the government says it is day time in the night we have nothing to say' (teacher, GPS urban Central)

The teachers and Principal of the South urban GPS were not pleased about the fact that they do not have any influence whatsoever over education policy or discussions about its implementation. Their views echo those of other teachers we have met. For example, they have

not been invited to participate in the development of policy for the new teacher recruitment. *'Anything new, any project, like these new policies we see now… when a government starts a new thing it always seems very good and it is strong, has a good approach. But at some stage it ends up being weak and not good any more'* (urban South Principal of GPS). Teachers and headmasters, who have the experience and ideas, never get the opportunity to voice their opinions regarding policy issues Government never asks for recommendations before they implement a policy. Whenever school staff are invited to meetings at Upazila level, or for sub-cluster meetings, there is never any provision for them to share their ideas. The people from administration, or policy makers, only deliver what they want, but they never give an opportunity for staff to interact or raise questions.

The following illustrate how helpless teachers feel. There were construction materials and a noisy cement mixer immediately in front of one GPS (urban Central). The teachers and children said it was very difficult to concentrate. This was private construction work being done some distance from the school. We experienced the noise, dirt and disturbance and found it intolerable. Had the school complained? We asked. No, they did not feel it was their place to complain. Teachers in a GPS had great difficulty explaining to us their new shift system and the school calendar. They said that they have no influence, no voice and are often the last to know. *'If the government says it is day time in the night we have nothing to say'* (teacher). As another example, only days before the 'model test' for Class 5, the teachers did not know the location of the exam or the timing. They also did not know what would be happening in December as the only instruction they had received was that all examinations should be complete by the end of November.

Policy Implications

The aim of the Reality Check is not to present recommendations to policy makers, but instead to suggest issues from the findings that may have potentially useful policy implications.

The first, as in health, is the need for more and better quality information for both users and providers, and greater transparency about what is supposed to be taking place. Parents do not have the knowledge or the confidence to engage with public education provides; nor do frontline providers feel that they have any real opportunities to influence decision making and policy. Both sides need to have clearer information about important issues such as the timing of exams, term dates, training schedules, postings and plans for expansion.

The second is the need to focus more attention on appointing and maintaining high quality senior staff such as school Principals, since our findings suggest that these individuals make the crucial difference in making schools effective, and ensuring that initiatives such as SLIP become operational and beneficial.

The third is to find ways to respond to changing contexts and demand for education. For example, the issue of 'second chance' is presently unmet. We found people who have gaps in their education (for a variety of reasons) seeking opportunities for gaining qualifications in English language, computer skills and vocational training.

Finally, there appears to be strong grounds for rethinking the stipend system (unpopular with both those of administer it and those who receive) and looking for ways to respond to the observed preference for universal forms of social protection such as school feeding programmes.

Themes

Linking the 2009 Reality Check findings to broader themes of governance: participation, non-discrimination, transparency and accountability

Sida promotes the use of a four-dimensional framework for analysis that encompasses participation, non-discrimination, transparency and accountability (PNTA). This framework was developed to provide guidance in operationalising the two central guiding perspectives promoted in Sida's Policy for Global Development which are *'the rights perspective'* and *'poor people's perspectives on development'* (ref 1). In this section, we relate findings arising from this year's Reality Check to these guiding concepts.

The third Reality Check took place against the backdrop of a return to Bangladesh's system of parliamentary democracy after a two year period of military-backed 'caretaker government' (CTG). As we saw in last year's report, many poor people cautiously welcomed the CTG, since it promised order and stability in a society that had become increasingly characterised by high levels of crime, violence, political favouritism and corruption. For poor people, the CTG was a period of respite from political patronage and increased feelings of insecurity. However as the second year progressed, poor people told us they felt more disillusioned and anticipated the return to democracy with more enthusiasm. Following the landslide victory in December 2008 by the Awami League, poor people told us they felt initially optimistic. But by the time of our study, this optimism had all but vanished. People are reluctant to talk about politics because they are already becoming disappointed with the new Government. While people told us they were relieved that the restriction of opportunities for employment created by the CTG's crack-down last year has eased, they also told us the only positive thing to have come out of this return to democratic government so far has been the reduction in the price of rice. They rue the increasing return to political patronage and interference in local areas by MPs.

These 'reversals of fortune' experienced at the national level mirror the fragility of stories of positive change at the local level. Two key general lessons emerge this year. The first is that there is considerable diversity as to how change takes shape locally – with one health facility for example able function well in one location, while nearby a similar one is failing. As might be expected, leadership is often the key factor that makes things work better. The second is that local improvements are fragile and easily reversible – from one year to the next we find enormous fluctuations, often the result of staff transfer or sometimes, political interference.

When it comes to progress with the health and education sector reforms, it is a lack of *participation* that continues to dominate the stories that emerge this year. A key reason is that people usually have poor

access to the information that would help them to participate. People rarely seem to know what kinds of services are available or what entitlements they are due. Few know, for example, about the Social Services support that is available in hospitals, about many of the health programmes for the poor offered by NGOs or whether they should be paying for Government health services or not. Adolescents do not know where to get confidential information and advice on family planning or sexual health. When people do not have good information, they are vulnerable to exploitation, mis-information and rumour. We see this with the continuing success of *dalals* (who provide intermediary services that should not be necessary) and in the poor quality treatment still meted out to poor people in schools and hospitals.

Yet as we pointed out in previous reports, we still find that poor people try hard to make careful selections from the limited choices available to the them, with the limited resources and information that they have. Where they make the decision to pay for services, we find that there seems to be greater willingness to question and critique these services. There is some evidence that private providers are more open to to such participation, and may even provide structured opportunities for this to take place (e.g. comments boxes in NGO and private clinics, active PTAs in private schools).

Lack of information is only part of the picture when it comes to public services. People also lack access to the platforms necessary to rise their voices, such as parent teacher associations that make participation possible. A key reason for this is that people remain dependent on the support of patrons and brokers who act as 'gatekeepers' to the institutions and organisations on which they depend for services. Status differences are acute and constantly reinforced throughout the hierarchies found across society. Parents feel excluded from decision making in relation to their children's teachers, while teachers say they feel disempowered in relation to the authorities and the government. Teachers know very little about the plans for their schools, the dates of term, or the arrangements for public exams. Nurses and even senior doctors often do not know when training will be provided, when facilities will be operational, or why staff are being posted or seconded. A key problem is the lack of transparency, and therefore of trust, within the communities where we undertake the Reality Check. All this makes it difficult for poor people to become effective 'users and choosers' of services, let alone to become the 'makers and shapers' that ultimately would be in keeping with their rights as full citizens.[7]

As a result, *accountability* tends to work only one way. There is little or no consultation with service providers or users on policy or practice. When service providers are called for meetings, it is normally to listen to directives or promises, and people are not given an opportunity to provide their views. This problem however is perpetuated by these same people when they call meetings. PTA meetings are usually called not for parents to air their views, but for teachers to motivate or berate parents, or to explain a new policy. When health extension workers call local mothers together, it is normally to instruct them, not to gather their opinions.

7 These terms are taken from A Cornwall and J Gaventa's (2001) work on participation *From Users and Choosers to Makers and Shapers: Repositioning Participation in Social Policy*, Institute for Development Studies (IDS), UK.

Even if there are in theory forums available within public service providers where people could share perspectives, give opinions and offer complaints, there is often a reluctance to use them. People living in poverty explained their discomfort with complaining to authorities on whom they depend for services, in case it jeopardises their use of those services. Service providers are reluctant to raise issues in scheduled meetings with superiors for fear of reprisals. A 'culture of disempowerment' therefore characterises interactions between citizens, front-line public sector providers and their superiors. This is also reinforced by the prevalence of a 'blame culture' that dampens the motivation of any but the most senior staff to offer their opinions, and leads to the perpetuation of outmoded 'received wisdom' in place of creative thinking or innovation. For example, school drop-out continues to be seen as a problem of 'poverty and parental ignorance', lack of uptake of health services as due to 'lack of awareness', and TBAs are slurred as 'incompetent'. But we have found that often it does not take much to open up discussions with local government service providers about rethinking some of this, and many are wiling to give their views and 'open up'.

Problems of *discrimination* emerges from the stories we heard this year in several ways. Policies that have correctly favoured girls' education in order to redress longstanding gender discrimination are now beginning to raise important questions in which new attention needs to be given to meet the needs of boys excluded by the system. Efforts to improve citizen's rights often unintentionally discriminate against people who are poor who cannot read. In one of our cases this year (Box 24), a team member accompanied a person to a hospital where information about patients' options and rights was clearly displayed in a public place, but since the person was unable to read this was of no value.

There were also some positive ways emerging this year in which some forms of discrimination were being addressed, such as the new Class 5 examination, which to some extent has 'levelled the playing field' to make progression to secondary school, and access to scholarships, fairer and more transparent. Whereas previously government schools tended to concentrate only on the best students (the potential scholarship winners on whose performance the quality of the school was based) teachers are now keen to get all their students through the exam. Gone are the extra tuition programmes for scholarship students only, and the practice of sitting the scholarship students in the front of the class and to concentrate on them to the detriment of the others.

Unlocking the perspectives of service providers through engaging them further could therefore bring useful some results. Since they currently lack opportunities to participate, local service providers often perform their tasks but with little responsibility or enthusiasm. Why open community clinics if nobody comes? Why provide primary school stipends to a few people, when so many are in need? We found that even though the level of local participation in the SLIP programme often remains somewhat disappointing, this initiative nevertheless shows that appropriate, locally-relevant local decisions in place of one-size-fits-all, are in fact possible.

Conclusions

Introduction

Once again this year the Reality Check teams visited and lived with a total of 24 households for five days and four nights in nine locations around the country. They listened to and documented people's experiences and perceptions of changing health and education services in each of the localities. There are few studies currently undertaken in Bangladesh in which close and sustained contact is made with people who are living in poverty, and the observations that result from this type of interaction are potentially very valuable.

Since we were returning for the third year to the same families and the same areas, the field teams found they had built up higher levels of mutual trust and respect. The teams this year were sometimes therefore able to 'dig a little deeper' than before in their conversations with people, and see further in their observations of local realities. This led to some potentially interesting and important new findings.

The Reality Check findings remain highly relevant to the ongoing health and education sector reforms. Some findings are borne out by other studies and lend further support to them, while other findings may still require further investigation and validation within ongoing monitoring and research within the two sector programmes. Either way, the aim of the Reality Check is to try to prompt action within the programmes that can improve the quality of life of people in Bangladesh.

Main findings in Health

- The capacity and utilisation of public health services (such as UHCs and MCWCs) continues to decline in favour of increased use of private health providers.
- Where we found examples of positive change in public health facilities as compared with last year (such as improved hospital cleanliness and food), positive leadership by different newly-appointed hospital and clinic directors was usually the main contributory factor.
- Many government facilities remain undermined by staff shortages, malfunctioning equipment and prohibitive unauthorised costs imposed by informal intermediary 'gate keepers'.
- The Community Clinic system (recently revived by the new government) is non-functioning and mainly used by people only as an occasional collection point for free drugs.
- Most people still feel unable to make complaints about poor public services, and view health professionals as remote and non-responsive.
- Most people prefer private diagnostic centres and other private providers, despite the higher prices they charge.
- While NGO health services are often of good quality, these are often monopolised by better-off households.

- People who feel failed by all of the formal service providers tend to go to polli doctors, pharmacies and traditional healers, where service quality is highly variable but cheap.
- Some medical staff disparage the work of TBAs (reported to us by patients as positive) and spread rumours about their incompetence.
- Increased observed use of mobile phones seems to improve the effectiveness of traditional birth attendants (TBAs) and helps other local health providers to make referral.
- The new health helpline services set up by social businesses have potential, but were very little used because of their perceived high cost.
- We observed that scarce public hospital beds were sometimes occupied by low-priority patients for fraudulent purposes (such as securing a medical certificate for a legal claim for compensation in an assault case).
- Some new public health concerns became apparent this year, such as the use of more salt to accompany prepared food (perhaps because of the declining affordability of good quality food), increased public spitting (even by some health agency staff as they go about their work) and a lack of first aid knowledge.

Main findings in Education

- Low income households tend to see education as an important priority and most seek to send their children to school.
- The expansion of 'low fee' private and NGO pre-schools reflects this continuing demand from people living in poverty.
- The introduction of a new Class 5 public examination has been a significant positive change this year, since it offers a more objective means for both government, private and non-governmental schools to prepare and assess students prior to moving on to the secondary education.
- There is a growth of local 'philanthropic' enterprises that are motivated by the combination of profit and 'giving back to the community', and this is opening up increased choice.
- There is still a high level of school 'drop-out', but contrasting explanations are offered for this. Teachers provide the conventional wisdom that it is due to economic or social pressures, but parents and children instead tell us the reason is often a simple failure of schools to engage and sustain children's interest.
- NGO schools are more attractive to children because of their open culture and children-friendly teaching style, but are disparaged by mainstream teachers as de-emphasising serious learning.
- This year, we found less support for the stipend system, and a stated preference for a universal school feeding programme. Stipends are regarded by people as divisive, inadequate and time-consuming to administer.
- Increased investment in teacher training seems to bring mixed results: some teachers were dissatisfied with aspects of the training, but felt it gave them more capacity to manage their relationships with their superiors. Long staff absences from school for training created major staffing problems.

- The use of teachers' time for non-teaching work (requested by the authorities), such as for census and polling, take time away from teaching.
- The new School Level Improvement Plans (SLIP) committees functioned poorly in any of our areas (due to lack of awareness / participation, or because they became politicised). Where there is an effective school Principal in place, we did observe positive outcomes.
- The existence of the SLIP programme sometimes discouraged local philanthropic contributions.
- Parents remain uninterested or unmotivated to participate in parent teacher associations (PTAs) and are normally unwilling to question the authority of teachers.
- Teachers, for their part, feel disempowered in relation to government education policy, and feel they could contribute useful ideas from their experience but do not have the confidence or opportunities.

A key aim of the Reality Check is to 'flag up' issues of concern that may be of interest to the two programmes, either to assist with programme course corrections, or which can be further investigated. These issues can be found in the list of 'main findings' above.

In the view of the team, a key priority further investigation in the health sector is the need to better understand and address the heterogeneity in need and provision within some health programmes. For example, our study indicates that there is still a need for house-to-house extension services to provide family planning, ante-natal check ups and nutrition advice in isolated areas in the north, but it also suggests that this would be completely unnecessary in many other better-connected areas. A second suggestion is to map certain 'hotspots' where there are particular public health issues such as TB, in order to reduce unnecessary expenditure on universal programming. Finally, our work continues to flag up the lack of free care available to address the increased emergence of non-communicable diseases among low income people such as diabetes, cancer and heart conditions. We suggest that further qualitative study and perhaps a pilot 'action research' initiative on this issue on this could usefully inform improving future healthcare policy for people living in poverty.

In education, there are also three issues that can be flagged up for further study; the first is to analyse the extent and causes of growing disenchantment with the stipend programme, and the options for creating a more equitable and manageable alternative. The second is to quantify actual teaching contact hours, which may be shrinking, and explore the means to ensure this does not continue. The third is to review with boys new alternative approaches to learning that they will find more relevant, engaging and exciting.

Themes and priorities

1. Addressing people's lack of 'voice'

We noted last year that most people lack the opportunity to exercise 'voice' in order to try to influence and improve public services. This problem continued to be feature highly in this year's findings. People lack the appropriate channels through which to complain, and many also have very low levels of confidence when confronting higher status

officials and professionals. They feel that if they do try to complain, they will not be heard, or worse, fear that there may be negative repercussions. The only option is to try to seek remedy by searching out alternative sources of services (which may be costly, unreliable, and largely unregulated) to try to supplement inadequate public service provision.

2. Providing people with better quality information

While people try to act as creatively as possible within a set of very constrained choices, and often try to seek advice from family, neighbours and providers, they do not have access to reliable information. This lack of information leads to poor choices, uninformed speculations and understandable anxieties about issues such as inconsistencies in fees charged for public exams, the lack of transparency in making deductions from stipends, the increasing budgets for hospital food with apparent improvement in quality, unclear delays in progress with planned construction or repair of infrastructure, and unexplained staffing deficits. We also noted this year the frustration among many frontline public service providers that they themselves are also being 'kept in the dark' about important issues such as the timing of exams, term dates, training schedules, postings and plans for expansion. Many frontline workers also feel they also do not have any real opportunities to influence decision making and policy.

In the health sector, people's dependence on advice from family, informal and formal service providers is critical in helping them to manage healthcare decisions, and accessing the various services that are available. The proliferation of mobile phones observed this year has definitely been an important factor improving communication. Better communication also seems to have reduced the need to travel, meant that there were fewer work days lost, and improved referral systems between service providers. Although there are some important 'downsides' to cell phones that we have also highlighted in the report, the advantages became obvious to us as we spent time with our families.

3. Improving standards and accountability

We observed a growing disenchantment with service provision and what is seen as a return to pre-CTG systems of patronage. This translates into growing frustration about the lack of concern and equity shown by service providers to people living in poverty.

But we also saw positive changes. In the education sector, without a doubt the most significant change has been the introduction of the public Class 5 terminal examination. This has impacted positively on the children studying, and on attitudes to education among older and younger school age children, parents and teachers. The introduction of a universal standard to which all schools are accountable, and the effort to limit ways in which these standards can be circumvented, has done much to improve commitment and fairness in education. As discussed in the previous section, this policy has contributed importantly to making education provision more equitable.

It has also helped improve the image of primary schools where Government teachers are now considered more sincere and committed, but no significant reduction in dependence on supplementary support through coaching.

4. Helping people to respond to wider changes and needs

We noticed the emergence of an important new challenge this year: the demand for 'second chance' education for teenagers. Youngsters and their parents have grown more acutely aware of the demands of the national and international job markets. Those people who have gaps in their education (for a variety of reasons) are now more actively seeking opportunities for gaining qualifications in English language, computer skills and vocational training. The statement that 'We have money, but no opportunities' seems to sum up this situation. This may be an important area to focus on in discussions during the coming year about future development of education services.

5. Responding better to basic public health issues

The need to develop and communicate new public health messages also emerged strongly this year. While there seems to be good awareness of and uptake of conventional hygiene messages around safe water, hand washing and open defecation, we noticed other serious but easily remedied problems remain neglected, such as increasing salt intake, unhygienic spitting in public places and a lack of first aid knowledge.

In short, the Reality Check 2009 report confirms the continuing importance of putting people living in poverty at the centre of efforts to improve health and education services. It highlights the need for policy makers and frontline staff to focus on grassroots consultation to better understand needs and demands, and to encourage greater participation and voice. Programme performance will improve if more consideration is also given to the views of local level service providers, and if more opportunities can be provided for the constructive questioning of received wisdoms among health and education professionals, staff and managers

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Annex 1

Host households; Changes 2007–2009				
Central				
Urban		**2007**	**2008**	**2009**
HHH1	One room own house, 4–7adults have lived here over the years. Old man sells vegetables, wife sells pitha	→	↗	→
HHH2	One room rented house, father is rickshaw puller, wife no longer works because of ill health	→	↗	→
HHH3	One room rented house, father now supplies ice cream. 4 children now aged 4–12 years	→	↗	↗ (better job)
Peri-urban				
HHH1	One room own house, father is rickshaw puller, mother is a garment factory worker, 3 children under 8 years	→	↘ (debts)	↘ (redundancy)
HHH2	One room house, widow lives with her separated daughter and granddaughter, earn from their milking cow	→	↗	↘ (cow not giving milk)
HHH3	Two houses to accommodate 6 of their 7 children. Father runs a grocery business in the market and also farms. Daughter earns as private coach	→	↗	↗
Rural				
HHH1	Two houses; one with parents and two sons, other with married son and his wife and daughter. Father is a farmer and married son is a pharmaceuticals delivery driver	→	↗	↗ (working sons send home money)
HHH2	Two houses; one with elderly widow, other her daughter, her husband. Their daughter got married this year and moved out. Father now works in wholesale banana business	→	↗	↗ (new business)
HHH3	One room house ;first wife lives here on her own with two sons	→	↘ (debts)	→
North				
Urban		**2007**	**2008**	**2009**
HHH1	One room accommodating family of 7. Father used to sell snacks now sells left over sweetmeat syrup. Elder son earns from private coaching	→	↘ (failed business venture)	↘ (as children grow more coaching costs)
HHH2	Two room house built with help from community. Father retired service holder. Although wife has worked as a maid she does not now. Elder sons employed in workshop and in a shop.	→	↘ (extra mouths to feed as married daughter returned)	↗ (daughter moved out, older boys wages increase/ new job)
HHH3	One room house. 1 son and 3 daughters. Father has had a stroke and cannot work in a grocery shop, wife has invested in a small shop with NGO loans, one daughter earns through private tuition, son takes casual work	→	↗ (father got new job, daughter got job away)	↘ (daughter lost job and moved back, father ill, debt)

Peri-urban				
HHH1	Two room house. Family of 8. Father is a carpenter but had serious head injury in 2008. Elder son learned welding but currently unemployed. Wife used to work for NGO but resigned in 2009	→	→	↘ (son resigned from job, wife resigned from NGO job, medical expenses)
HHH2	Two room house, parents and 2 sons. Father is a van driver, wife used to sell fire wood. One son suffers from sever arthritis	→	↗	↘ (collection of firewood banned, debts)
HHH3	Two room house. Widow and 3 daughters. Mother works as a housekeeper and also receives private charitable donations.	→	↗	↘ (loan repayment)
Rural				
HHH1	One room house accommodating family with 3 children. Despite not being able to walk properly after a work related accident in 2008, the father takes on road construction work	→	↘ (lost crops in flood, father injured. Business collapse)	↗ (better crop, work and elder son now working)
HHH2	Three room house accommodating two brothers and their families and their parents. One brother is farmer/labourer, other is Madrasha teacher.	→	↗	→
HHH3	One room house. Parents and 5 children. Father works as agricultural labourer and quarry labourer.	→	→	↗ (debts settled, purchase milking cows)
South				
Urban		**2007**	**2008**	**2009**
HHH1	Brick house partly shared with other relatives. Parents and 3 children (one is actually married but has problems). Parents run a tea stall. Son has lost his scrap collecting business and has become alcohol and drug addicted	→	→	↘ (son's loss of business and addiction)
HHH2	One room house and renting out three further rooms. Elderly father runs a business. Wife is a TBA. Have had other members of the family move in over the years but now only the two	→	↘ (repayment of business loan)	↘ (tow rented rooms vacant, took loans for business, wife sick)
HHH3	Brick house. Father, mother and three children aged 5–11. Father sells meat.	→	↘ (medical expenses)	↗ (planning to move out of the slum)
Peri-urban				
HHH1	Two room house rebuilt after Cyclone Sidr. Father, mother and two children aged 7 and 3. Father is a van driver and pan cultivator (although this has yet to restart after Sidr).	→	↘ (cyclone Sidr destroyed crops)	↗
HHH2	Two room house. Father, mother and 5 children. Father and eldest son sell their labour and catch fish	→	↘ (took 3 loans for Sidr repairs)	↗ (fishing good)
HHH3	One room house, widower father with second wife and 4 children aged between 11 and 15. Father breaks bricks but is currently unemployed.	→	↘ (post Sidr)	↘ (no work)

Rural				
HHH1	Spacious house as it is the old family house. Now only one brother and his wife and 2 children live here. Father is a clerk in the Land Registration Office.	→	→	→
HHH2	Two storey tin house. Father, mother and 3 children. The father used to run a tea stall but it was destroyed in Cyclone Sidr. Hopes to go abroad to work were dashed because of an accident and he has now fled away to avoid debtors	→	↘ (cyclone Sidr destroyed home and tea stall)	↘ (accident has put family in still more debt)
HHH3	Small house with father, mother and 4 children including married son and his wife and baby.	→	↗ (share cropping, son's income)	↘ (closed grocery shop, stopped fish cultivation and share-cropping, dowry costs)

Annex 2

List of people met during the course of the study		
North	**Central**	**South**
HEALTH		
• Staff of district hospital, UHC and private clinics • Private health practitioners/ qualified doctors • Medicine sellers/ Pharmacy • Staff of private diagnostic centre • Polli doctor • Kobiraj and village quack • Snake charmer providing medical treatment • Traditional Birth Attendant • SBA, FWA and HA • Imam of the local mosque • Officers of Medical Social Service • NGO staff working on health • City Corporation staff working on health • Patients in the hospitals • Ward Commissioner of City Corporation • Ward Councillors • UP ward members • Local political leaders • Community leaders	• FWV at FWC • Ayah at FWC • Staff nurses (UHC) • Ayah (UHC) • Receptionists (private diagnostic centre) • Pharmacist (UHC) • Kobiraj / medicine seller • Nurses (District hospital) • Nurses (Sadar Hospital) • Cleaners (male and female District hospital) • Diagnostic centre staff • Patients and relatives • Consultant orthopaedics (surgery) (District Hospital) • OT technician (District hospital) • Ayah (Sadar hospital) • Community Skilled birth attendants (in training) • FWVs and their supervisor (MCWC) • Patients at MCWC • MLLS technician (MCWC) • BRAC shebikha at District Hospital (DOTS) • RMO (District hospital)	• Doctors (government, MBBS) • Nurses • Urban health clinic counsellors • Urban health clinic manager • Polli doctors • Pharmacists (with certificates, government approved) • Dalals (operating at main district hospital) • Hospital clerks • Midwifes (TBAs, SBAs) • Patients in hospitals (and family members) • Managers of private diagnostic centres • UHC UH & FPO • Dentist • Lab technicians • Manager of private diagnostic centre • TB/DOT clinic managers • Fakir • Medical company representatives • Trained homeopath • Monsha (religious healer)

EDUCATION

- Teachers of GPS, NGPS, RNGPS, Madrasha teachers
- Retired school teachers
- Volunteer teachers
- SLIP members
- SMC members
- NGO staff working on education programme
- Parents of students
- Ex students of the schools
- Drop out students of the schools
- Students of neighbouring schools
- Private coach/ tutor of coaching centres
- Staff of Upazila Education Office (TEO)
- UP members and Ward Councillors
- Book sellers
- Snack vendor in front
- Teachers of GPS, RNGPS, BRAC schools, private schools
- BRAC teachers (pre-school and cohort schools)
- BRAC school supervisor
- Teachers of private philanthropic schools
- Parents
- School children and out of school and drop out children, their elder siblings
- Snack vendor outside school
- School principals
- ROSC teacher
- Private coaching centre
- Private home school teacher
- Head masters from GPS and Kindergarten
- Teachers (men and women) from GPS, Kindergarten and BRAC
- Parents and students, (GPS, Kindergarten, NGO schools, primary and secondary level)
- NGO teacher
- Chairman of school committee, Kindergarten

Annex 3

METHODOLOGICAL APPROACH

Summary of the basic methodological approach used for the Reality Checks (From the Reality Check Report 2007)

REALITY CHECKS:

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

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

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

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

The study team members live with host households for four nights in each location (except some slum areas because of lack of space) and adopt an approach which draws on the ideology of participatory processes which encourages non extractive forms of engagement. The emphasis is thus on two-way conversations, shared and visualised analysis, listening and observation. Conversations are conducted at different times of the day/evening and with different constellations of household members throughout their stay. Conversations have the advantage over interviews and some other participatory approaches of being two-way, relaxed and informal, and can be conducted as people continue with their chores and other activities thus keeping disturbance to normal routine to a minimum. The study thus adopts the principle of sensitivity to people's routines and flexibility in relation to timing of conversations.

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

checklist takes consideration of the four guiding principles of Participation, Non-discrimination, Transparency and Accountability (PNTA) which Sida uses to operationalise people's perspectives on development and the rights perspective. The checklist provides structure for the conversations and provides a basis to ensure sufficient probing of issues and clarification of issues arising. This checklist is reviewed and updated each year based on new studies and information provided by the Reference Group.

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

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

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

Location selection

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

In each of the three Districts selected, an urban, peri urban and rural location was identified with the assistance of a range of local key informants including school teachers, local government representatives and NGO workers in order to select study sites which were considered to be 'poorer'. Following team visits to shortlisted locations, final selections were made. The three locations in each District all relate to the same Municipal town. The urban sites are defined as wards or part wards of the Pourashava having a distinct boundary (e.g. railway line, main road). These sites are classified as slums and comprise squatters, those renting and some owning small plots of land. Main occupations

include transport services, informal sector, factory employment, domestic service and construction. The peri-urban location is defined as a ward or part ward of the Union Parishad, 8-11km from the centre of the Municipal town centre. Occupations tend to be a mix of urban and rural such as transport, construction, factory work, informal trade as well as cultivation and agricultural day labour. The rural location is defined as a village or para within a ward of the Union Parishad which is at least 32km from the centre of the Municipal town. Main occupations are agriculture and fishing.

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

Annex 4

SWAP PROGRAMME SUMMARIES

Health, Nutrition and Population Sector Programme (HNPSP)

Goal

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

Priority Objectives

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

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

Duration

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

Total Cost

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

Primary Education Development Program (PEDP-II)

The fundamental aim of Second Primary Education Development Program (PEDP-II) is to ensure the quality of primary education for all children in Bangladesh.
The program has been designed by the Ministry of Primary and Mass Education (MOPME). It is based on a coordinated, integrated and holistic sub-sector wide approach.
Important features of PEDP-II include Government led Planning and Implementation, and joint Financing and Monitoring by the Government and Development Partners. A Program Performance Management System under PEDP-II will contribute to strengthen the Primary Education Management in Bangladesh.

Key Objectives

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

Aims of Educational Reforms

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

Duration

From 2004 to 2010

Total Cost

1,815M USD: GOB 1161m (63.9%) and 654m (36.1%) from 10 multilateral and bilateral organisations.

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

Acronyms

ANC	Ante Natal Care
BRAC	Building Resources Across Communities (formerly Bangladesh Rural Advancement Committee)
BTV	Bangladesh Television
CI sheet	Corrugated Iron Sheet
CNP	Community Nutrition Promoter
CTG	Care Taker Government
CS	Civil Surgeon
C/S	Caesarean section
DOT	Direct Observation Treatment
DPHE	Department for Public Health and Environment
EPI	Expanded Programme for Immunisation
FHH	Focal Household
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
F/HHH	Focal/Host Household
GPS	Government Primary School
HHH	Host Household
H/FHH	Host/Focal Household
LGED	Local Government Engineering Department
KG	Kindergarten
MBBS	Bachelor of Medicine & Bachelor of Surgery
MCWC	Mother and Child Welfare Centre
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
PNTA	Participation, Non-discrimination, Transparency and Accountability
PTA	Parent Teachers Association
PTI	Primary Teachers Training Institute
RAB	Rapid Action Battalion
RC	Reality Check
RH	Reproductive Health
ROSC	Reaching Out-of School Children Programme
RNGPS	Registered Non-Government Primary School
SBA	Skilled Birth Attendant
SLIP	School Level Improvement Plan

SMC	School Management Committee
SSC	Secondary School Certificate
STD/STI	Sexually Transmitted Disease Sexually Transmitted Infection
SWAp	Sector Wide Approach 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
USG	Ultra-Sonogram

Bangla Terms used in the text

Ayah	Female paid attendant in the hospital
Biri	Local cigarette
Boro bhai	Literally 'big brother' used more widely to imply a man who is older but close to them
Boro lok	Literally 'big person' – higher status, elite, rich
Caromb	A traditional game played on a board involving potting discs into pockets
Choto one	Literally 'little one' or 'baby class'. This is the name given to Government primary schools new classes for 4–5 year olds which feed into Class 1
Dai (ma)	Traditional birth attendant
Dalal	Broker, middleman
Lungi	A sarong like length of cloth worn wrapped round the waist by men
Khichuri	A mix of pulses and vegetables, considered to be very nutritious
Madrasa	Islamic religious education institution
Maund	A local measurement equivalent to 37kg
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)
Ruti	Bread
Sadar	Main/ central
Shalish	Informal but judicially recognised village level court
Shebika	
Shongho	Club
Tabiz	An amulet; metal charm with a small hole where 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 a union.
Upazila	Several unions make an Upazila. All the GoB services are channelled to the union from the Upazila.
Ward	Political constituency within a union. Nine wards in each union
Zila	Alternative name for District – an administrative unit

Currency exchange rates (January 2010):

Tk100 = USD 1.45
Tk100 = SEK 10.54
Tk100 = GBP 0.91
Tk100 = EUR 1.04
Source: www.exchange-rates.org

Terms and programmes

HEALTH SECTOR

(**Denotes a programme under the HNPSP)

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

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

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

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

Direct Observation Treatment Short Course (DOTS)
TB is a major public health problem in Bangladesh. Bangladesh ranks 6th of the 22 countries regarded as having the highest TB burden in the world. The DOTS strategy started in Bangladesh in 1993 under the National TB control programme and is supported by the WHO. It comprises five components including the free diagnosis, direct observation treatment and supply of drugs. BRAC works in collaboration with Government on the DOTS programme, organising Shastho Sebikas (health volunteers – see Shastho Sebika for further information) who are supposed to disseminate information and identify suspected cases through home visits, refer them for sputum tests and supervise the daily

intake of medicines (although in certain cases they support self administration with the support of family members). By late 2008, the programme was operating in 42 districts and five city corporations covering 86 million people.

Essential Drugs Programme

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

Fakir

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

Family Welfare Assistant

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

Family Welfare Visitor

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

Health Assistant

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

Hujurs

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

Kobiraj

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

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

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

Paramedics

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

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

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

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

i. develop the midwifery skills of Family Welfare Assistants (FWAs) and Health Assistants (HAs) so that they can ensure quality services for women, children and the family;

ii. ensure the best healthy outcome for mothers and baby during pregnancy, delivery and post partum.

The programme has increased its 6 months training to 9 months comprising classroom, clinical and community practice which leads to official accreditation. It is now being implemented in 19 districts.

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

EDUCATION SECTOR

(** denotes a programme under the PEDP II)

BRAC Primary School

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

BRAC pre- primary schools

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

Certificate in Education **

This is a one year course of training given to newly recruited teachers and non-trained teachers of Registered Non-government Primary Schools through 54 Primary School Training Institutes (PTI). Every year about 2000 teachers receive this training. It is a nine month course which is compulsory for all primary teachers working in schools supported by the Government, even if the teachers already have degrees. If the teacher does not undertake the course their salary is frozen and increments and promotion denied. This year (2008) the Course has been renamed Diploma in Education and the course will be for one year.

Citizens Charter for Primary Education

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

Government primary school

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

Madrasa

The madrasa system of education is controlled by the Madrasa Board and is Islamic based education. The Ebtedayee Madrasa is an independent five-year primary level educational institution, which is parallel to the primary school. They are, therefore, incorporated in primary education statistics. There are over 3,400 such Madrasas in Bangladesh.

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

Registered non government primary schools are partly supported by Government. The teachers receive salary support up to a maximum of 90%. The school receives free text books and other resources. There are over 19,000 RNGPS unregistered NGO schools (about 2000) receive no Government support.

Primary School Stipend programme**

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

Primary School terminal examination in Class 5

Introduced for the first time this year, more than 1.83 million children in Class 5 took a common public exam in November, 2009. Children must pass the exam to become eligible for enrolment in Class 6. 88% passed the exam and scholarships (talent pool and general) will be awarded. Despite this excellent pass rate nearly 200 schools had no children pass the xam.

Reaching Out of School Children (ROSC)

This programme has been undertaken to create opportunities for primary education from Class 1–5 for out-of-school children and dropout students. It is supported under a separate agreement to PEDP II by the World Bank and SDC. Under the programme learning centres are established in areas where the dropout rate is very high because of extreme poverty. This project will cover 60 Upazilas during the period July 2004 –2010.

School Feeding Programme

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

School Level Improvement Plans (SLIP)**

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

The Reality Check Team in action

Dee Jupp PhD is the overall team leader for the Reality Check as well as team leader for the Central sub-team and author of the Annual Reports. She has worked in development for more than 24 years, including 12 years living and working in Bangladesh. As an expert in participatory approaches, she has led a number of initiatives including the first participatory poverty assessment (PPA) in Bangladesh, a series of listening studies and the Views of the Poor study in Tanzania and has contributed to Action Aid's Immersions programme.

Enamul Huda MSc is the team leader for the North sub-team and overall co-ordinator in Bangladesh. He has been working for over 30 years with different development programmes, focusing on people's participation and rural development within and outside Bangladesh. He is a freelance consultant and the author of three books on people's participation. Currently he is engaged with Reality Check on Basic Education Programme of the Ministry of National Education, in Indonesia as group team leader sponsored by AusAID.

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

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

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

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

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

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

Syed Rukanuddin PhD is a freelance Training, Monitoring, Participatory Research consultant with 26 years experience in development. He has been involved in a number of participatory listening studies and has considerable experience of local government and rights issues. He is author of a number of books on facilitation techniques. Currently he is engaged with Reality Check on Basic Education Programme of the Ministry of National Education, in Indonesia as group team leader sponsored by AusAID.

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

Mahfuzul Haque Nayeem BSS is a student at Dhaka University. Over the last two years he has been involved as an interpreter/facilitator in a number of research studies in Bangladesh.

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

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

Joost Verwilghen MSc is the Project Manager for the Reality Check and has been managing development projects and NGO initiatives for 15 years, including six years working with CBOs and NGOs in Bangladesh at grass roots level. Presently he is involved in various development projects funded by a range of international development agencies, such as AusAID, Sida, EC and the Dutch Government in the capacity of project director, manager and technical consultant.

Sida works according to directives of the Swedish Parliament and Government to reduce poverty in the world, a task that requires cooperation and persistence. Through development cooperation, Sweden assists countries in Africa, Asia, Europe and Latin America. Each country is responsible for its own development. Sida provides resources and develops knowledge, skills and expertise.
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Reality Check Bangladesh – Year 3

BANGLADESH

The Reality Check Bangladesh is an initiative of Sida and the Swedish Embassy in Bangladesh, where it was first introduced in 2007. The Reality Check is a longitudinal study and it is expected to track changes and people's perceptions and experience of these changes with regard to health and education.
This is the Annual Report presenting the findings of the third year of the Reality Check.

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