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Reality Check Bangladesh 2010

– Listening to Poor People's Realities about Primary Healthcare and Primary Education – Year 4

Sida

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Foreword

The purpose of the on-going Reality Check study in Bangladesh is to improve our understanding of poor people's reality. Its design allows researchers to interact and build trust with communities and households. By living in the target communities for intervals over a five year period, a more in-depth understanding of grass root's realities have emerged and poor people's voices have been heard.

The Governments of Sweden and Bangladesh cooperate in the areas of primary health care and primary education and the focus of this study is to monitor perceptions in these two areas. Direct observations on how services are provided and utilised are part of the study as well as listening to both receivers and providers of these services. The inclusivity of the target population in this study will improve our understanding of the complexities involved in providing healthcare and primary education. It is our responsibility to digest this information and reflect on its possible use for our policy decisions.

This is the 4th year of the Reality Check study in Bangladesh, and for this report the researchers were asked to provide concrete recommendations that could be fed into the preparations for the new sector programmes in health and education. These conclusions and recommendations are included in the final chapter.

Next year's Reality Check is the 5th and final one. The Swedish Embassy plans to review what we have learned from these five years and to assess the value of further qualitative studies to complement other quantitative data.

Meaningful and equitable involvement of poor people is critical to sustainable development in Bangladesh. Hearing poor people's views and concerns first-hand is imperative in order to involve them meaningfully in identifying challenges and solutions. Without their participation, our efforts to assist cannot be effective.

Anneli Lindahl Kenny
Ambassador

(The conclusions and recommendations and views expressed in this study are those of the researchers and do not necessarily reflect the position of the Swedish Government.)

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Table of Contents

Summary

Background

The Reality Check Approach (RCA) is now in its fourth year in Bangladesh. Using a 'listening study' methodology, the aim is to better understand how people living in poverty are experiencing the ongoing health and education reforms. It seeks to flag up issues that can be pursued in more depth by those involved in research and monitoring in the ongoing SWAps. As in the previous three years, in 2010, the RCA field teams revisited the 27 families and their neighbours in nine locations around the country. The teams lived with them for five days and four nights, listened to their comments and stories, and observed their situation.

Strategy for this year's RCA

As usual, the team met before and after fieldwork with the RCA Reference Group in Dhaka, composed of representatives from Government, development partner organisations, and representatives from civil society. These meetings ensure the relevance of RCA to ongoing policy discussions. This year, readers should note two changes in our approach. First, we avoid covering ground already explored in previous reports, and concentrate on the main newly-emerging findings. Second, while the original aim of the RCA is to convey the largely unmediated views of ordinary people, this year in response to the Reference Group's request for 'more information that we can use', we offer policy implications based both on what people have told us, and on our own growing experience and reflection from four years of work within these communities. These policy implications are intended to stimulate further discussion and research.

General country conditions

The report begins with an overview of the general situation in the country as seen through the eyes of our study participants. Generally poor harvests during 2009 meant that several of our study households used to growing rice for their own family needs were forced to buy in rice. Flash floods in our Northern location in early 2010 had a devastating impact and wrecked the boro winter rice harvest.

Overall, there was concern at rising food prices, disappointment that lower rice prices promised in election pledges in late 2008 had proved short-lived, and a reluctance to talk politics in what was perceived as a difficult political atmosphere. Although a dip in overseas employment and remittances was reported, some non-traditional host countries are offering new opportunities, such as Italy and South Korea.

Main findings in health

People living in poverty tell us that they usually cannot afford the health care services made available to them by either private or public providers. Yet we suggest there is good potential to put more emphasis on simpler, more affordable basic alternatives.

We observe, and people report, that professional cultures of medical care remain in many cases unhelpfully rigid and status conscious. Yet in the few cases where the 'right' person is in post, we observe that it is definitely possible to shift attitudes and build a culture of effectiveness in public sector facilities.

Our observations show that many of the mid-level government health facilities (UPHs, FWCs, MCWC) function poorly and are unpopular with our people in our host and focal households. Doctors tend to over-prescribe medicines and they over-use costly diagnostic tests, such as ultrasound. Despite being heavily subsidised, they seem to offer people few useful services, and they are rarely our study participants' providers of choice. People tell us, and our observations confirm this, that many local Community Clinics do not currently function properly but that they do have potential to meet their needs.

Traditional birth attendants (TBAs) continue to do a reasonable job with limited skills and resources, drawing on strong local community knowledge and high levels of social trust. People continue to be less positive about the 'skilled birth attendant' (SBA) training programme, since this tends to create practitioners who are less networked into the local community, who sometimes place commercial over social considerations in their work, and who may sometimes actually increase risk to mothers and children by working beyond the level of their skill capacities (as both this, and earlier Reality Check reports, have found).

Pressures of economic hardship and a lack of basic public health messages means that poorer people increasingly fall back on unhealthy survival strategies, such as reduced nutritional content in meals, and increased use of cheaper food seasonings such as salt and chillies which have negative health implications.

We suggest that the following 'policy implications' follow from these findings and merit further discussion and reflection:

1. There could be a case for reviewing, and if necessary rationalising, the role of mid-level health facilities in the public system. It would be worth considering the closure of some under-performing facilities by the authorities, and re-allocating resources.
2. Community Clinics could be restructured to better meet local needs through basic services such as monitoring long term conditions (e.g. hypertension, diabetes, asthma), giving basic health advice on diet and lifestyle, and following up patients released from hospital (e.g. re-dressing wounds, monitoring medication). Such clinics hold potential as a resource for people living in poverty, but only if a more locally-appropriate mix of basic services is provided.
3. New targeted public health messages could be developed at low cost to address rapidly changing lifestyles that have profound health implications for people living in poverty, such as increased salt intake, processed children's snack consumption etc.
4. Despite their limitations, TBAs have high levels of community level acceptance and this is a key asset. More could be done to enhanced their capacities. For SBAs, ways need to be found to ensure more

community participation in their selection and training if the problems we observe are to be addressed. Progress towards MDG-5 will require that both TBAs and SBAs are equipped to identify complications in pregnancy earlier.

5. We suggest that ways should be found to encourage doctors (and other health professionals) to develop their 'people skills' further, as well as spending more time and communicate better with patients in order to establish their life histories and make more physical examinations. There should also be less use made of unnecessary diagnostic tests.

Main findings in education

The new primary school Terminal Examination introduced last year provides a standardised and more transparent test for primary school leavers. However, despite early promises, it appears to be narrowing teaching content, generating excessive emphasis on memorization, and creating incentives for schools not to re-admit students who fail.

While the recent investment in teacher training is welcomed in principle, the curriculum lacks relevance to students' daily lives, and therefore fails to give teachers the skills to engage and interest students. The 'joyful learning' concept promoted by government is poorly understood and rarely implemented. The quality of education risks being harmed by an excessive focus on performance at the expense of wider educational goals.

Parents continue to encourage their children to stay in education, and use complex strategies to this end. For example, children may attend several different primary level schools in succession and repeat years. There are two consequences of this: (i) low attainment levels for the number of years of education, and (ii) complex school 'careers' are hard to track and produce statistics about school drop-out that may be misleading.

Education costs have risen steadily in recent years, with informal school costs and additional costs of coaching becoming more commonplace. An additional pressure is created by the increasing ubiquity of 'exam guidebooks' and increased demands by children for 'tiffin money' within a growing consumer culture. We continue to observe a preference among our households for school-based feeding programmes. The government's Stipend Programme is not much of an incentive for children to go to school, because parents are already motivated.

Pre-school is gradually being introduced into government primary schools and is universal from January 2011. Observation of early experience with this was not encouraging, but this situation could be improved if adequate resources are deployed in support.

We suggest that the following 'policy implications' follow from these findings and merit further discussion and reflection:

1. Consideration should be given to revising the Terminal Exam so that it can better test children's functional and applied skills. We suggest it should be a means to assess outcomes in line with the stated policy of 'joyful learning'.
2. Similarly, the teacher training curriculum could be revised to bring instructors more in touch with classroom realities, such as dealing with overcrowded classrooms in imaginative ways, engaging all abilities (including work with slow learners), and win the interest of

boys in particular. Expert teachers may be recruited to provide mentoring support to teachers.

3. Alternative ways could be explored to provide remedial and special needs education using local volunteers, community teachers and peer support. Building wider community involvement in local education would also help create support for making the longstanding but largely dormant parent teacher association system operate. This might also link with the recent Citizen Charter initiative that has remained largely unimplemented.
4. There appears to be strong support for the replacement of the school Stipend Programme wherever possible with a system of school-based feeding. These feeding programmes could be managed by different types of providers, depending on local context.

Linking the RCA with Sida's PTNA principles

The RCA aims to connect its findings to the broader framework of Swedish development policy that emphasises poor people's perspectives on development and a rights-based approach. These two perspectives are underpinned by a further four principles: Participation, Non-discrimination, Transparency and Accountability (PNTA).

The team found that there is a need to promote stronger citizen participation within both programmes. At present, we find that little opportunity exists for people to influence the nature of public services in either health or education, for example through citizen initiatives or local elected bodies. This is partly no doubt due to the fact that such groups tend in practice to get 'captured' by political or elite interests. Yet despite increasing economic hardship, the teams found a growing level of trust and confidence among our households to speak their mind about the realities that they face. The key challenge is to translate this into more demand-led service reform.

The issue of non-discrimination remains an important priority. While initiatives such as school feeding programmes may contribute to challenging the forces of social exclusion that keep the poorest out of school, discrimination remains prevalent at the level of institutional culture in public institutions such as hospitals.

This year's report highlights some major concerns about transparency issues. In particular, the new primary school Terminal Examination had the potential to improve student experience by introducing a standardised, fairer, single assessment procedure to all types of school. However, in practice we found that it had the effect of narrowing the educational experience.

The issue of accountability is critical. Most people who are poor retain a strong desire to access both education and health services as best they can. People show a remarkable level of motivation and ingenuity in trying to make the best of their difficult situations. They are constantly engaged in strategic choice-making and try to manage difficult trade-offs. These efforts are often undermined by low levels of institutional accountability, and by service providers who frequently lack motivation, leading to sub-optimal use of resources. Neither health nor education providers are effectively regulated, particularly in the private and non-governmental sectors. The Right to Information Act (2010) offers potential to redress this and the fifth Reality Check (2011) will include an assessment of the impact of this initiative.

Acknowledgements

The Reality Check Approach 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 Approach and making it successful.

The Reality Check Approach is an initiative of the Swedish Embassy in Bangladesh and Sida (Swedish International Development Cooperation 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, Mahfuzul Haque Nayeem, Shuchita Rahman, Humayun Kabir, Golam Kibria and Hasan Abdur Rahman. Dr. Hans Hedlund and Professor David Lewis (LSE) 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. Brigitte Junker from Sida's Head Office has provided valuable comments to the report.

Samuel Egerö, Ylva Sörman Nath, Monica Malakar and Mohammad Zahirul Islam 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

The 2010 Report

This report marks the fourth year of the five year Reality Check Approach (RCA) in Bangladesh, launched by the Swedish Embassy in Bangladesh in 2007.[1] It presents findings from the fourth period of field work carried out in October–November 2010.

The aim of the report is to present as accurately as possible the day to day realities of people living in poverty, and in ways that minimize imposition of an authorial voice. We hope to avoid perpetuating received wisdom, and try instead to present what people actually tell us about their experiences. By documenting what people say, and what the teams observe, we aim to 'flag up' issues that can be responded to, or if necessary, be investigated further by those engaged in monitoring and research within the two sector reform programmes.

As usual, the team met before and after fieldwork with the RCA Reference Group in Dhaka, composed of representatives from Government and development partner organisations engaged in the health and education reforms, and representatives from relevant civil society organisations. These meetings help to ensure that the RCA remains relevant to ongoing policy deliberations. The section headings used in the report are taken from the list of concerns identified by the Reference Group.

This year, readers should note two changes in our approach to writing the report. First, in an effort to avoid excessive repetition and detail and make the report more 'reader friendly', we avoid covering ground already explored in previous reports, and concentrate only on the main newly emerging findings (for summary of previous findings please see www.reality-check-approach.com).

Second, while the original aim of the RCA is to convey the largely unmediated views of ordinary people, this year in response to the Reference Group's request for 'more information that we can use', we offer some policy implications based both on what people have told us, and on our own growing experience and reflection from four years of work within these communities. These policy implications are intended to stimulate further discussion and research.

Background

The RCA builds on the 'listening study' tradition in social science and policy work in order to make a more direct link between policy makers and citizens' own experiences and voices. It focuses on primary healthcare and primary education, which are supported by two large-scale five year Sector Wide Approaches (SWAps) that began implementation in 2005. New follow-on phases of both programmes are currently being negotiated.

1 For earlier Reality Check Approach reports, and a detailed note on methodology, see www.reality-check-approach.com.

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

The RCA is intended to provide deeper insights than are normally possible with conventional monitoring or research into how these investments are being translated into the 'experienced realities' of people living in poverty, and to better understand gaps in service provision.

The study is conducted in three districts of Bangladesh, one in the North, Central and South, with the exact locations kept anonymous to protect our study participants. In each of the three study districts the teams visit and live in three locations: urban, peri-urban and rural. Since the RCA is a five year longitudinal study, the same research team interacts with the same households, communities and frontline services providers at the same time every year. Each team member spends a minimum of four nights and five days staying in each of the homes of three families living in poverty, sharing in their daily life and engaging in informal conversations with all the family members, their neighbours and relatives as well as local service providers.

Use of the 2009 Report

A key aim of the RCA is to influence the main policy actors. The Swedish Embassy and Sida contracted Campaign for Popular Education (CAMPE) and UBINIG *(Unnayan Bikalper Nitinirdharoni Gobeshona)* to host launches of the 2009 Report to stakeholders in Education and Health respectively. The Education findings were presented in Dhaka on April 25, 2010 with a total of 110 participants in the presence of the Advisor to the Prime Minister on Education, Social Development and Political Affairs. Participants felt that it was the first time that many of the findings were properly documented and valued the longitudinal nature of the study.

The Health findings were discussed in Dhaka on May 20, 2010 with over 100 participants in the presence of the Additional Secretary and Project Director of the Community Clinic project of the Ministry of Health. The study was heralded as unique and an important reminder of voices and experiences which are often overlooked in planning health programmes. Strong support was voiced to support traditional birth attendants and to promote appropriate affordable medicines and treatment for people living in poverty. Both events were widely reported by national press and TV.

Sida hosted a meeting with donors in Dhaka in March 2010 to identify health policy implications. The RCA study was applauded for its useful insights for future policy formulation, especially since a new health sector programme is under preparation. Key lessons included the need for more rational resource allocation, improving public consultation, new measures to curb misuse of Government resources, additional programmes for men and adolescents, and new public health messages on issues such as basic first aid and reviewing TB management programmes. UNFPA indicated that they would undertake in depth studies on two issues raised by the RCA: the effectiveness of Skilled Birth Attendants (SBAs), and the reasons for low utilization rate of Maternal and Child Welfare Centres (MCWCs).

Context

This section links wider national trends with experiences among our study families and their neighbours.

Economic trends

Poor harvests in 2009 meant that several of our study households were not able to be self-sufficient in rice this year, so had to buy in rice. Table 1 shows that there were increases experienced in the prices of most common food items in all our locations with only potato costs falling and salt staying more or less the same. The World Bank reports that growth in Bangladesh during 2010 is estimated at 5.8% '*despite the slow global recovery and continued severe power shortages*'.[2] The relatively healthy growth is attributed to the service and industrial sectors driven by growth in consumption which has been fuelled by strong remittance inflows (although recent indications suggest that remittance flows have increased by only 1.4% this year which is the lowest rise in thirty years (RMMRU, 2010).

Table 1: Food Prices, 2010 as indicated by our study households

Item	Cost range (North) (percentage increase over 2009)	Cost range (Central) (percentage increase over 2009)	Cost range (South) (percentage increase over 2009)
Rice	Tk. 35 (+17 to 40%)	Tk. 35 (+50%)	Tk. 35–40(+33 to 50%)
Pulse	Tk.120 (+33 to 50%)	Tk. 100–120 (0%)	Tk. 100–140(+25%)
Vegetable oil	Tk. 100 (+18 to 48%)	Tk. 90–120 (+30 to 50%)	Tk. 90 (+30%)
Onion	Tk. 30–40 (+7 to 33%)	–	Tk. 26–30 (+4 to 100%)
Chili	Tk. 135–140 (+4 to8%)	–	Tk. 150 (+50%)
Sugar	Tk. 35–56 (+15 to 50%)	Tk. 50–70 (+50%)	Tk. 52–56 (+33 to 60%)
Salt	Tk. 14–18 (0)	Tk. 22 (+20%)	Tk. 14–18 (0)
Potato	Tk. 15 (–25%)	Tk. 20 (–20%)	Tk. 20 (0)

The ADB notes that the growth rate in agriculture has fallen compared to 2009 mainly due to adverse weather and despite government subsidies although the most recent boro and amon harvests are regarded as good in most areas.[3] Inflation increased to 7.3% (World Bank) this year which is mainly driven by rising food prices. Rice prices rose because of shortages in domestic production in 2009 and high prices in India. The comment '*We are taking cheaper and less food*' (HHH, North peri-urban) is typical as is *'to cope we take only one full meal and buy cheap vegetables'* (HHH, North urban). This is in contrast to the previous years. More families in all three areas are taking NGO loans for purely consumption purposes and many have credit arrangements with local shops.

2 www.worlsbank.ord.bd accessed January 2011
3 www.adb.org/document/news/BRM/brm-201002.asp accessed January 2011

Local investment is regarded as robust and domestic employment rates have increased and include opportunities created by re-opening of the state owned jute mills. In the North the construction industry which stagnated during the Caretaker Government has resumed, but it mostly employs labour from outside the district as they are regarded as more reliable so F/HHH do not benefit from this upturn. Domestic poultry rearing, fish cultivation and goat and cow rearing have expanded notably in the Central and South locations. In urban slums there is an increase in petty business in all three districts and a significant increase in scrap dealers in the Central and South slums. Day labour rates are regarded as quite good with a minimum wage of Tk.150 per day.

Garment factories in the Central district which provide employment for women in the peri-urban location re-opened after various closures earlier in the year due to cash flow problems and tensions between the work force and owners. A new national minimum wage is now being paid after widespread worker protests, and these families are clearly in a good position compared to others. Here, we observed more varied and better diets, and no cutback of household expenses as seen in other areas (in the North in particular). Many people, particularly youth in the South and Central areas, aspire to work overseas. Although some workers have been forced home this year, some new countries such as Cyprus and Italy are reported as making requests for export labour.

Most families remarked that power cuts were fewer than in previous years and at least they had enough power to irrigate crops.

Political trends

2010 was the second year of the Awami League-led government, which was elected by a large majority in the December 2008 general election. The Supreme Court ruled in July to restore secularism to the Constitution of Bangladesh and several Islamist political parties and organisations have been banned. Some study participants reported a growth in political protest and cases of political repression, and our participants seemed more reluctant than before to discuss politics.

One central reason for dissatisfaction is that many people who voted for the current government now feel let down that food, and particularly rice, prices have once again escalated. Another is that economic activities have once again become affected by political interference and extortion, after a period of relative improvement during the military-backed caretaker government. Business face demands for extortion and other illegal 'tolls', leading people to make comments like *'this even happens in the daytime'* (Central peri-urban). Such activities are said to take place in broad daylight with no attempt to conceal them, and may often be linked to political parties. These conditions, we are informed, make it very difficult for small-scale informal businesses to operate. For example, in the South, slum street vendors are required to pay Tk. 50 per day protection money. The most extreme reaction we found was in the Central urban slum where the following comments were made about the level of confrontation in local politics: '*We cannot open our mouths*' (about politics), *'Before we could talk about anything freely and anywhere but not now'*, *'If I say something I will be caught by police for remand'* and *'I heard people get beaten for speaking out'*. In the Central rural village, we were told '*people in Dhaka have no idea how bad it (village politics) can be*'.

Using cooking pots to catch the incessant rain water

Environmental trends

Floods affected many areas and the rainy season was unusually long. Land remained waterlogged longer than usual. We heard about flash floods that hit our Northern location in early 2010, resulting in loss of the entire boro rice harvest, despite good harvests reported elsewhere. Grass which is normally used for both animal fodder and fuel rotted under the standing water which stayed for many months. In our rural study village, nearly 50% of the cows died of starvation. *'We have lost everything in the last flash flood'* (HHH, North rural). Elsewhere, particularly in the South, heavy rains delayed vegetable production. The floods also severely damaged internal and connecting roads, doubling travel times and resulting in increased transport fares.

Overall, floods have had devastating effects (Box 1). However, one positive outcome for people living in poverty in all areas is the increased prevalence of fish. This has provided a much needed free protein source to supplement what were mostly poorer diets than observed in previous years.

Ceiling repaired with polythene sheets to prevent rain water from coming in

Box 1: Impact of rains on communities

I was walking through water which was almost to my knee. The paths were covered in sewage. My HHH and neighbours houses were under water. Gas stoves were under water, so they couldn't cook for the family. They told me that in the rainy season often they face this sort of trouble. Three years ago new drains were constructed but these are breaking and getting filled up with waste. My HHH mother told me that 'we don't know how to maintain our streets and drains.' She complained that there is no follow through by the Municipality after installing drains (Field Notes, Central urban).

People could not go out to work. As they depend on daily earnings for their daily food, they went hungry. Most of the house CI sheet roofs leak and rain pours inside the house. They put all curry bowls and water pots on the floor to catch rain water to try to keep the floor dry. In another household, the mother protected her house by draping polythene sheets under the damaged roof. The floor in the third household became muddy for several days (Field Notes, North urban).

Technology trends

According to the Bangladesh Telecommunication Regulatory Commission, by November 2010 there were 66.5 million mobile phone subscribers serviced by six companies, compared to 50.5 million in November 2009. There are fifteen government and private TV channels and eleven national radio stations. The Government pursues its vision of 'Digital Bangladesh' and this includes initiatives to set up e-centres throughout the country.

This year we noticed the growth of media and telecommunications technologies more than ever before. Ownership of mobile phones has increased significantly among our F/HHH. In particular, teenage boys (and some teenage girls) now own their own phones, even in the least developed of our nine locations, the rural north. We noticed that informal brokers who sometimes govern access to public services and levy informal fees from people living in poverty now use mobile phones to build up their contacts and connections. One even spoke to us about the strength of what he described as his 'hello power', the term he used to indicate how many powerful people he was able to reach. There is a thriving market for second-hand mobile handsets and TVs. Many of our families watch their own or neighbours' TVs. Youth living in our study areas increasingly use computer shops to access the internet, and some even have Facebook accounts.

Main Findings in Health

1. Government Health Facilities

After four years of conversation, observation and experience, it is apparent that people living in poverty regard some mid-level Government facilities (certain UHCs, FWCs and MCWCs and some Sadar hospitals) as redundant. Over the years we have seen the services provided by these facilities ebb and flow. Periods of greater efficiency are always due to strong leadership but there are some facilities which have never seen any positive periods. The opinions gathered are supported by an observed decline in patient numbers (Box 2).

Box 2: Declining patient numbers at mid-level Government facilities (UHCs)

When visiting the UHC we found the place quiet, with only three patients waiting (Thursday, 12 noon) at the out-patients section. We were told that about 30–40 people come each day. The female ward was empty and there were only five patients in the male ward (all of whom had been brought there by third parties). We asked our study families why there are so few patients at the UHC. One man explained declining numbers were partly due to perceived corruption in public services: 'Doctors know that we understand their insincerity and dishonesty'. A local pharmacist added, 'Some of the doctors are making money every day, and this is poor people's money ... no money, no treatment. They charge Tk. 100'. The pharmacist also claims that the doctor regularly sells off petrol intended for the ambulance as well as medicines, runs it as a private ambulance service, sells bandages and plaster material, and takes some of the food supply for himself (Field Notes, South rural).

Four days ago Urmilla was hospitalized with extreme diarrhoea. Despite paying at each step, the family felt that she did not get proper care and the food 'was terrible'. She ended up bruised and injured after the nurse had made several attempts to administer a saline drip. The family said: 'Maybe this is their way of telling us they don't want us here, they are just discouraging us. And who would want to be a patient here anyway? We don't think they need patients, that maybe they are closing it down gradually. Why else would they be treating us this way? There will be no patients here in the near future' (Field Notes, South rural).

We arrived at about 9.15 am on a Wednesday and the place was deserted, despite the advertised times of outpatients as 9am – 1pm. Nobody arrived until about 10.30 am. By the end of the morning 57 men, 86 women and 60 children (most of whom had come for the EPI session organised in the foyer), so a total number of 203 patients (similar to 2009 numbers but 30% less than 2008 numbers) had been registered. All but one bed was occupied in the men's ward but almost all (except three) were elderly men with gastric problems, high blood pressure or breathing problems and were from the immediate neighbourhood. There were fewer women in the women's ward and mostly they were middle aged and also local. They were suffering from gastric problems, diarrhoea and asthma (there was one baby with diarrhoea). The doctor on our team felt that none of these patients seemed to genuinely need hospitalisation (Field Notes, Central peri-urban).

Families who have used Government facilities this year tell us that they must still make unofficial payments for treatment (Box 2), cannot get the medicines or diagnostic tests (Box 3), do not get attention from medical staff (Box 4), and dislike the lack of cleanliness. Our data indicates that there have been few changes over the years of the Reality Check.

The emergency room at the UHC in the North rural area is empty.

Box 3: insufficient medicines and inefficient diagnostic services increase costs for people living in poverty.

There are fewer free medicines available in the District Hospital compared with last year as indicated on the display board in the lobby. Observing patients who presented their prescriptions to the medicine counter, I found that at least seven out every ten failed to get medicines and were told to purchase from outside. The poorer patients purchased part prescriptions or none at all. 'What is the use of visiting government hospital? Doctors should prescribe medicines based on the ability of the patient to pay' said a poor old man and a boy who had failed to get the free medicines they required (Field Notes, North urban).

Most patients at the District Hospital are referred to private diagnostic centres as there are long waiting times and slow turn around in the hospital. An old lady we met was told to get a second X-ray and blood test from a particular diagnostic centre, but when she went there was told she could only have a range of tests in a package costing Tk. 1,750. She returned home and took a loan from a neighbour, having to pay transport costs back and forth three times to do the tests and collect the diagnostic reports (Field Notes, North urban).

Patients complain about the dirty ward at the UHC in the North rural area.

Our observations confirm what many of our study families and government health facility staff tell us that these facilities have been reduced to centres for EPI, places for the non-ill to collect free medicines (Box 5) places which receive victims of assault and accidents (wherever litigation may result) and places for 'bed rest' for local elderly. Our study families in all areas tend to avoid these facilities. We asked if some of

the UHCs should close and were told '*we would not miss them*' and others suggested that the Government should put the failing ones in '*private hands but provide subsidy to the poor.*'

Box 4: Inadequate medical staff attention at the UHC

Four doctors are now assigned to the UHC, but two are on deputation to the Sadar Hospital. No staff were found on duty in the early morning. Two emergency patients turned up but they did not find any doctor or nurses in the emergency room. A street dog and a cat roamed the room. During a subsequent morning visit with a patient, we also did not find any staff in the UHC. Everything including the emergency room, was open but without any staff (Field Notes, North rural).

Pushpo was recently admitted to the UHC with diarrhoea. She said that doctors rarely made rounds and nurses spent most of their time 'in their office, feet up, chewing pan, picking lice and gossiping'. They were reluctant to come to her assistance when her saline drip ran out and one nurse suggested she should remove the needle herself (Field Notes, South rural).

We noted in the 2009 Report the existence of a totally redundant MCWC (2009 Report, Box 11, p.34) situated 15 km from the city with no patients at all. Similarly nobody we met knows of the existence of a FWA in the Central peri-urban area, and refers to it only as the 'police bhaban' (which shares its building and uses the waiting room to store its motorbikes). Another FWC in the North peri-urban areas is operated from a small dilapidated house of the Union Parishad but the doctor does not attend because of the poor condition of the building. They are planning to move soon to a new building, but this has been constructed far away so, like the MCWC above, people tell us that 'probably nobody will go there'.

Box 5: Using Government facilities to stockpile medicines

Some villagers said that they go to the UHC only to collect medicines (Paracetamol or vitamin tablets) to keep a stock at home for emergencies because the hospital is too far from the village (field notes, North rural). We spoke with the young pharmacist in the UHC who confirmed that he mostly gives out paracetamol and antihistamine tablets for 'colds'. Many of the patients are 'well known to me' as they come regularly just to collect medicines, and he knows they are not really ill. These are the most frequently requested drugs which, from our observations, seem to be handed out to whoever asks for them (Field Notes, Central peri-urban).

Our observations over four years suggest that when Government health facilities improved from one year to the next it is as a result of the transfer of a new head. Similarly when they decline suddenly it is because this person has been transferred away. This was very noticeable with the District hospitals in the North and South (2008 Report p.43, and 2009 Report p.31–32). Only one of the five UHCs and one MCWC out of three in our study areas function well.

2. Potential for community clinics

'*Establishing a Community Clinic without assessing the need and without any involvement of the community is a mis-use of public money*' (community people commenting on their Community Clinic which is constructed on the canal bank without any access road, North peri-urban).

The principle of locally accessible health services is supported by our conversations with study families but they feel that the community clinics are not currently providing the services which will make a dif-

ference to them. Basic services provided by community clinics can be accessed more conveniently from private providers (see 2007 Report p.24) whereas there are many needs which are not being met by the community clinics.

The re-opening and building of 18,000 community clinics throughout the country was an important election pledge of the current government. Staffed by a Health Assistant (under the Directorate General for Health Services) and a Family Welfare Assistant (under a different wing, the Directorate General Family Planning) they are supposed to provide primary health care services at community level with an emphasis on maternal and child health services. This year the Government has announced that an additional 'community health worker' will be recruited for each clinic and will be responsible for the compilation of patient data. The first batch of clinics opened last year, but there were fewer than planned because of staff shortages. In last year's report (2009 Report p.34–36) we noted that the clinics were facing many problems; poor infrastructure, inadequate medicine supply and poor uptake by patients. Furthermore the staff of the clinics were unhappy about the additional burden associated with running the clinics as well as their existing tasks. '*But we are doing many other things that take up most of our time and this prevents us from keeping the clinic open everyday*' (HA, South rural).

People sharing their views on the community clinic.

Community Clinic locked.

There continue to be widespread problems with community clinics in both the rural and peri-urban study areas (Table 2). The community clinic in the North peri-urban area is located in the middle of a paddy field some distance from the village, and few people know of its existence. About 10–15 patients attend on the days it opens, mostly (as mid-level facilities) to get free medicines 'to stockpile at home'. The Health Assistant told us that '*A doctor has been posted here but he does not come because there is no electricity connection. He phones me almost every day to inquire about the attendance of patients and the current stock of medicines.... a doctor will not stay in such a small room without a fan*'. In the North rural area the building has been taken over as accommodation for local people. In the South peri-urban area people thought the clinic is primarily for women and children and men said they would go to a pharmacy or hospital if they needed treatment. Others said they thought that there is a 'doctor' on duty '*perhaps twice a week, I am not sure';* and *'after one visit I wouldn't go back, I don't feel encouraged to do so';* and *'I don't know what services they provide there*'. In the Central peri-urban, people only go to collect free medicines and the clinic in the Central rural village has closed because of staff shortages.

Poorly constructed and poorly maintained Community Clinic.

Table 2: Current state of Community Clinics

	North Peri-urban	North Rural	South Peri-urban	South Rural	Central Peri-urban	Central Rural
Date opened	July '09	June '10	? '10	July '10	July' 09	One not yet open, other closed due to staff shortages
Water supply	X	X	X	X	X	
Electricity	X	X	X	X	X	
State of building	Very poor	Very poor about to collapse, inaccessible	Very poor	Moderate but very dirty and smelly	Basic	
Staffing	1 HA, 1 FWA	1 HA, 1 FWA	1 FWA	2 HA, 1 FWA	1 HGA, 1 FWA, 1 CNP	
Equipment	Stethoscope only	None	?	Scales	Scales	
Opening times	3 days/week	Once per fortnight for EPI	1 day/week	Irregular	2days/week	
Management committee	Not active	Non existent	?	Not active	Never able to fulfil quorum	

In all the Community Clinics, staff and patients complained about the supply of medicine both in terms of quality and quantity. The FWA in the South peri-urban area and the HAs in the North peri-urban and South rural areas told us that they had to collect medicines from the UHC themselves bearing their own transport costs. The HA in the North has instituted a Tk. 5 fee for all medicines to cover this cost but is concerned that this is not an official instruction. The HA (South rural) told us that the medicines they stock are mostly ones which are readily available in the market and are '*low quality*' and it seems pointless to dispense these.

These clinics are short of basic equipment; some do not have scales, blood pressure monitors or thermometers. For example the HA at the Community Clinic in the South rural area said that since they do not have this equipment, '*We just guess and may provide medicine that is completely wrong!*' The HA at the clinic in the North peri-urban area intends to buy equipment herself with her own resources but she expects to be able to take a fee to help to reimburse her for these outlays.

Box 6: Diary of a Community Clinic

Day 1 (Tuesday)
The HA opened the clinic a little late so there were people waiting. He ran the clinic on his own and spent 3 hours only dispensing medicines. There were no prescriptions, he simply asked patients what they wanted and supplied it, with no information on dosage. 118 patients (including only two males) obtained medicines in this way. In the chaos, elderly patients were pushed to the back. The HA said that 50% people coming to the clinic are 'not real patients.... they come to grab the medicines.... less than half this crowd are real patients but if I don't give them anything, they will shout at me'. The landowner's daughter-in-law arrived and was given priority over the others who had been waiting. The Community Nutrition Promoter (CNP) attended only for a short while as she had to go home to entertain her guests. In her absence the HA tried to help a young women who came to weigh her son but he could not work out how to use the weighing machine.

Day 2: (Wednesday)
The HA came to the clinic but said 'this is not a patient day' and spent the time record keeping. This means that out of the three days he is supposed to run the clinic, people only get two days official services from him. For the three days assigned to the FWA, the clinic remains closed. She thinks that her family planning services are always available from her home (10 minutes walking distance from the clinic), so she doesn't think it is necessary to work at the clinic.

Day 3: (Thursday)
This was monthly EPI day, so the HA came although this is not normally his duty day. The CNP who had arrived at 9am was waiting outside, because she had lost the key. Since this was the fourth time this had happened he was publicly very angry with her. The FWA arrived at noon and observed the EPI session. Her adolescent girl and pregnant women clients were directed to the HA to receive their vaccines. Once only she helped, by holding the legs of one child as the HA vaccinated. Only 20 patients attended all day and they said they were surprised that the HA 'was not shouting today'. The CNP, like the FWA, did very little. There was supposed to be a pushti committee meeting but only two of the eight member committee arrived. They ate snacks, signed the meeting attendance and then left (Field Notes, Central peri-urban).

The lack of resources is further exacerbated by weak governance, management and unclear roles. The operation of the Community Clinic is supposed to be shared between the HA and FWA under the supervision of the UH and FPO based at the UHC. These staff have different backgrounds, competence and supervision lines as well as different working styles and relationships in the community which may lead to working tensions. Our observations indicate that these staff often find it difficult to work together. There are quarrels over who keeps the key, which rooms they occupy, which days they work, who collects and dispenses medicines, who can use equipment and who completes the record keeping.

The Community Management Committee is ineffective in each of our study areas. In the North peri-urban clinic, the HA told us that none of the committee members ever visited the clinic and no meetings have been held. She is worried about the future of the clinic as she feels the UP chairman and other members '*will not give any support in the future if they don't get any personal benefit*'. She added '*the government should involve local people from the beginning – in selecting the right place, monitoring construction quality,*

making committee members accountable to the community for proper functioning of the clinic, ensuring medicines and equipment like blood pressure monitor, glucometer, blood grouping reagents. The clinic should collect a minimum fee for providing treatment'. A recent Government Circular requires the Committee to increase in size from nine to sixteen members. It is now almost impossible to get a quorum for meetings. In the Central peri-urban area, there has never been a formal meeting of the Committee.

Our study families have many unmet needs which could be addressed at Community Clinics. Many of these would result in considerable cost savings for families. The range of needs is explained below.[4]

i. Provision of post-hospitalisation care

Over the years that the team has been visiting government hospitals, we have been told that many patients are required to stay in hospital for long periods. This is so wounds can be dressed and stitches removed. Sometimes these periods are artificially prolonged to meet the requirements for litigation cases (see 2009 Report, p.58–59), while in other cases hospital staff say they prefer to retain patients because they think they will not return for follow up if discharged. We have met several people in the course of the study who have fled hospitals because of the mounting costs of staying there. Others have told us that they want to return home, felt well enough to do so but were prevented by staff. We also frequently observed patients, sometimes terminally ill, who had been prescribed long term hospital 'bed rest'. Such people could be encouraged to go home to recover or to die in dignity if staff from the Community Clinic could provide palliative care and social support. Removal of sutures, re-dressing wounds and post operative monitoring are also roles the Community Clinics could take on.

ii. Monitoring and support for people with non-communicable ailments

Since 2007 we have noticed a steady increase in the numbers of people in our study areas suffering from non-communicable diseases such as diabetes, heart disease and blood pressure problems. Successful diabetes awareness campaigns have led to increased screening and diagnosis. Once diagnosed, people are required to have regular check-ups at Diabetic Hospitals or district hospitals. These require most of the day and may entail high transport costs. They tell us they cannot afford the

Bags of medicines kept by one of our FHH. She dips into this bag at random whenever she feels a need for relief from her symptoms of high blood pressure

4 This section, which includes some suggestions for rethinking the role of Community Clinics, should be read in conjunction with the 'policy implications' at the end of this report.

medicines (Tk.500–700 per month) and so '*we follow the diet and exercise advice only* (which they get at the Diabetic hospitals or from doctors) *because the medication is too expensive*'. We found many examples of this advice being followed with changed diets and more exercise being taken. In the Central rural area an early morning walking group has been established among diabetic patients. High blood pressure has also increased, particularly among older people. Again medication is regarded as too costly to be taken continuously. Some members of our study families suffer from asthma and as with other lifetime ailments, they are not well informed about how to manage their condition.

iii. First response

This year we were made aware of a number of medical emergencies; injuries resulting from the tornado in the South peri-urban area, snake bites in the South rural area, dog bites in the Central peri-urban and South peri-urban areas, a bee attack in the North peri-urban as well as other accidents and minor injuries. The Community Clinic in the South peri-urban area had responded to the needs of those affected by the tornado and many had received support for minor injuries and colds and fever resulting from the poor weather. But we find this positive response is the exception, and the Clinics in other areas provided no help for the other emergencies.

Since 2007, we have reported on the widespread problem of over-prescribing diagnostic tests and medicines (2007 Report, p.27, 2008 Report, p.41–42). Old but nevertheless efficacious practices of first aid at home have faded, often displaced by drug company promoted alternatives. For example, the elderly polli doctor we have met every year in the Central rural area says nobody uses iodine or gentian violet[5] these days as doctors have discouraged its use, saying it is not 'top medicine'. A discussion with a dai and her neighbours revealed that only a few remembered gentian violet (they called it *nil osudh*, literally 'blue medicine') and all said this was not used now except for animals. The *dai* said it is not a 'developed medicine'. However it only costs Tk. 10/bottle and has no expiry date (compared to Tk. 35–55 for cream) but people say it is only available from main markets. On our visits to Government hospitals we see many patients with cases of septicaemia in relatively minor wounds when simple preventative measures taken at home or promoted by the Community Clinic such as saline bathing or use of gentian violet might have avoided this.

iv. Information provision

In previous reports we noted that people have very little information on where to go for various medical conditions. For example, a FHH mother and daughter in Central rural and a FHH man in the North rural all need cataract operations (2008 Report, p.39) and elderly FHH members have glaucoma but do not know where to get treatment. A HHH in Central rural includes a young polio survivor who has limited knowledge and access to available support. It seems possible that Community Clinics could become an important repository for district wise information on free and subsidised services to people with disabilities and

5 Gentian violent (also called crystal violet) has antibacterial, antifungal and anthelmintic properties and is still listed by the World Health Organisation. It is regarded as one of the best agents for preventing infection in any wound or burn and quickly assists in scab formation.

chronic ailments, and special programmes for people living in poverty such as cataract removal, family planning and sterilisation camps.

v. Counselling and advice

Box 7 illustrates a number of situations typical of many we hear which could be addressed through local-level counselling and family based support administered through the Community Clinic.

Box 7: Potential for local level counselling and advice provision.

People told us they need advice on many basic health issues (such as those listed below), and suggest that Community Clinics could easily provide this.

a. Breast feeding
L has not been able to breast feed as, according to the dai, one breast 'is blind'. The baby 'cried a lot and was never satisfied'. He was given Lactogen, she feeds him 'a little every day with the good breast'. The Lactogen costs Tk. 650 per month. But more could easily have been done to encourage breast feeding (massage and pumping of the breast) and reassure and inform the mother (Field Notes, Central rural).

b. Infertility
Infertility can severely impact lives, but we found the FWA was unable to advise three infertile couples. Available advice of this type is considered expensive and requires costly trips to a city (Field Notes, Central rural).

c. Sexual dysfunction
The husband in one of our closest families confided that he had erectile dysfunctional problems. He was confused when trying to explain his problem. He wondered if it had something to do with his wife's hysterectomy. He had no idea where to go to get advice (Field Notes, South urban).

d. Family planning counselling
A sixteen year old FHH woman who had taken the family planning injection was experiencing heavy bleeding and sought treatment from pharmacists. She was very anaemic and is now frightened to get a second injection because she thinks it will cause more bleeding. It struck us as surprising that an otherwise good FWA is unable to give the counselling support she needs (Field Notes, Central rural).

e. Family tensions: advice to mothers from mother-in-laws
According to this SBA, mother-in-laws hold a powerful position in giving advice but say their advice often 'goes against scientific knowledge'. Some give spurious advice such as telling a mother to avoid sleeping during the day, going to the temple in the evening, taking vaccinations, or eating meat and eggs (Field Notes, South rural).

Bottle fed for want of good advice.

3. Dalals and pharmaceutical reps

We have reported before on the power of drug company 'representatives'. One HHH told us '*nowadays the reps are much more aggressive. They even enter the wards, and walk up to the patient's bed to check their prescriptions to*

Every time we visit the hospitals, there are always Medical representatives waiting in the corridors.

see if it matches their own brand' (South peri-urban). Others told us how the reps can intervene during out-patient consultations to persuade doctors to change the prescription. People tell us, and we have observed, a very fine line between the activities of some pharmaceutical representatives and the informal brokers or '*dalal*' who control people's access to services and facilities. Inside doctor's rooms at the UHCs it is not possible to distinguish patients from *dalals* and reps trying to push services and medicines. A pharmacist told us that a *dalal* can make Tk. 300–500 per day, and some charge Tk. 5–10 for just showing directions to a doctor's chambers. Cell phones seem to increase *dalals*' power and influence.

4. Government Skilled Birth Attendants (SBAs)

We have previously reported our observations regarding SBA training of FWAs (see 2009 Report p.62–64, 2008 Report p.34–35, 2007 Report p.26) mostly from the Central study area. We reported that (i) SBAs were less ready than TBAs to work outside normal hours, (ii) their work becomes more driven by commercial considerations following their training, leading to outcomes that are not necessarily in the interests of clients, and (iii) SBAs may provide services beyond their competence level in search of personal gain.

This year we met recently trained FWAs in the North who told us that they face problems because they are unfavourably compared with TBAs by the community. One FWA who received SBA training has not yet conducted any deliveries as she told us that 'People, especially women, are not confident with me as I am younger than the local TBA and I'm not very experienced. Women are worried about privacy, and don't like to expose themselves to an outsider during delivery. So I am getting few opportunities for deliveries in this area.' This year, for the first time, we managed to observe a delivery at close quarters. This confirmed many of the concerns people had raised in previous years about the quality of SBAs' work. Table 3 describes the observations of our team member (herself a qualified doctor) and compares it to what is recommended in the training guide. We subsequently confirmed our observations with an SBA trainer.

Table 3: Observations at a delivery conducted by two trained Skilled Birth Attendants

Mother's condition	SBA/Shebika's actions	SBA Training Guideline/ Trainer's comment	Comment of observer
This is the mother's 3rd pregnancy (2 daughters, 3 yrs and 1yr old). Pain started 24 hours ago, but no progress. She was very weak. The family called the SBA.	As soon as the SBA reached there, she performed a per vaginal exam and started an intravenous saline drip to increase pain as well as medicine (2 ampoules) and one ampoule intramuscular injection to open the mouth of uterus (cervix).	Any labour pain which continues for more than 24 hours, the SBA must refer the case to hospital.	No referral was considered.
The frequency of pain was more but she could not bear down.	The Shebika was wearing a hand glove on her right hand and she did repeated per-vaginal examinations as well as other work with the same gloved-hand.	There is no provision in the training to provide any intravenous injection to increase pain. Rather It may increase the risk of rupture of the uterus, if there is any cephalo- pelvic disproportion or obstruction.	Her hand glove was contaminated, as she touched everything and did everything using the same hand.
The mother lying on her back became very restless; she wanted to turn on her side but she was not allowed.	Pervaginal exam was done every 10–15 min but the cervix was not dilated as the SBA expected, so 2 more ampoules were added in the drip to increase pain. They thought saline is not fast enough with normal needle, so the SBA asked for a 'canula' but the shebika did not have it, she supplied a butterfly needle (old/ used- washed in water) to replace the normal needle, SBA increased the rate of the saline drip to increase the contractions. She pushed another injection directly into vein to increase pain. Total 10–12 intravenous and intramuscular injections were given within 30–40 minutes.		I wonder whether some of these injections are just water, otherwise the woman could die of overdose!!! and think that SBA is trying to increase her payment by showing -off how her presence is important.
The mother was very restless. With a sudden strong pain the waters broke.	Both the shebika and SBA were bathed with the amniotic fluid and they were very embarrassed – then another strong pain came, but although the baby's head was bulging it was not coming out; then the shebika pushed her legs up and pinned her with her own body, and forcefully pulled the baby out. Placenta came out after 10 min; there was not much bleeding before the placenta came out. But again she pushed IV/IM injections.	The guidelines recommend that the SBA waits and rub uterus above the symphysis pubis to induce contraction to expel the placenta and control bleeding. As the bleeding was not severe, and already too many injections were given, there was no need of more injection after the delivery of placenta.	No monitoring of maternal and foetal distress It was so forcefully done that I and the relatives thought that baby's head/shoulder would be damaged
The baby did not cry for some time. Mother was also breathless for some time.	Shebika was so exhausted from pulling the baby so forcefully, she could not hold the baby, so dropped her to the hands of the SBA and then she cried loudly as she had severe muscle pain in her legs. SBA turned the baby up side down and slapped it on the back, baby became blue; SBA pinched her skin in different places for several times- finally it took a breath and cried.		Everybody in the room was puzzled how to help the shebika, leaving the baby and the mother. They pulled the shebika on the bed/wooden cot and stretched her legs, massaged her muscles; she got relief of pain and fell sleep within 5 minutes. This is her 2nd night without sleep – she went to another village last night to conduct delivery

Table 4: Extreme food intake problems in the North study area

HHH	Number of family members	Number of meals taken per day	Food type	Weekly cost of food	Weekly income	% income spent on food	comments
HHH1 (slum)	6	1	Rice, vegetables fish	Tk. 1,190	Tk. 1,125	106.00%	Always in debt to relatives. Father sells used syrup for sweet making & elder son gives coaching. Sons not interested to work
HHH1 (peri-urban)	7	2	Rice, vegetables, onion, chilli, roadside leaves v. occasional fish	Tk. 745	Tk. 902	83.00%	Father is a carpenter but is often unemployed. Son regularly quits jobs as he says it is too hard
HHH3 (peri-urban)	4	2	Rice, vegetables and fish, roadside leaves	Tk. 1,181	Tk. 986	122.00%	Father is a van puller and mother collects firewood to sell. Their one earning son (tea stall worker) keeps all his money for his own clothes and snacks. Since the mother had a severe accident (bee attack) the income has dropped and the deficit is supported by an NGO loan

5. Lifestyle and health

Staying inside the homes of people living in poverty provides us with good opportunities to observe lifestyle changes that have taken place over the last four years. Diet is one area where we have gained useful insights. Although our observations suggest that both the quality and quantity of food intake has reduced over the years (see 2009 Report, p.19), diets in the North study area are particularly poor. The land here is too low quality to sustain vegetable production and this year persistent standing water destroyed rice crops. While almost none of our families in any of the study area eat meat except for special occasions, and instead eat fish and vegetables with rice, in the North study area it is not unusual for people to only eat rice with salt. One host family in the slum, whose only income is from the eldest son, take only tea with salt throughout the day and occasionally eat a handful of puffed rice (Muri). Table 4 illustrates the struggle just to eat faced by three other of our host households in the North.

Everywhere in our study area the increased availability of fish in ditches, khas ponds as well as escaped fish from flooded fish farms, has been important in supplementing the diet. One HHH in the rural North said '*The fish in the haor saved our life during the flood; otherwise most of us would have starved to death*'. Many families have dried some fish as emergency food for the coming season. However, public access is now restricted in the North slum is now prohibited as water bodies have now

Boy from a host household eating rice with salt only.

A girl is processing dried fish which were caught from the river.

been leased out by the City Corporation. One HHH heads said '*We are not allowed to catch fish that was naturally available in the water bodies. Now rich people catch all the fish in the name of fish cultivation*'.

Food intake varies hugely among our study families from one extreme where the family tells us '*we have had no fish during the last five months, and we cannot recall when we last had beef. We have chicken once a year, at Eid ul Azha*' and add that most of their son's meals are only enough for 'half a stomach', his elder sister often goes to bed early because there is not enough food for her and the youngest toddler frequently wakes up in the night because of hunger (South peri-urban). One rural doctor told us last year that he is seeing more children with a low resistance to disease as a result of poor diets (2009 Report, p.19) and teachers tell us frequently that children come to school hungry and cannot concentrate

Billboard promoting that iodized salt is good for the brain.

Star fruit and salt, lunch for the day.

Hawkers add a lot of salt and chilli to the snacks sold to students outside the GPS.

Snacks for sale in the playfield of the government school, all the children buy something every day.

(see primary education section in this report). By contrast, other families enjoy relatively good diets and children snack throughout the day. We observed the growth of 'pester power' among children who increasingly demand snacks from their parents. Children refusing to go to school without money for snacks is becoming a major issue. We regularly see children throw tantrums if their parents will not give them snack money (see also 2009 Report, Box 49, p.94). A snack vendor outside a school told us that all children buy snacks everyday and if they do not have money she sells to them on credit. Some kids go to school without shoes, but require Tk. 150–300 per month for snacks.

Last year we reported increased salt levels in the food we take with our families (2009 Report, p.57). As mentioned before several of our F/HHH in the North slum now even take salt in their tea as the price of sugar has increased. Box 8 describes examples of the extent of salt consumption and some of the confusion around whether it is good or bad for health.

Box 8: Salt intake

The wife of my HHH persistently put a large lump of salt on our plates, although she was asked not to. One man said 'I cannot taste the food if I don't use a certain amount of salt' and added that old as well as young people all have the habit of taking extra salt (Field Notes, South rural). We played a game with about twenty children where we asked them to stand in a line and then jump forward if they ate (a) a lot of salt, (b) a lot of chillies and (c) a lot of ice cream. The poorer children were the ones who ate the most salt and chillies. Some children told us that they thought too much salt is bad for health and it was even suggested that 'perhaps it causes diabetes'. But others told us that they have seen everyone eating a lot of salt so 'it can't be a bad thing' (Field Notes Central peri-urban). In the Central rural area, a family told us that eating salt is both good and bad; the iodine is good 'to help you see in the dark'. Others said that iodine is 'good for developing your brain' and 'prevents blindness' but they also know that high blood pressure is a possible result.

Iodised salt has been promoted to reduce the prevalence of iodine deficiency but its commercial promotion through billboard and TV advertisements. This campaign may be misleading and has encouraged many people to take more salt with or without food. Children are seen in all our study areas taking salt with fresh fruits like green mango, olive, papaya, jackfruit and tamarind or even just eating salt on its own and snack vendors add large quantities of salt to most of the savoury snacks they offer for the day. A hawker said, '*students love snacks prepared with salt, chilli and spices like pickle, jhal-muri, chola bhaja. I can sell jhal-muri worth at least Tk. 300 per day in front of the school*'. Many of our families are also eating more red and green chilli with their rice. Other traditional spices have increased in price and many are now beyond the capacity of most study households. Many relate the increase in gastric problems with this increase in chilli consumption.

Smoking and substance abuse

A cigarette vendor in the Central urban slum told us that sales have increased '*it is the only recreation we have... it relaxes us.*' At Tk. 2.5 per cigarette, men here spend about Tk. 30 per day. Boys in the Central peri-urban area told us that smoking at school has increased and young men in the North slum take betel nut with tobacco regularly. Betel nut and pan consumption is also increasing by both men and women and is a much cheaper habit to sustain (Tk. 2 three or four times a day). One of our HHH heads in the Central slum spends all his earnings from veg-

etable selling on cigarettes, betel and tea and never brings any home. Another in the North peri-urban area said after he analysed his whole year accounts from the year before together with a team member, '*I never looked at my family accounts in this way. It has opened my eyes. I see how much I am spending on betel, but the problem is that I am addicted to it.*' But we only see campaign posters to highlight the health problems associated with cigarette and betel consumption tucked away in corridors in hospitals where they are not seen by the general public.

More serious drug use and addiction is quite high in the Central study area in particular. Inhabitants estimate that about 10% of households in the slum and the rural village have at least one addict in the family. Heroin addiction is a particular problem in the slum whereas ganja is more often used elsewhere. There is some recent alarm over the abuse of 'Tusca' (a patented cough medicine which induces drowsiness and 'a sense of wellbeing') by young people in the Central area. Illegal home-brewed alcohol is readily available in some areas, and foreign originated spirits circulate in the North slum.

This FHH boy in the Central slum has an ice cream everyday as well as snacks throughout the day.

Depression and stress

Last year we noted that many people in the slums and villages suffered stress and depression (see 2009 Report, p.29 and p.56). It seems to be increasing. People tell us stress can arise from financial worries (NGO debt is often cited), chronic health problems and from personal relationships. People blame mobile phones and increased overseas employment for a rise in extra- and pre-marital affairs. Work conditions too can be stressful, with street vendors often threatened by both local mustaan gangs and by police. This level of stress was well illustrated by a scrap dealer in the South slum who told us '*Everyday I walk several kilometres to a new place to visit new families, asking for scrap. It is hazardous, not because I may be dealing with harmful substances or pieces of metal, plastic and glass that can be dangerous but because of the mental pressure. I will offer a family Tk. 12 per kg for scrap, which is higher than the normal Tk. 10 they would get if they sell it on the market. But when I weigh the scrap I cheat the costumer: I claim that 5 kg is only 2 kg. Usually the customer accepts what I offer, in the belief they have done a good deal*'. The man explains this pressure how doing this makes him feel bad on a daily basis.

Last year we reported an apparent increase in suicide attempts, witnessing two (see 2009 Report, p.29) and another this year. Nurses suggest that these are mostly due to failed love affairs and are as often men

Shutki prepared with lots of chilli

as women. Nurses also pointed out a new trend of suicide attempts by older women when their children have left home. They say that Ramadan is a '*suicide season*', as increasingly family members fail to return home for observance of the festival together.

Sleeplessness

Road noise and disturbance from TVs and mobile phones late into the night mean that many of our study families get very little sleep. The time for going to bed is much later than it used to be and it is not unusual to be as late as midnight. Students study late into the night if there is electricity. But everyone still gets up early. Women in particular like to take baths in the cover of early morning darkness (although in the Central area there is a new trend this year to erect screens made of sacking around the bathing area. Some Government primary schools have introduced pre-school classes, but limited space means these start at 7am, causing students to wake before 6am. Bed bugs seem to have increased over the years of our visits, and many members of our families cough, suggesting mattresses riddled with dust mites and fungal spores. As beds are always shared there is constant disturbance throughout the night. Box 9 describes a typical night.

Box 9: Sleeplessness is a major problem

Mother went off to the factory early this morning saying she would see us this evening at the usual time of about 7pm. She did not come home and eventually a message came through that she had been asked to do overtime. Her children (aged 5, 7 and 9) did not want to go to bed until she came home. She arrived about 11 pm and only after some chatting did the three children go to bed. The eldest child coughed badly, keeping everyone from sleeping until well after midnight. I was then aware of a creature climbing over the bed. At first I assumed it was the family cat. A few minutes later there was a huge screech as baby chickens escaped. Torch lights were snapped on and the grandmother, mother and children leapt up to see what had disturbed the chickens and found a large mole/rat. It was about 1am before getting to sleep. Grandmother woke at 4.30 to start cooking and the eldest daughter (9 years) was up soon after to get ready to go to the Madrasah for Quran study before school. She had had about 3–4 hours sleep. Her teacher told us that she often falls asleep at school (Field Notes, Central peri-urban). The younger son of my HHH said, 'I am preparing for the SSC exam this year and I have to study until midnight but my study has become impossible because the neighbours enjoy songs throughout the evening. I protested many times but they did not listen.' Quarrelling among neighbours using slang languages loudly and beating is very common here and keeps people awake (Field notes, North urban).

Main Findings in Primary Education

1. The new Primary Education Terminal Examination- emerging issues

2009 was the first year that the Department of Education held nationwide compulsory public examinations for the completion of primary school. Last year we visited our study areas in the last few weeks leading up to the examination in November and reported that it had had a significant impact not only on Class 5 students but primary education as a whole imbuing a sense of 'seriousness' and 'commitment' among students and teachers alike not seen in previous years (see 2009 Report, p.76–80). We observed students doing homework for the first time and teachers giving coaching to all students rather than the selected few scholarship potential students as in the past. The initiative was seen as more fair and corruption free. The pass rate for the 2009 Primary Education Terminal Examination turned out to be 88.8%, and was publicly heralded as a great success.[6] This year teachers in all study areas expressed their relief that their students had done well and all schools had achieved very high pass rates. In the South study areas, in particular, the teachers were very positive about the impact of the exam saying it had improved quality, reduced corruption and enhanced parental interest.

The general impression among students, teachers and private tutors was that the 2009 exam was very easy. Teachers at a RNGPS in the Central rural area said that the exam was intentionally 'very easy so people would not be worried' and students said it '*very, very easy… much easier than we expected*'. The Principal of a private school in the Central peri-urban area said that they had been worried about weaker students, but '*everyone found the exam easy*' as all the questions were what they expected and all came directly from the text book so it only required memorisation. He continued, '*the Government's primary aim was to ensure the highest number passed… so we now feel the tension we felt last year has gone*'.

But some teachers felt the standard was too low: '*We are constantly under pressure from above. We have to show a percentage (pass). So it does not matter that the standard is going down. It is the percentage pass that matters*'. A Principal reported '*I always try to arrange serial numbers so a good student will sit next to a bad student so that bad students would get some help and both will pass. Unfortunately some bad students were put in another room for the exam so they could not get the support from good students*'. And in the Central urban area, teachers said the exam held at a local high school was '*well organised*' but they nevertheless '*told students to help each other where possible*' (during the exam). A parent of a child in Class 4 (north peri urban) told us '*Everything still remains the same. I do not see any improvement at all in the quality of education.*

6 It was actually lower, but a 6% grace mark was added to all papers as 'as this was the first time the exams were held' Government Department of Education website (www.moedu.gov.bd, accessed June 17, 2011).

Students are memorizing lessons, not learning. They neither can read Bangla well nor can calculate a simple addition or subtraction. What is the benefit of this public exam other than admission to the next class and scholarship for the meritorious students?'

The '*results from public exams reflect on our prestige*' is typical of teachers' comments, in this case by a GPS teacher in the North urban study area. The performance of teachers and schools is now firmly linked to pass rates and the numbers of children securing scholarships. '*This is a question of survival for us. We may be excluded from the list of Monthly Pay Order if our students are unsuccessful*' (teacher, North rural). The scholarship and talent pool numbers once more become the distinguishing performance factor as pass rates are so high. This has led to a resumption of the old practice of grooming the best scholarships potential students in special coaching classes, a practice which stopped in the first year of this new exam.

Another concern is the emerging practice of refusing re-admission to students who fail the terminal exam the first time even though Department of Education policy stipulates that they should be allowed to take the exam three times. One GPS Principal told us, '*I gave transfer certificates to two students who did not pass in the last public exam. I am sure they will not pass this year also. Then why should I take the risk of taking back such poor students?*' In the Central peri-urban study area an old school has re-opened and is taking all the children excluded from the GPS because the teachers there fear they are failing. In a RNGPS in the Central urban area half of the students failed the model test held in October and the Principal has threatened their parents in a public meeting that those who have failed all six subjects will be barred from taking the exam this year saying, '*if you insist that they take the exam then we will not re-admit them next year if they fail*'. Several shared with us their concerns about students who fail as nobody wants them to tarnish their pass rates. One private school Principal said, '*so what will those who are refused re-admission do?*'. Teachers said they did not want older children back in the classroom who failed as they '*disrupt the class and larger numbers will be harder to teach*'.

Although we came across evidence of some failed students who have managed to bribe their admission to Class 6, there is growing concern that the exam will lead to higher drop out rates as children do not want to face the exam. As many as 1 in 6 dropped out before the exam in some of our study areas. Failing students said, '*the public exam is good for the good students but not for us – because if we fail twice we have to stop our education forever*'. And a teacher at a RNGPS in the Central rural area said, '*I might have told you this last year but I am very worried that more children will drop out. We have a big problem with the boys in particular because they feel they will fail and so drop out... before there were chances for children to go on with their education without the concern about having to pass an exam. This helps late developers. Now they will stop before the exam. Others will take the exam and not bother to go on any further.*'

The nature of the exam with simple multiple choice answers, direct quotes from textbooks and no expectation of applying knowledge has led to a stronger reliance on unofficial exam question guidebooks. These add another cost burden for parents and, according to some parents and some teachers, repress creativity. For example, 95% of the

Class 5 students in one GPS school in the North peri-urban area have guidebooks which their teachers say encourages '*memorization without understanding*'. Students said '*we use the guide book to get ready-made answers. It is easier than reading whole text books. But we cannot answer exam questions that are not in the guidebook.*' (North peri-urban). A teacher, also concerned by the reliance on memorizing answers, said '*Anyone can memorise. How do we now distinguish between good and bad students?*' In some schools the students do not even bother with the text books at all and concentrate only on the guidebooks, copying and memorising throughout the school day. There is strong market competition for guidebook sales. Teachers are remunerated for endorsing them and sometimes their names are printed inside the book itself. The guidebooks are available before the text book and some are printed incorporating the text book (now available online) in attempts to circumvent the ban on these unofficial publications.

The perception that private coaching is necessary to pass the exam is still prevalent. For example in the GPS in the North peri-urban area, 90% of Class 5 students have a private tutor. In the South urban area, students worry that they will not pass the exam if they do not have a private tutor. The provision of school based coaching has reduced this demand in some areas but, as mentioned above, the size of such classes does not allow for individual attention which private tutors can provide although some say '*we have enough guidebooks so don't need coaching*' (girl, Central peri-urban). Maths and English seem to be the subjects which children are most likely to fail. Much of the additional coaching being provided at schools concentrates on these two subjects. Whereas last year most of the school based coaching had become free of cost, fees are once more being charged. For example, all Class 5 students in the urban GPS in the South pay Tk.200 per month for coaching at school even if they do not attend. People object to this since private coaching is considered better because there are fewer students, yet the school makes this a mandatory charge. In another GPS school in the North urban area an ex-student has been recruited as a 'volunteer' teacher solely to coach Class 5 in the mornings. Although the school told us that they request parents to make contributions to the Tk. 1,500 monthly salary for this teacher, parents told us they are charged a compulsory Tk.100 per month. In other GPS schools optional private coaching by teachers is being given before school starts at varying rates of Tk. 100–200 per month.

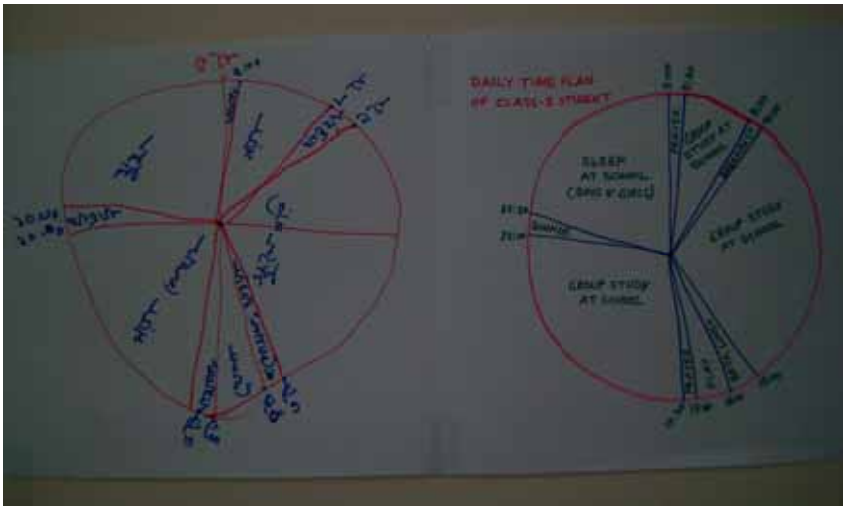
The focus on passing Class 5 exam has impacted on the teaching throughout the school. Although timetables indicate that there are supposed to be periods for sport and arts and culture, these are rarely undertaken. Children attending GPS in different classes told us that they '*never do anything but the six core subjects... and mostly maths, English and Bangla*'. Our observations sitting in the back of classrooms confirmed this. In the BRAC cohort schools we noticed how the play, cultural and interactive elements of teaching which had distinguished them in the past have gone and been replaced by recitation all day of passages from the text and guidebooks. Their only advantage over the GPS now seems to be the relatively small size of the class and the attention of one teacher for the entire four years (assuming no teacher turnover, which we see as an increasing trend because of perceived poor remuneration).

Bedding piled up in the back of the class room ready for staying overnight at the school

The concentration by teachers on Class 5 leaves other classes unsupervised and leads to long eight hour school days for these students (with additional coaching on top). In the most extreme example, the only teacher in the school in the North rural study area leaves all the other classes to get on by themselves while he concentrates on the Class 5 students. He said '*I enter into one class and tell the students to read from a book out loud and then go to another class and tell them to do maths and tell students of another class to read out loud. From the sounds I know that they are doing this, then I spend time with Class 5. All the time I am running from one class to other. I am now tired and I may not be able to continue if no new teacher is recruited soon.*' This year these children are even required to stay at school overnight so that the teacher can maximise coaching time (see Box 10).

Box 10: As an example of extreme concern over pass rates one school requires round the clock study

The chart made with students of Class 5 indicates that they start classes at 6:00 am after waking up and continue until 8:00 am. They go home to take breakfast and come-back for the class at 9:00 am which continues up to 3:00 pm without any break. They get one hour to go back home, take bath and lunch. At 4:00 pm they come back to school to play games for an hour in the school premises. At 5:00 pm they get half an hour for evening prayer and resume study at 5:30 pm which continues until 10:00 pm. They go to bed at 10:30 pm after dinner. These students of Class 5 are basically confined day and night within the four walls of the school to prepare for the public exam (Field Notes, North rural).



Class 5 from this North rural school made time charts to demonstrate how much time they spent studying

Rumours continue of misconduct in relation to the administration of the exam (see 2009 Report, p.80). Teachers and parents are unsure whether the present marking system is fair and would prefer if the marking was done at upazila level by independent markers rather than those chosen from primary schools by the UEO. There was gossip in the North study area that a syndicate had been formed to ensure high pass rates. The allocation of scholarships as a finite quota per union is regarded as unfair and de-motivating for good students. All students are supposed to receive their mark sheets but this does not appear to have happened and some private schools have not yet received the certificates as this seems to require a bribe. The Principal of one such school went to the Education Department on the day of our visit to try to get them but he said, '*the authorities know I will not pay a bribe … so I don't know if I will be successful*'. One boy (North urban) who was regarded as a good student of maths failed and could not explain why. In administer-

ing an exam on such a large scale errors in marking are to be expected but neither the boy or the school knew how to challenge this result.

2. Impact of teacher training on quality of education

Considerable resources under PEDP2 have been channelled into teacher training. All primary school teachers are now required to have Certificate in Education qualifications without which their salary will be frozen and increments and promotion denied. For the first time we visited two of the fifty four Primary Teacher Institutions (PTI) in the country where many of the teachers in our study schools have completed their nine month training programmes: one in the North study area and one in the Central study area. The PTI in the Central study area is depressing and dark and we observed 'chalk and talk' style training, even though the subject was physical education training. We spoke to instructors who were open and frank, who admit to being very de-motivated and '*waiting to retire*'. The curriculum, they say, is old and not relevant to the current demands of teaching. Although the curriculum has been revised in recent years (and the one we obtained was from 2001) they said *'there is nothing new- it is the same it has been for the last 25 years. They imply there are differences by using different language but nothing has really changed.*' One instructor described the training offered at the PTI as '*a house with a hole in the roof, broken windows and doors – so nothing is kept inside*'.

The current push for certification of all teachers has, they said, turned the PTI into nothing more than a 'certificate machine'. When the drive to get teachers qualified started, early batches were, they said, '*at least motivated – they had been teachers and wanted to stay in this profession; they were committed to education*' but recent batches comprise young graduates '*who have never taught and are just looking for better employment... many will not stay in teaching*'. These students were described as '*hopeless*'. The instructors said all the students were just coming for certificates and '*can't apply what they learn and don't want to apply what they have learned*'. (see also reported conversation with trainee teacher below). Instructors at the PTI in the North study area said, '*The PTI is merely giving certificates for the teachers mainly to upgrade their salary scale. It is not a place of inspiration and model for others because the teachers do not get any appreciation for better performance. Overall impact of the Certificate in Education? It is a waste of time for the teachers*'.

At both the PTIs there was a shortage of instructors, with only five out of nine present at the one in the North study area. They were clearly stretched, catering to two batches of 200 students per batch per year. Students and ex-students complained that the instructors were mostly '*elderly and out of touch*' and '*do not go into the classroom themselves to see the problems we face these days' and 'have little practical experience*'. The shortage of instructors means that the three month teaching practice component of the course is very poorly supervised. In the North many students go into the same class for teaching practice and some never get a chance of actually teaching. In the Central study area instructors initially told us that each trainee teacher gets visited by a supervisor every other day during their teaching practice however they agreed that this is impossible for 10 instructors covering 167 students particularly as they are also required to continue teaching the second batch of students.

Both PTIs have an Experimental School on campus. The instruc-

tors in the Central study area PTI explained that this was where PTI students could observe teaching. As far as we could ascertain there was no research or 'experimentation' actually going on here – what it seemed to be was an 'experiential school' (somewhere where PTI students could experience the school setting). The class rooms were bare with no teaching/learning resources. The toilets smelled bad. The only difference we could observe between this and the schools outside is that the student numbers were quite low (about 25 per class). Teachers have said to us in the past that they have not been able to implement what they have learned from the PTI because the situation is very different in the 'real world' where they do not have resources. But there were no resources in this school. In the PTI in the North study area, the shortage of staff has meant that assistant teachers from local primary schools have been drafted into taking classes in the experimental school and are not regarded as competent as the staff of the PTI. According to ex-students we spoke to the children in here '*are mostly from better off well educated families*'.

Box 11: Conversation with a trainee teacher at the gate of PTI

This trainee teacher was waiting at the gate to be picked-up to go home. She has an Honours Masters degree and as a new teacher is currently on the C in Ed course

Me:	What attracted you to this job?
She:	Well, it's a good job with plenty of vacations and less work load. Good opportunity to take care of my family. Also some members of my in-laws family are teachers – as such I get support from them.
Me:	OK, anything else?
She:	It's close to my home and salary is not bad.
Me:	How long is this training? How will it benefit you?
She:	Its more than 10 months. No, there will not be any change in teaching at school when I go back.
Me:	Why no change?
She:	It's hard work to implement in a meaningful way, who will do that? And why should they? It's a Government job, you are not paid for the extra effort – salary will remain same with or without extra effort and hard work. Why bother?
Me:	So what is the benefit of this training?
She:	But its beneficial for me – I will get a certificate.
Me:	Oh yes. Thanks for the chat, bye.

As in previous years, we observed no actual impact on the quality of teaching in the classroom as a result of this training and children concur that their teachers do not do anything differently except, as we noted last year, they may '*laugh more*' (2009 Report, p.86). Teachers are always more ready to talk about their salary pay scales and terms and conditions with us than their teaching approach or style. Reviewing the PTI curriculum and the weighting of marks confirmed what teachers had told us before that only 8% of marks are awarded for the theory related to attitude, behaviour and teaching methods elements of the course (the bulk of marks are for administration and subject content knowledge). And when asked why they do not try to implement more of what they have learned, teachers always say there is no time, the classes are too big and there are no resources.

Over the years we have also seen that any initial enthusiasm among trainees is squashed by fellow teachers and a culture in which there is general reluctance to do anything but the minimum (as the conversation in Box 11 with the trainee reveals so frankly). However, the Princi-

pal of the Mission School in the South rural study area puts this in perspective when he said that quality changes only come about if the teachers have the right attitudes, are well supervised and provided incentives. Children tell us that most of their teachers are '*lazy and don't want to teach', 'spend time on their phones in class', 'gossip with other teachers', 'are late', 'absent', 'sit in their chairs and don't move around the class', 'don't listen to students' and 'ask us to run errands'* which suggest that inappropriate attitudes are the main problem. In the South urban area, GPS students sum up their teachers' attitude with the term '*kamchora*' meaning that they are always trying to avoid doing any work.

This year we spent considerable time sitting in the back of various primary classes to observe for ourselves what the culture of the classroom was like. These teachers already know us well, and we explained that we were following the children from the families we stay with and encouraged the teachers to ignore us. Our observations show that there is very little difference between teaching in government, RNGPS and private schools except class size.

One of the catch-phrases promoted as an important outcome of the C in Ed training is the idea of 'joyful learning'. However, it is not clear what the teachers understand by this concept. It is often simply reduced to singing a song or clapping the beat of a rhyme. Box 12 presents some of the teacher answers to the question 'what is joyful learning?' A teacher in the South peri-urban study area told us '*Out of three teachers, the headmaster is always out of school so only the two teachers left take the full load to manage 5 classes. Then how can we practice joyful learning? It takes more time than the normal teaching we usually practice.*'

Box 12: What do teachers think is joyful learning?

The teacher explained that they try to apply joyful teaching in spite of limitations. He volunteered to demonstrate this and, on entering a classroom, started reciting a rhyme, clapping his hands and asking the students to copy him. The teacher finished the rhyme and clapping, and said to me, 'This is the style of joyful learning that we practice!' After further discussions, we got the firm impression that the concept of 'joyful learning' was not well understood at all and was not perceived as the creative use of new techniques (Field Notes, GPS, South peri-urban).

We asked teachers in our village what 'joyful learning' was and they said it was doing things which attracted interest like telling a joke, getting children to clap, or asking them to come up to the chalk board. One teacher who regularly gets requests to demonstrate to PTI students as a model teacher gave an example; 'You see at the beginning of the class I get something such as this bunch of bananas and hide them under a folded newspaper. The children are eager to know what is under the newspaper. This creates a lot of interest. So at the end of the lesson I reveal the bananas and the children are very excited'. Asked if the bananas are then used to demonstrate something or shared, the teacher said 'Oh no, it is just to create excitement' (Field Notes,RNGPS, Central rural).

Previous reports have highlighted teacher suggestions for improvement to the Certificate in Education training which include making it shorter, more practical, more focused on the functional needs of students and more engaging (2008 Report, p.78–79, 2009 Report, p.85–86). They rarely get an opportunity to share this kind of feedback with the authorities and where they have, they are frustrated by the lack of response. They feel that the Government is only concerned with the quantitative aspects of churning out 'trained teachers'. Teachers in the North peri-urban study area told us that '*we shared our difficulties to apply learning from the C in Ed training in schools with the UEO and raised these issues*

several times in the Upazila coordination meetings, but we did not observe any changes yet in the C in Ed training'. They recommended that the training should be modular so as not to disrupt schools by creating shortages of teachers. They also felt that time between the modules would allow teachers to internalise what they have learnt and apply it within their schools.

Although the conversation in Box 13 is actually with a student who had just taken the Class 8 public exam rather than primary, it nevertheless illustrates the current emphasis on memorizing facts rather than understanding them, a tendency that also permeates the primary system:

Box 13: Conversation with Class 8 student

Me:	How did the exam go today?
Girl:	'Very well – it was easy'
Me:	'Give me an example of a question you found easy'
Girl:	'We were asked to compare Nelson Mandela and Sheik Mujibur Rahman'. She then spouted a memorised passage in a sing song voice barely taking breath.
Me:	That sounds interesting – what do you know about Nelson Mandela. What country does he come from?
Girl:	India?
Me:	Is he alive today?
Girl:	No, I don't think so.
Me:	Do you know what the Nobel Prize is?
Girl:	No.

It turned out that the answer she had given had been taught them verbatim from a guidebook which the teacher had herself. Yet we understood that this question was supposed to have been one of the open unseen questions designed to test applied general knowledge rather than recall.

3. Complex school careers- how the statistics can mislead

We have made the point in previous reports that mostly families are very motivated to send their children to school and for them to do better than they themselves did at school. This is illustrated by a very poor family of seven in the North urban study area. They manage on the incomes of the father, who resells used syrup in the sweetmeat business and the eldest son, who provides private tuition, to support the education costs of the four children of school age. The total education costs amount to Tk. 27,570 per year which represents 51% of the combined incomes. Support in cash and kind is also provided by the grandfather and the mother's brother from time to time. The father said, '*Managing the cost of education is always difficult for me. My elder son manages his own costs (from coaching) and I have to pay for the other children. Even though it is a struggle just to ensure daily food, I do not want my children to be illiterate like me and do the same as I am doing for survival.*'

Families generally want to keep their children in full time education for as along as possible. More often than not it is the children who make the decision to leave school. This often happens because the children get bored, are lured by the excitement of a 'free life' loitering and playing with friends or are embarrassed to be older than most of the children in their class. This reason for dropping out is not picked up by the statistics. Many children, as Box 14 illustrates, spend many years in full time education but never complete primary because they are required to repeat years many times, start over again or temporarily drop out and then resume their education. Parents move them from school to school in attempts to inspire them and/or avoid negative peer pressure.

Table 5: School careers; late starters and many repeat years (Central peri-urban and rural)

Name	Age	No. of years in school	Level reached	No. of repeat years	Comments
Musa	14	7	4	3	Now a welding apprentice with good income potential
Aklima	12	8	4	4	Chasing stipends so changed school
Taslima	10	4	2	2	Chasing stipends so changed school
Kader	12	4	2	2	Erratic attendance led to beatings at school. Seeks job prospects abroad or in welding so not bothered by lack of schooling
Raihan	12	4	2	2	Not interested, prefers to play
Tanvir	13	9	4	5	Did not do well or like school, now enrolled with BRAC
Bithi	13	7	5	2	
Shakil	15	6	6	0	Started school late
Juel	16	6	5	0	Started school late
Sumi	13	7	2	5	Now at the Madrasa
Mahur	11	4	2	2	Dropped out for 2 years before resuming
Arif	14	8	4	4	Was failing in the GPS so moved to BRAC and started again
Ratna	13	7	4	3	Failing in one GPS so moved to start from scratch again
Maruf	14	8	4	4	
Sabina	11	6	4	2	
Marija	14	8	4	2	Dropped out and then resumed schooling

Repeating years leads to boredom, frustration and the high incidence of 'old for year' children whom teachers tell us they often find a problem to manage in the class.

The reasons for leaving school are sometimes recorded as 'the need for employment,' or 'marriage' which masks the fact that these children may be 15 or 16 years old and may have spent eight or more years in school but have failed to get past primary. As we have stated in the past, they are more likely to leave school because repeating years serves no further function and they feel embarrassed to mix with younger children than actually to get a job or be married. These actions happen later because parents are worried about having idle children at home. Another impact of the Class 5 terminal exam, which is already evident in the schools in our study areas, is that children are even more likely to be held back in Class 3 and 4 than in the past and this phenomenon of 'old for year' students will almost certainly increase. Table 5, which resulted from visualised discussions with groups of children, illustrates this well. 60% of these sample children had repeated years of school or were late starting school and were therefore 'old for year'.

Box 14: Old for year - a common issue

We have in previous reports reported the experiences of Naima, the youngest daughter in one of our FHH. When we first met her in 2007, she had just transferred from the Madrasa to GPS because of low quality of education in the former. During our second visit she remained an enthusiastic student of Class 2. Last year Naima had moved to stay with her older sister in Chittagong, with the plan to start school there. This did not happen as she spent time helping her sister with work instead. This year she was back with her parents, and having lost a whole year enrolled in her old GPS, this time in class 3 where she is older than all other students. Nevertheless, she seemed happy to be back in school (Field notes, South peri-urban).

The elder son of one of our host families first enrolled in the primary school at the age of eight. He failed Class 3 and 4 for two consecutive years. As a result he was 15 years old in Class 5, while his other classmates were only ten. The age difference with the classmates made him embarrassed. He left school without completing Class 5. He explained, 'I was not feeling at ease to play with the junior classmates. Also they were doing better in the class and exam results. I could not give the correct answers to questions asked by the teacher in class. Others can memorize quickly what they learn. I couldn't follow the topics taught by the teacher. Teachers didn't pay any attention to me if I failed. Meanwhile, some of my older friends left school before completion of primary and engaged in earning and became role models. So I decided to leave too' (Field Notes, North rural).

There is every reason to doubt the official drop-out figures. We observed school registers being falsified in front of us, and depleted classes actually were more likely to be attended by high roll call students (i.e. the better ones). However, even with half the class missing, the classrooms are full and there is little incentive for teachers to actively encourage attendance which will result in bigger and unmanageable classes. In the South urban study area we encouraged two young GPS-going girls to help us with conducting an informal survey among their neighbouring families on school attendance, showing that out of 62 school-aged boys and girls 45 go to GPS, and 17 do not go to school. Some of those 17 had not ever enrolled with school. We found this figure surprisingly high considering that the GPS in the area maintains that enrolment and attendance is high (they estimated that 5–7% of students do not come to school). They say the reasons for non-attendance are working with family business, parents are careless, they have had no food in the morning, the students are mixing with children who are a bad influence, they have not received any tiffin money. A straw poll in the South peri-urban study area among parents indicated that they estimated that at least one third of students drop out, usually against the parents' wishes, and that this happens mostly because the students themselves do not want to go to school any more.

In previous reports, we highlighted how children win support for dropping out with 'acceptable excuses'. The following is just one example (but typical of many) of how the first answer given needs further triangulation before the true picture is revealed:

I asked the boy '*Aren't you going to the school today? Your exam is knocking at the door.*' He was quiet for sometime and then replied '*No. As my family has no money I could not purchase a guide book. That is why I am not going to school.*

I asked his mother about his regular absence from the school. She said '*The boy pretends to go to school in the morning but actually he goes out to play with his naughty friends who also do not go to school. Now, I have handed him over to my father to teach him to make herbal medicines'.*

In reply to the same question, the boy's father said '*The teacher did not*

tell me yet which guidebook I have to purchase for my son. I am always ready to purchase the guidebook if I could know the name. That is why he could not attend school'.

I talked with the class teacher who told me, '*The boy was attending school regularly but suddenly he disappeared without notice. We requested his father to send him to school regularly but he did not do it'.*

Finally, I talked with the boy again and asked him about his friends, his future vision and the reasons for not attending school. Eventually he said, '*I do not understand what teachers discuss in the class. Teachers never give me attention or make the lesson clear as I am not a good student. I have no guide book to prepare for the exam and I do not get a chance to play in the afternoon due to extra classes. So, I finally decided to leave school. Now I am getting lots of time to play with my friends when I get time off from learning herbal medicine preparation with my grand father'.* The boy finally agreed that his earlier statement of economic hardship was not true. He said it only as an easy excuse.

4. Pre-schooling – new directive, but under-resourced

The Government plans to introduce universal pre-primary education from January 2011 but encouraged schools to start this initiative as soon as possible. The one year course is presented as 'playing in a joyous environment' which will 'help to reduce school phobia among children… which is the reason behind dropout[7]. These classes are supposed to be run by specially recruited teachers. Several of the GPS in our study areas have indeed started pre-school classes this year. This means that some BRAC feeder schools have closed. In all cases the schools are experiencing a shortage of space with the pre-school having to be held together with Class 1 (South peri-urban), on the verandah (North urban) early in the morning before other classes (Central uban) or with restricted numbers (North peri-urban). Only two teachers had received the 7 day training at their respective upazila resource centres but others have not and no specially recruited teachers were in evidence. Rather, Class 1 teachers are taking these pre-school classes in addition to their current workload. One RNGPS (Central urban) had taken its own initiative and has hired a 'guest' teacher and is passing the cost onto the students who each pay Tk. 10 per month.

Many of the classes have more than twice the recommended 30 in a class (in one school an admission exam had been administered to keep the numbers down but still 78 were admitted) and classes last between an hour and two hours. The head of a private school in the Central peri-urban study area welcomed this initiative saying '*at least something is better than nothing*' but was concerned that the current GPS teachers were trying to teach this age group with neither appropriate training nor the right attitudes. Our observations of pre-school classes saw no difference in the way these were conducted from conventional Class 1. Children wore uniforms, sat at desks and learnt by rote. The Principal of the GPS in the North urban study area said, '*we have just followed government instructions to open Choto 1 but we do not have enough space. No books are supplied by the government for this class. Students come at 9:30 am and stay up to 10:30 am. We do not have enough teachers to conduct this class. So the students come and scream and that disturbs other classes. Parents have no idea about this class. They just send their children to develop a habit of attending school.*'

7 Daily Star, 27 August 2010.

5. School Costs and increasing support for school based feeding programme to replace stipends

The following table (Table 6) shows the annual costs for GPS students of Class 3 obtained from talking with a number of students and their parents in the different study locations. The costs, excluding coaching fees, add up to between Tk. 1,200–2,400 per year. Tiffin costs have been included since these have become over the years non-negotiable costs with children refusing to go to school without this pocket money. An exception can be seen in the North rural study area where families say they cannot afford this expense, there are no snacks sold at the school and no peer pressure to demand tiffin money.

Table 6: Education costs for children in Class 3, GPS

Cost	SPU	SR	NU	NU	NPU	NPU
Uniform	550	None	150	150	150	150
Stationery	345	Spon-sored	220	360	430	285
Exam fees	60	90	45	45	45	45
Guidebook	150		50		175	
Contributions	40	15			5	5
Tiffin		300	1,100	2,200	1,100	1,100
Total (Taka)	**1,145**	**405**	**1,565**	**2,755**	**1,905**	**1,585**

Cost	NR	NR	NR	CPU	CPU	CR
Uniform	200		200	50	100	250
Stationery	90	95	85	950	350	1,600
Exam fees	45	45	45	300	90	90
Guidebook	200		200			
Contributions				30		30
Tiffin				1,100	1,600	2,200
Total (Taka)	**535**	**140**	**530**	**2,430**	**2,140**	**4,170**

Costs have increased considerably since 2007 due to guidebooks and tiffin. Increasingly we have heard that children go to school with little breakfast – this is sometimes because it is not ready in time or because they have little time as they have to fit in Arabic classes before school or because there is not enough food for more than two meals per day. This does not always tally with the fact that children pressure their parents for snacks and snack money. However, whatever the reason many children are hungry at school. The increasingly long school days delay the taking of lunch sometimes until 4 or 5pm. Last year we noted a growing interest in school based feeding programmes. The comments of the Principal in the North urban area is typical when he indicated that a feeding programme would be very welcome at his school as '*children are very hungry*'. He thinks that biscuits or eggs at tiffin time would be appropriate and boiled eggs could be supplied easily by a local supplier. There is concern that this provision should be for all students and a general willingness in most communities to support this by supplying and cooking food although many teachers retain reservations as they fear it might entail further workload for them.

6. What do people make of the idea of Primary School Student Councils?

The Government has plans to introduce School Student Councils at primary level 'to infuse democratic norms in student's minds'. The Council will comprise seven members elected by Class 3 to 5 students for a one year tenure. Their duties are envisaged to include 'preservation of the environment, ensuring midday meals, health, sports, cultural activities, water management and entertainment'[8]. No student councils have been introduced in any primary school in our study areas but we did ask people what they thought of the plans. In the Central urban area, the RNGPS Principal told us that he had not heard of any plans to start Student Councils in primary schools but thought it might be a good idea if it promotes leadership and they can organise games and competitions. He was worried that it might become politicised. Teachers from the GPS in the same area had mixed opinions of the School Council although one who is very active in the Teachers Union thought it would be '*an excellent idea as it would encourage leadership skills*'. She thought it was good that they could evaluate teachers although she added, '*they will always want ones who don't punish*'. But others were not very keen on the idea that they might interview teachers or raise complaints. The principal of a private school in Central peri-urban said it was a very good idea as it would '*contribute to building relationships between students and would have a good impact on society*'. Another private school principal is completely against it as he feels that is bound to become political as it has in colleges and universities. Teachers, he feels, currently have authority but it would be eroded if the student council became too strong. '*Bhalo patree, bhalo khaber runna kora jai' (Without a clean bowl you cannot put in clean food).* Other GPS teachers had not heard about the possibility of student councils but thought it might be a good idea. One young teacher (a recent Certificate in Education graduate) said that '*it would be good for students to hear the views of others and tell the teachers*' and felt that this was consistent with the rights of the child. Teachers in the North peri-urban area felt that it would inevitably become politicised and promote further indiscipline whereas the Principal in the North rural RNGPS thought the students might do a better job than the SMC or SLIP committees.

8 New Age, 10 June, 2010

Conclusions

The Reality Check Approach and Sida's PNTA

Each year, the RCA aims to connect its findings with the broader framework of Swedish development policy. The Swedish Policy for Global Development (PGD) and the Sida Perspectives on Poverty[9] place at their centre the idea that poor people's perspectives on development should be privileged, and that a rights-based perspective informs all development assistance. These two perspectives are underpinned by a further four principles: Participation, Non-discrimination, Transparency and Accountability (PNTA).

The team found that there is a need to promote stronger citizen participation within both programmes. At present, we find that little opportunity for people to influence the nature of public services in either health or education. There are several mechanisms available for doing more on this, such as through the Citizen Charter initiative or creating watchdog committees at some health facilities, through establishing primary school student councils, or through reviving the parent teacher association system, each of which could help to inform service providers of problems and if necessary to place pressure on locally elected representatives at Union Council level. The key challenge faced by both the education and health reform efforts is to harness citizens' energy more effectively to create demand-led service reform.

The issue of non-discrimination remains an important priority. Initiatives such as school feeding programmes may contribute to challenging the forces of social exclusion that keep the poorest out of school, yet discrimination remains prevalent because of an exclusionary institutional culture in public institutions such as hospitals. Study participants report unpleasant behaviour by medical professionals as a key reason for preferring private providers

This year's report highlights some major concerns about transparency issues. In particular, the new primary school Terminal Examination had the potential to improve student experience by introducing a standardised, fairer, single assessment procedure to all types of school. However, in practice, we found that it had the effect of narrowing educational experience.

The current situation for many of our families was one characterised by increasing economic hardship in the form of higher food prices and concerns about the deteriorating political situation. At the same time, the study teams found a growing level of trust and confidence in this fourth year of our field work among our households to speak their mind about the realities that they face.

The issue of accountability is critical. Most people retain a strong desire to access both education and health services as best they can.

9 Sida (2006) Current thinking on the two perspectives of the PGD, Development for Policy and Methodology, POM Working paper 2006: 4.

People show a remarkable level of motivation and ingenuity in trying to make the best of their difficult situations. They are constantly engaged in strategic choice-making and in trying to manage difficult trade-offs. These efforts are often undermined by low levels of institutional accountability, and by service providers who frequently lack motivation, leading to sub-optimal use of resources. Neither health nor education providers are effectively regulated, particularly in the private and non-governmental sectors. This is an important problem for people living in poverty, who tend to try to combine services from many types of providers without clear information. The newly introduced Right to Information Act (2010) offers potential to redress this and the fifth Reality Check (2011) plans to include an assessment of the impact of this initiative.

We have further addressed the issue of accountability this year in relation to the Reality Check Approach itself. Policy makers have found our earlier reports informative, for example, we are told that the World Bank in Dhaka now issues a copy of the Reality Check Report to each of its visiting consultants. However, this year policy makers have asked us to provide more in the form of concrete recommendations that might be fed into ongoing health and education sector design and planning processes in Bangladesh. We have complied with this request in this final chapter and hope that this report will provide information in a form that may allow informative dialogue on policy and planning.

Health conclusions

People living in poverty tell us that they usually cannot afford the health care services made available to them by either private or public providers. Yet we argue there is good potential to put more emphasis on simpler, more affordable basic alternatives.

Pressures of economic hardship and a lack of basic public health messages means that poorer people are increasingly falling back on unhealthy survival strategies, such as the increasing use of salt and hot chillies in their food that appears to be reaching unsafe levels.

Our observations show that many mid-level government health facilities (UPHs, FWCs, MCWC) appear to be in decline. Despite being heavily subsidised, they seem to offer few useful services, and they rarely turn out to be people's providers of choice. Doctors tend to over-prescribe medicines and they over-use costly diagnostic tests, such as ultrasound.

People tell us, and our observations confirm this, that local Community Clinics do not currently function properly. Yet these clinics do hold great potential as a resource for people living in poverty, if a more locally-appropriate mix of services is provided.

Traditional birth attendants continue to do a good job with limited skills and resources, drawing on strong local community knowledge and high levels of social trust. There continue to be problems with the acceptance and use of 'skilled birth attendants' in the community partly because the programme does not build effectively on existing knowledge and roles.

Policy implications – health

1. We suggest that given the current preparation phase, now might be a good time to review, and if necessary rationalise, the role of mid-

level health facilities in the public system. It would be worth considering the closure of some under-performing facilities by the authorities, and re-allocating resources.

2. Policy makers may also reconsider the role of the Community Clinics, many of which seem to be under-performing. These could be restructured to put more emphasis on providing basic services such as monitoring long term conditions (e.g. hypertension, diabetes, asthma), giving basic health advice on diet and lifestyle and following up patients released from hospital (e.g. re-dressing wounds, monitoring medication).
3. There is a priority to ensure that these Clinics have simple basic equipment and running water, and that safeguards are put in place to ensure that staff are recruited using objective skill-based criteria, rather than political ones.
4. Our experiences suggest an urgent need to develop new, simple, targeted, public health messages to address the many new lifestyle issues (such as increased snacking among children and enhanced salt intake) that may have profound health implications for people living in poverty. This could be done cheaply and cost-effectively.
5. We recommend exploring ways to build upon and enhance the skills of traditional birth attendants (TBAs), whose high levels of community level acceptance remains an important asset. Progress towards MDG-5 will require that both TBAs and SBAs are equipped to identify complications in pregnancy more effectively.
6. We observe, and people report, that professional cultures of medical care remain in many cases unhelpfully rigid and status conscious. We suggest that ways should be found to encourage doctors (and other personnel) to develop their 'people skills' further, as well as spending more time and communicate better with patients in order to establish their life histories and make more physical examinations. There should also be less use made of unnecessary diagnostic tests.

Education conclusions

The new primary school Terminal Examination introduced last year has succeeded in providing a standardised and more transparent test for primary school leavers than existed previously. However, early promise is now being undermined by its effect of narrowing the teaching content, generating an excessive emphasis on simple memorization, and creating new incentives for schools not to re-admit students who fail.

While the recent investment in teacher training is welcomed in principle, we observed two important problems. The first is that there is still a lack of relevance in the PTI curriculum, which fails to give teachers the skills to engage and interest students. The second is that the way the Terminal Exam is used risks harming the quality of education by its excessive focus on performance issues at the expense of wider educational goals.

Taking the current reality into account, we suggest that the teaching training curriculum should be revised to include more guidance and practical skills to help teachers (i) to deal with overcrowded classrooms in more imaginative ways, (ii) to engage pupils of all abilities within a classroom, (iii) to work with slow learners, and (iv) to engage the interest

of boys more effectively. Effort also needs to be made to progress children through school so that they reach an attainment level that is concomitant to the number of years spent in school.

We recognise that many schools have a shortage of teachers, and we suggest that alternative ways might be explored to provide better teaching to children with remedial and special needs who get left behind in the present system. These might include exploring the use of community teachers, local volunteer classroom assistants, and forms of peer support. There may also be a role for involving Parent Teacher Associations in these efforts.

Parents continue to use complex strategies to encourage their children to stay in education. For example, children may attend several different primary level schools in succession and repeat years. There are two consequences from this: (i) low attainment levels for the number of years of education, and (ii) complex school 'careers' are hard to track and produce statistics about school drop-out that may be misleading.

Education costs have risen steadily in recent years, with informal school costs and additional costs of coaching becoming more commonplace. An additional pressure is created by the increasing ubiquity of 'exam guidebooks' and increased demands by children for 'tiffin money' within a growing consumer culture. We continue to observe a preference among our households for school-based feeding programmes. The government's Stipend Programme is not much of an incentive for children to go to school, because parents are already motivated.

Pre-school is gradually being introduced into government primary schools and is universal from January 2011. Observation of early experience with this is not particularly encouraging, but this could be improved if adequate resources are deployed in support.

Policy implications – education

1. We recommend that attention is given to revising the primary school Terminal Exam so that it can better test children's functional and applied skills. We suggest it should be a means to assess outcomes in line with the stated policy of 'joyful learning'.
2. We suggest that the teacher training curriculum is comprehensively revised to bring instructors more in touch with classroom realities. In particular, teachers need to be able to deal with overcrowded classrooms in imaginative ways, engage all abilities (including work with slow learners) and win the interest of boys in particular. Expert teachers may be recruited to provide mentoring support to teachers.
3. It should be possible to explore alternative ways to provide remedial and special needs education using local volunteers, community teachers and peer support. Building wider community involvement in local education would also help create support for making the longstanding but largely dormant parent teacher association system operate. This might also link with the recent Citizen Charter initiative that has remained largely unimplemented.
4. There seems to be strong support for the replacement of the school Stipend Programme wherever possible with a system of school-based feeding. These feeding programmes could be managed by different types of local providers, depending on local context.

Annex 1: Host Households Changes

Annex 1: Host households; Changes 2007–2010					
Central					
Urban		**2007**	**2008**	**2009**	**2010**
HHH1	One room own house, 4-7adults have lived here over the years. Old man sell vegetables, wife sells pitha	→	↗	→	→
HHH2	One room rented house, father is rickshaw puller, wife no longer works because of ill health	→	↗	→	↘ (debt due to illness of the wife)
HHH3	One room rented house, father now supplies ice cream. 4 children now aged 4-12 years	→	↗	↗ (better job)	↗ (better house)
Peri-urban					
HHH1	One room own house, father is rickshaw puller, mother is a garment factory worker, 3 children under 8 years	→	↘ (debts)	↘ (redundancy)	↗ (re-employment, paid off debts)
HHH2	One room house, widow lives with her separated daughter and granddaughter, earn from their milking cow	→	↗	↘ (cow not giving milk)	→ (cows sold in Eid-ul-Azha)
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. Two other sons, who do not live here, but contribute to family work in garments factory	→	↗	↗ (working sons send home money)	↗ (working sons continue to support, better harvest, paid off loans)
HHH2	Two houses; one with elderly widow, other her daughter, her husband. Their daughter got married this year and moved out. Father started working in wholesale banana business, but has gone back to previous job as caretaker in a Madrasha	→	↗	↗ (new business)	→ (left business, joined the previous job)
HHH3	One room house ;first wife lives here on her own with two sons	→	↘ (debts)	→	→

North					
Urban		**2007**	**2008**	**2009**	**2010**
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)	↘ (roof is leaking after the monsoon)
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)	↘ (stopped saving money, elder son has resigned)
HHH3	One room house. 1 son and 3 daughters. Father had a stroke and had to stop working. He died in 2010 after unsuccessful treatment, which indebted the family. Wife has invested in a small shop with NGO loans, one daughter earns through private tuition, son takes casual work, 2 other daughters are studying.	→	↗ (father got new job, daughter got job away)	↘ (daughter lost job and moved back, father ill, debt)	↘ (debt for treatment father, father died in 2010)
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)	↘ (father had no work, son resigned from job after not getting paid)
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)	↘ (van is out of order, wife stung by wild bees, incurred debts for treatment)
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 took on road construction work again, but is now without a job.	→	↘ (lost crops in flood, father injured. Business collapse)	↗ (better crop, work and elder son now working)	↘ (lost crops in flood, cows and drowned, father has no job)
HHH2	Three room house accommodating two brothers and their families and their parents. One brother is farmer/ labourer, other is Madrasha teacher.	→	↗	→	→ (moved house)
HHH3	One room house. Parents and 5 children. Father works as agricultural labourer and quarry labourer.	→	→	↗ (debts settled, purchase milking cows)	↘ (lost crops in flood, cow died)

South					
Urban		**2007**	**2008**	**2009**	**2010**
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)	↗ (son is back on track, and oldest daughter has resolved marital issues)
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)	↘ (ill health, financial difficulties)
HHH3	Brick house. Father, mother and three children aged 5–11. Father sells meat.	→	↘ (medical expenses)	↗ (planning to move out of the slum)	(the family has moved from this slum to another slum-area)
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)	↗	→ (large NGO loans to set up business, slight set-back with tornado ruining part of 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)	↘ (little income, survives on credit)
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)	↘ (no work, illness)
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)	↘ (husband ill, costly medicines, cannot work regularly)
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)	↘ (took loan, income reduced)

Annex 2: List of people met during the course of the study

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

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 of the school entrance
- 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
- 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 Participa-

tion, 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 study participants 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- July 2003 to June 2011

Total Cost

Approved taka 94100 million, GOB (Dev 14000m + 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 30 June 2011

Total Cost

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

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
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
RCA	Reality Check Approach
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	Health worker
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
Thana	Literally 'police station'. Used to be a sub-district, now the term 'upazila' is used for this.
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, a sub-district. All the GoB services are channelled to the union from the Upazila.
Ward	Political constituency within a union. Nine wards in each union
Zila	Alternative name for District – an administrative unit

Currency exchange rates (January 2011):

Tk. 100 = USD1.41

Tk. 100 = SEK 9.67

Tk. 100 = GBP 0.91

Tk. 100 = EUR1.08

Source: www.xe.com

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 Shebikas* (health volunteers – see *Shastho Shebika* 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. In 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 2,000) 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 Tk. 100 per month for the first child and Tk. 25 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 in 2009, more than 1.83 million children in Class 5 took a common public exam for the first time 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 exam.

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 were established in areas where the dropout rate is very high because of extreme poverty. This project covers 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 4,000 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 Approach Study as well as team-leader for the Central sub-team and author of the Annual Reports. She has worked in development for more than 25 years with an interest in Bangladesh since 1986 which included 12 years actually living and working there. As an expert in participatory approaches, she has led a number of initiatives including the first ever participatory poverty assessment (PPA) in Bangladesh, a series of listening studies, the Views of the Poor study in Tanzania and contributes to Action Aid's immersion programme. She has also led Reality Check Approach Studies in Indonesia and Mozambique.

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. He was also engaged with the Reality Check on the Basic Education Programme of the Ministry of National Education, in Indonesia as group team leader funded by AusAID. Currently he is engaged with Food Security Programme of Canadian Foodgrains Bank and Maternal and Child Health programme of German Doctors in Bangladesh.

Malin Arvidson PhD (Sociology) 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 the 'Third Sector Research Centre at the University of Southampton, UK, researching aspects of social impact assessment of charities, and organisational change in third sector organisations.

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 25 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 providing consultancy services and currently the Deputy Team Leader of the Governance Improvement and Capacity Development (GICD) component of Urban Governance and Infrastructure Improvement project (UGIIP-2).

Nurjahan Begum MSc has been working as development researcher for the last 10 years and is currently working as a Freelance Consultant. 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 and Management Consultant.

The Reality Check Team in Action

Amir Hossain MSS, MBA has over 21 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 a European Union funded project named *Rural Employment Opportunity for Public Assets* implemented by UNDP-Bangladesh.

Syed Rukanuddin PhD is a professional in the field of Participatory Grassroots level Qualitative Research, Monitoring and Training with 28 years experience in the development sector. As Freelance Consultant, he has been involved in a number of participatory listening studies and has considerable knowledge of local government and rights issues. He is author of a number of books covering facilitation techniques, qualitative research tools, qualitative monitoring, group gradation and maturity assessment, etc. He was also engaged with the Reality Check on the Basic Education Programme of the Ministry of National Education, in Indonesia as group team leader funded 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 junior development professional who has been involved in a number of research studies and evaluations, involving qualitative and quantive data collection and analysis.

Shuchita Rahman BSS is a junior development professional who is currently studying for her Masters in Anthropology. She has been involved in a number of research studies and evaluations, involving qualitative and quantive data collection and analysis.

Hans Hedlund PhD is an associate professor in Social Anthropology and Senior Advisor to 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 Approach and has been managing development projects and NGO initiatives for over 15 years, including six years working with CBOs and NGOs in Bangladesh at grass roots level. Presently he is involved in various development projects, including a Reality Check study in Mozambique, funded by a range of international development agencies in the capacity of project director, manager and 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.
This increases the world's prosperity.

Reality Check Bangladesh – Year 4

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 Approach 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 fourth year of the Reality Check Approach as well as implications for policy development.

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Address: SE-105 25 Stockholm, Sweden.
Visiting address: Valhallavägen 199.
Phone: +46 (0)8-698 50 00. Fax: +46 (0)8-20 88 64.
www.sida.se sida@sida.se

Sida