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Reality Check Bangladesh 2011

– Listening to Poor People's Realities about Primary Healthcare and Primary Education – Year 5

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The views and interpretations expressed in this report are the authors and do not necessarily reflect those of the commissioning agency The Embassy of Sweden, Section for Development Cooperation, Dhaka

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Foreword

This Reality Check Bangladesh 2011 Report is the fifth and last in a five year series.

The Reality Check Approach was initiated in 2007 as an effort to strengthen the voices of women, men, girls and boys living in poverty, in the primary education and health sector programmes in Bangladesh. How do these primary beneficiaries perceive the access and quality of primary education and health services? How do education and health related issues influence their lives? Have their attitudes, perceptions and experiences changed over the five years covered by the Reality Checks?

The Reality Check is an innovative approach for collecting and linking the voices of the user of services to the providers of services, and not least to policy makers. Creating and maintaining the connection between evidence and results on the one hand, and policy making and implementation on the other, is constantly a challenge. In this case, the link was ensured through a Reference Group comprising of representatives from the Government, donors and civil society, as well as a series of dissemination activities related to the launch of the Reality Check Annual Reports.

Four key principles underpin the Reality Check Approach. Depth: using a variety of methods it strives to provide detailed, fine grained information not usually collated through M&E systems and it does so over a longer time period (five years). Respect for voice: it aims to document and transmit the unfeigned voices of people. Flexibility: the flexible formats enable the researchers to adapt their discussions and lines of inquiry to new and unexpected data. Simplicity: it is a simple and immediate approach that utilises a variety of basic data collection methods to document people's views.

Many valuable insights have been generated by the Reality Checks over the past five years. Already in the first year the RC contributed to a better understanding on the complex issues of school dropout. Contrary to conventional wisdom, findings indicated that rather than parents keeping children out of school for economic reasons, one of the main reasons for dropout was children's low motivation. In fact, parents showed very strong commitment to their children's education and made very strategic choices to ensure the best possible education for their children. Observations also indicated very mixed results from teachers training due to adverse aspects of the school environment and curriculum.

With regard to health, the RCs found among other things that staff shortages, poor maintenance, malfunctioning of essential equipment and unauthorized charges by medical personnel and brokers, continue to undermine the effectiveness of many government health facilities. Poor people still tend to prefer pharmacies and local doctors for common ailment as they are cheaper, nearer and remain open for longer hours. A gap in the public provision for non-communicable diseases like high blood pressure, cancer, diabetes and stress was noted. In general poor people complain that irrespective of providers all healthcare services are increasingly becoming more profit driven.

The Reality Checks have been carried out by a group of international and national researchers. Divided into three field teams they have over the past five years spent considerable time with 27 Bangladeshi families living in rural, semi-urban and urban setting.

The Embassy would like to extend a warm thanks to the Reality Check Team as well as to the 27 families for the five years of co-operation. The findings in the six reports are far from the only results of their endeavours. They have also contributed to important discussions and food for thought concerning methodology, quantitative and qualitative data, and how to close the gap between the experiences of people living in poverty and policy makers.

Dhaka, October 2012

Anneli Lindahl Kenny
Ambassador

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Summary

BACKGROUND

This is the fifth and final year of the Reality Check Approach in Bangladesh. By living with families for several days and nights, the study team seeks to better understand how people living in poverty are experiencing health and primary education programmes in order to inform the stakeholders of the two Sector Wide Approaches. As the study provides immediate insights into changing behaviour it has the intention of flagging up issues for further research. As in the previous four years the team stayed with the same 27 families and their neighbours in nine different locations.

GENERAL COUNTRY CONDITIONS

As usual, the Reality Check reports on people's perceptions of the changing wider context in which they live. There have now been two consecutive years of good harvests. Rice prices have stabilised and households which grow their own rice report that they have sufficient stocks to meet their needs. Inflation has reached double digits this year and has impacted people's buying habits and, in particular, had the effect of reducing the diversity of diets. Potato has become more central to diets than before. It now features as the main vegetable, displacing others as its price has remained constant. As before, locally caught farmed or ditch fish provides the main protein staple. Remarkably, most families' incomes have kept pace with inflation and while making savings on food costs they spend more on snacks, cosmetics, cigarettes and increasingly purchase appliances (particularly mobiles, TVs and motorbikes) on credit. There is dissatisfaction in all study areas with micro-credit services provided by NGOs.

Local elections took place in 2011 but although people mostly voted they generally feel frustrated by the post-election lack of interest in them. People are concerned about the re-emergence of politically motivated violence as well as increasing criminal and domestic violence and several households had had first hand experience of this upsurge over the past year. Many indicated that this is the worst change that had happened over the last five years.

MAIN FINDINGS IN HEALTH

The main issues emerging from the health findings this year are the continuing and worsening mismatch of resources to needs and, as a result of a health service under pressure to deliver quantitative targets including tacit acceptance by medical staff of systems loss such as hand-

ing out free medicines to the non-ill and filling hospital beds with those whom nursing staff confirm do not need hospitalisation.

New health facility construction is taking place in inaccessible locations or where there has been no demonstration of demand while other dire needs such as specialised trauma centres to deal with the growing number of victims of road accidents and assault are not met. Personnel are posted where they do not have the facilities to do their work (e.g. an ambulance driver without a vehicle, dentists and radiographers without basic equipment) or there is new equipment without qualified doctors to use them. Advice and treatment continue to be influenced by opportunities to make personal gains through official or unofficial incentives.

Although some improvements in government hospital services (particularly in the north study area), have encouraged some of the study families to avail them, they remain limited to emergencies (particularly cases which may involve litigation), for collecting free medicines or for the provision of clinic-type services to the immediate local population. People still prefer to use pharmacies and local doctors which meet their needs better, less often use kobiraj and traditional means but complain that increasingly all healthcare, no matter who provides it, has a strong profit-making motive.

The drive to operationalise community clinics is very evident this year with repair, re-painting, posting of new community healthcare providers and better supply of medicines in the clinics in the study areas. However, as noted last year, the services are not well publicised, not necessarily geared to the needs of the population and continue to be inefficiently managed. In the six community clinics which were open during the study, we observed unqualified staff making diagnoses and generously dispensing medicines especially antibiotics.

Family planning advice is particularly weak and values or incentives-driven. Men and unmarried persons remain marginalised from family planning information and advice despite a growing demand to enable people to make informed choices. People tell us that house to house visits are not required. Rather, a more open environment for people other than the conventional target group of married women of reproductive age to be able to seek advice and get information needs to be established which should, they say, make increased use of the media.

MAIN FINDINGS IN EDUCATION

In primary education we find that the impact of efforts to address the problem of shortage of teachers is evident and most of the primary schools in our study area have their full complement of teachers this year, some for the first time in many years. We have observed that with full staffing, a dynamic Principal and supportive school management committee schools can turnaround.

Three years since the introduction of the Class 5 terminal exam, primary schools continue to be driven by quantitative targets and teachers feel under pressure from the Government to achieve 100 % pass rates. The result is a system which demands memorisation only and which has spawned a range of strategies to ensure this. The legitimacy of some of these is questionable if the Government is really committed to enhancing the quality of education. There is growing concern among parents and some teachers that with the political imperative to

prove improvements year on year, standards are, paradoxically, declining. Students find it difficult to apply the learning from the current exam oriented education system and less relevant to their lives. They increasingly complain of boredom resulting from condensing their education to mere memorisation of standard answers and very long study days in order to pass the exam.

For the first year in the five year study we became more aware of some reversal in how parents feel about education. There are some signs that the combination of frustration with failing children, realisation that the terminal exam is too big a challenge for some as well as the growing experience that education does not necessarily equate to better job prospects, has led some families to accept the inevitability of drop out once more, especially for children who have spent many years in primary education without progressing beyond class 3 or 4.

The introduction of pre-school classes became mandatory for all government primary schools at the beginning of the school year (2011). The one week course provided to prepare teachers seems to have been quite effective as we observed several classes where children were engaged interactively and enthusiastically. Where there are space and teacher shortages there are some disastrous attempts at inclusion of pre-school children within large and intimidating classroom settings.

The 2011 High Court ruling to outlaw corporal punishment in schools has created concern among teachers. Whilst teachers, parents and children concur that such punishment should not be meted out for academic shortcomings, they are not convinced that it is not needed to control what people regard as increasing unruly behaviour in schools. People are confused about what might be interpreted as punishment (can, for example, raising one's voice to a child be regarded as punishment?) and unfamiliar with alternative strategies for dealing with difficult behaviour.

People continue to avoid complaining about health and education because of fears of being singled out, blamed and deprived of services as well as feeling that poor people are not listened to anyway. Local level service providers also feel unable to influence decision making within their disciplines for largely similar reasons. Throughout the study the most vocal have been those who were about to be retire or leave the job. Whilst both people living in poverty and local level service providers accept their powerlessness, they feel they have much to contribute to shape future policy and have welcomed the opportunity the Reality Check Approach has given to express their opinions openly.

This report does not cover ground where there has been little change this year and a summary of the issues reported in earlier years is provided online on www.reality-check-approach.com.

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 and Shuchita 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.

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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 2011 REPORT

This report marks the fifth 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 fifth period of field work carried out in October–November 2011.
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.

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 have been agreed and started in July 2011.

SWAp	Period	Number of consortium partners	Total budget
Primary Education Development Programme (PEDP II)	2004 – 30 June 2011	11	US$ 1,8 billion
Health, Nutrition and Population Sector Programme (HNPSP)	2003 – 30 June 2011	18	US $ 3,5 billion

The RCA is intended to provide deeper insights than are normally possible under conventional monitoring or research into how these invest-

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

ments 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 informants. 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 (see Annex 1), 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.

Context

As in previous years we start the report with an understanding of the prevailing situation which may have an influence on health and education attitudes and behaviour. This section therefore examines the context of changes experienced by our study families and their neighbours within the wider national changes taking place in 2011.

ECONOMIC CONTEXT[2]

The overall economic context continues to be positive. The World Bank reports strong growth in 2011 with GDP for the period June 2010–11 reaching 6,7 %. This is attributed to good performance in manufacturing, construction, two years of good agricultural production as well as sustained high contribution from the services sector. However, inflation has been exceedingly high (estimated at 12 % in September 2011, the highest in 12 years). The consumer price index increases have been primarily driven by increased food prices but towards the end of 2011 also by non-food items such as clothing, transport and household goods.

The Bangladesh Bureau of Statistics has reported that the incidence of extreme poverty has fallen from 25,1 % in 2005 to 17,6 % in 2010. All our host families are either in the same or in a better economic position than they were in 2007 when the study started (see Annex 1). All were categorised as extreme poor (living on less than $1,25 per person per day) in 2007 and 2 HHH would now be regarded as poor. Those who fared less well live in situations were employment opportunities are limited (e.g. north rural) or had major health costs or debts to service. Several told us that they were pleased to be debt-free after years of paying off micro-credit loans which they had often used simply for cash flow smoothing and had found economically and psychologically burdensome. Despite the double digit inflation, many families have acquired new assets including mobile phones, fans, TVs, furniture and utensils this year and regularly purchase cosmetics, medicinal tonics, snacks, cigarettes and betel nut. In all but the north rural study area, there has been an increase in small roadside shops which cater to this growing demand for consumables (e.g. in the north urban study area seven new roadside shops have opened this year). Electrical goods are increasingly easy to buy on hire purchase. In order to make these purchases (which this year even include fridges and motorbike) families will often choose to eat less.

"Today I could not earn money so I am fasting. I'll take some food tonight. This is my strategy nowadays. If I have little income I will eat less food. My goal was to reduce my debt and in order to do that I eat less. I have reduced my debt from Tk.12,000 to Tk.10,000 this year". (FHH, south urban)

Price of food. Food inflation is reported to have risen from 8,7 % in July 2010 to 12,5 % in June 2011, creating particular hardships for the poor. Oil prices have seen three incremental increases this year and the national newspapers in December 2011 were speculating that inflation would rise further. We heard people complain about the rise in

2 Data for this section obtained from World Bank Bangladesh Economic Update, September 2011; Asian Development Bank Economic Update, November 2011.

food prices in all our study areas and eating patterns have been adjusted as a result (see diet section). Nevertheless, most of our study families said that they are managing to keep pace with these increases either because they are self-employed and have adjusted the prices they charge (e.g. for transport services or petty trade) in line with inflation, have seen wages increase (e.g. day labourer wages have increased to Tk.175 – Tk.225 per day, 20–50 % increase over 2010 rates) in the south study area) or have diversified their income sources. As we have noted before, families limit their food intake when they have other expenses to meet.

There have been two successive years of good harvests (2010 and 2011). The 2011 *Aus* rice harvest was officially 23 % higher than 2010, *Amon* rice harvest was 5 % above the previous year despite the lack of rain in July and August and there was also a modest 1,6 % increase in the *Boro* rice harvest. Nevertheless retail rice prices increased over the winter and peaked at an average of Tk.34,7/kg in February 2011, returning to Tk.29,5/kg in July 2011. The Food and Agriculture Organisation predicts that Bangladesh may not need to import any food grain for the first time ever. Those study families with their own land have been able to meet their family rice needs this year and those without were relieved that prices have mostly stabilised at lower prices than 2010. In the rural north study area, the Boro crop was four times the yield of previous years and for the first time in ten years they were able to cultivate *Aman*, wheat and mustard as there was no flooding in August and September. To minimise the effects of inflation on the poor, the Government intervened this year with open market sales of rice at subsidized prices but experience of this system indicates that savings for the poor are reduced by corrupt practices (see Box 1) and some dislike the stigma associated with queuing and being branded a poor person.

Rice harvests were good in 2011 (better than 2010) but there are fears that they may not be so good in 2012

Tk. 700 worth of fish lasts the extended family in the central urban area seven days

Box 1: Open Market Sale

We weighed the rice obtained by our HHH mother from the Open Market Sale (OMS) intended for the poor and found that, as per local suspicions, it was short by 0,8 kg (it was 4,2 kg when it should have been 5 kg). This means that the actual price is only Tk. 4,4 /kg less than the market prices when it should be Tk. 9 /kg less.(Field notes, central urban)

One of our FHH weighed the 'line rice' (OMS rice so called because you have to stand in line for it) after purchase and noticed, without being surprised, that the supposedly 5 kg bag contained a bit over 4,5 kg. 'We go several times and buy several bags per day (despite the official restriction on 5 kg per day) and then sell it for a small profit' she told us. (Field notes, south urban)

The pile of small fish in this rural market costs
only Tk. 20

Table 1 : Food prices, 2011 (as experienced by our study households)						
Item	Cost in north area (percentage change over 2010) Tk.		Cost in central area (percentage change over 2010) Tk.		Cost in south area (percentage change over 2010) Tk.	
Rice	30–35	(–11 % to +9 %)	28–35	(–17 % to +25 %)	24–41	(–40 % to +0,2 %)
Pulse	120	(0)	120	(+20 % to +33 %)	93–100	(–43 % to +16 %)
Vegetable oil	120	(+20 %)	120–125	(+26 % to +50 %)	120	(+50 %)
Onion	28	(-30 %)	–		–	
Chilli	200	(+43 %)	300	(+100 %)	225–250	(+50 % to +67 %)
Sugar	64–75	(+25 % to36 %)	60–74	(+9 % to +42 %)	70–80	(+35 % to +67 %)
Salt	16–22	(+10 %to 22 %)	21–22	(0)	19–25	(+5 % to +80 %)
Potato	15–16	(–7 % to +6 %)	10–20	(–25 %– 0)	17–19	(–15 % to -5 %)

As a result of high prices, pulse is rarely eaten and families have cut back or excluded sugar and chilli consumption.

Incomes. Employment opportunities in construction, transport and garments sectors remain good and many of our study families and their neighbours benefit from this. World Bank reports suggest the garment industry grew by 43 % in 2011. This has noticeably benefited study families in the central study area who have sustained employment, bonuses and promotion.

"When you first came we only took two meals per day, sometimes only ruti made with government relief wheat. We were starving then but now take three meals with fish at least once per day" (FHH who now has a regular job in a garments factory)

The increase in new forms of cheap transport such as the electric-powered auto-rickshaws threatens the livelihoods of traditional pedal rickshaw and van drivers and some traditional snack sellers suffer increasing competition from inexpensive commercially packaged snacks. Work in quarries (north) and brick fields (central) attracts workers from outside the districts and local workers seem reluctant to take these jobs: '*Why work full time when we can live well enough by working half a day in the fields?*' (central rural) or it is regarded as low status work.

Basket making is lucrative, the profit on each basket is over Tk. 80 and five can be made each day

Poultry and livestock production continues to increase in most of the study locations except the north study area where frequent theft, shortage of fodder or restrictions on grazing and disease have de-motivated people. However, people in this area have learnt from neighbouring villages that duck and sheep rearing are productive.

The remittance flow figures for 2011 provided by the World Bank and Asian Development Bank are contradictory but the slow down noted in 2010 seems to be picking up again in 2011 due to an increase in overseas employment, especially in non-traditional countries. Although there are stories from our study of overseas employment *'not being worth it'*, there are also many stories of people paying off the high broker costs and having surplus to invest in property, land and household assets and there are still many who aspire to this (e.g. in the central peri-urban study area 1 in 6 households has a worker overseas). We heard in both the rural south and rural central locations that families are concerned that young men are *'being spoilt'* by their fathers working abroad and they become idle and *'may resort to drugs'*.

Traditional snacks are being displaced by packaged snacks and making it harder to make ends meet

Box 2: Family highs and lows

Our HHH was happy that the rice harvest was good this year and they will not have to buy in rice but they were unhappy that two cows died of a throat infection and one had died last year from anthrax. As there is no electricity in the village they worry about theft of the remaining cows as there are no security lights, particularly as they had their boat stolen last year in the middle of the night. (Field notes, north rural)

The two sons of the HHH have gone to Dhaka to work and send money back regularly so the family feels confident about the future and they have paid off their loans. But the social stigma around the recent rape of their daughter and high costs which will be incurred by the consequent Court case worry them immensely. (Field notes, south peri-urban)

She said that there had been no good changes really except the construction of her house by a well-wisher from abroad. She and her adolescent daughters live on charity as her late husband was an imam. She is very worried that the girls will not be able to work because of the increasing insecurity in the area. (Field notes, north peri-urban)

Micro-credit is often talked about by our study families. Many people told us they wanted to pay off debts and not take further loans often citing tension and worry as the reasons. Some people talked about being *'cheated'* by the high interest rates charged by NGOs, having not understood the terms when they took the loans. Some feel that they were encouraged to take too many loans and got into debt cycles which made them feel under stress (see Box 3).

Box 3: Some want to be debt -free, others want customised loans

One HHH told us that he has taken a total of Tk.70.000 in micro-credit loans from four organisations. His weekly instalments amount to Tk.1705. He spent 30% of the total loan on house repair and another 33% on repaying other debts, medical expenses and household consumption and the rest services the interest payments. His daily expenses are Tk.120 plus Tk.245 for debt repayment. He says that the loans have brought no benefit economically and considers them 'a curse'. (Field notes, south peri urban)

There are fewer NGOs offering credit here now as the loan repayment rate was low. People are once more taking loans from better-off people which can be negotiated individually and fit needs better even if high rates of interest are charged.(Field notes, south rural)

Several NGOs providing micro-credit have closed due to mismanagement, 'They have run away after taking money from the poor'. The well-known larger ones remain. 'With an NGO loan you feel under pressure constantly because of the weekly instalments. With a moneylender I only have to pay twice. Yes, it is more expensive but it is better. I have seen many people getting sick from the pressure of facing the NGO each week and wondering how they will cut down on expenditure to meet the instalments' (HHH relative) but others find moneylender loans harder to repay. (Field notes, south urban)

POLITICAL CONTEXT

"The UP members never work for us. We are suffering from lack of drinking water and have to cross three hills to get it but nobody looks after our problems". (HHH, north peri-urban)

"We only see them at election time". (Comment frequently heard in all areas)

"We collect a boat-full of stone and have to pay 40% of our profits to musclemen (extortionists). If we don't pay up, the ansars will let their dogs on us. Both ansars and police are involved with this". (north rural)

"There were attempts to resist the brickfield development led by the high school principal but the rights to development had already been granted to political interests". (central rural)

"Now we are always scared" (south rural)

Union Parishad elections took place between March and June 2011, eight years after the last local elections (2003). Some City Corporation elections also took place. Generally, people we talked to during this year's study said they had voted in these elections suggesting to us that they felt it was *'an obligation'* (a requirement of the government) but few seemed to think that the ward members would do anything for them. Some felt that the job of ward members was largely administration (e.g. distribution of social welfare benefits) and this should not be undertaken by politically-appointed persons.

In the rural south, rural north and peri-urban north people were a bit more optimistic as they had voted in members from their own village for the first time and were hopeful that they would take at least some action for their benefit. In the south peri-urban study area the new ward member who people said had *'replaced a mastan'* has already facilitated electrical connections for a group of houses with a smaller (speed money) payment than expected. But the urban north residents have voted in the same ward commissioner three times and, although he is a resident of the area and depends on the residents of his rented houses for his votes, he has yet to address the problems of the community.

People in the central rural area were worried about the re-emergence of *'nasty politics'* and Box 4 provides some insights into the rise of politically-motivated violence. Newspapers have reported increasing levels of post-election violence in contrast to the earlier phenomenon of pre-election violence. Several hospitals in our study areas pointed to higher levels of politically-motivated violence in recent months and we saw for ourselves several victims of political quarrels when we visited the wards.

As reported last year politics continues to infiltrate economic activities as the following examples demonstrate. The quarry activities in the north rural study area and brickfield development in the central rural area have been taken over by political interests. We also came across patients in hospitals who had been viciously attacked for non-payment of protection racket tolls.

SOCIAL CONTEXT

Crime and violence. National newspapers report that law and order has deteriorated further this year with increases in gang-led muggings, political violence (as noted above) and the term *'guptohottya'* (secret killing) increasingly infiltrating public discourse. Our study families had direct experience of increased crime and feelings of insecurity (Box 4). Some said it *'feels like the post Independence Period (of the '70s) when we felt constantly under threat'* (central urban). People said they felt unsafe walking out at night and girls felt insecure walking to and from school and college in the urban areas in particular. The increase in crime is attributed by our study participants to the increase in political activities and the exploitation of youth by political leaders, unemployment, high prices, diminishing parental control, lack of role model leadership and increas-

ing drug abuse. Only in the south urban area did people talk about a slight improvement in crime which they attribute to the crack down by the Rapid Action Battalion which has made *'criminals fearful and careful'*.

Box 4: First hand experience of increased violence

The whole community was in a state of high tension during our visit as a result of a murder which took place outside one of our HHH 10 days before our visit. Many neighbouring households had taken refuge in relative's houses. People were reluctant to talk and demonstrated their frustration towards political leaders who had not bothered to visit the area despite the community's call for help in light of the police harassment and general feelings of insecurity. Some feel that the murder was drug-related and a reprisal for the incident last year (also shortly before our visit) where a man's arm was amputated over failures in the drug supply chain. (Field notes central urban)

Hijacking has increased significantly on another bridge near to the Muslim part of our study area. Evening and early morning, they snatch valuables and money from bus and train passengers coming into the town. This has made the community very worried about crossing this bridge at night. (Field notes, north urban)

Mahila (15) was walking beside a jute field when a teenage boy from a neighbouring family dragged her into the field and raped her. She returned home, muddy and battered, whereupon her mother beat her. When her father came home, he beat his wife for not looking after his daughter properly and letting her go outside. The family has filed a court case but faces high costs to pursue this. (Field notes, south peri-urban)

Some people say there are now guns in the community and this is the first time they can remember this ever happening. (Field notes, central peri-urban)

Motorbike gangs roam around making people feel insecure. Some are supported by politicians who provide unemployed youth with the bikes and expect them to provide 'protocol' (meaning provision of security when the politician is moving around). (Field notes, south rural)

There is an area at the edge of the village where young men meet for drug-taking and gambling. These are boys with SSC or HSC pass who are waiting for overseas jobs. There are reports of muggings and snatching related to this but not as prevalent as the other two central study areas. (Field notes, central rural)

The ex school principal (our FHH) was given Tk.100.000 from one of the candidates to buy votes. But his family and neighbours (our HHH) supported another candidate from the same party. A few months ago the neighbours had a violent clash ostensibly about cow grazing but actually because of the election results which ended in two people being hospitalised for 21 and 7 days. A case was filed but withdrawn following a financial settlement of Tk.30.000. (Field notes, north rural)

'We see more violence initiated by women than before... perhaps 40% of the cases we get here is perpetuated by women. People see violence on TV and copy it. They have less respect for each other than before, less gentleness... they resort to violence rather than trying to sort it out'. (nurse UHC, central peri-urban)

"People are better off than five years ago ... they have more possessions now; electricity, TVs, even fridges but it is worse because we feel under threat by the drug-takers who harass girls and do stupid things. I feel very afraid now" (HHH grandmother, central urban)

Youth. In all study areas, people talked about an increase in drug-taking. The practice in the slums is very open both outside and inside the home. In the south urban area, the increase is noticeable among 16–20 year olds who take strong sleeping pills which they mix with juice. There is a bridge in the south peri-urban area where young people hang out. Whilst this is mainly recreational in the day as night falls, this spot transforms into a haven for drug addicts and *phensidyl, ganja*, alcohol and heroin are openly traded. In the central urban area, people told us that the worst change that has happened over the last five years is the increase in drug-taking.

"My daughter's only interest is boys, not study" (mother of 14 year old girl, central urban)

Families continue to worry about their adolescent children, in particular their *'disrespectful behaviour'* and increasing 'illicit' boy/girl relationships. Marriages have been hastily arranged between young teenagers to protect reputations and quell gossip. Box 5 provides just a few examples of the quandaries facing parents and communities dealing with the increase in relationships between adolescent boys and girls.

Box 5: Kites without strings: young boys and girls

'My second son passed SSC and I sold many of my assets to get him enrolled in college but three months ago he fell in love with a Muslim girl. He talked all through consecutive nights on the mobile phone to her pretending to me that she was just a friend. Her brothers were against the relationship and physically threatened him to stop. The whole family was in tension because of this and finally he agreed he would give up but the girl continued to phone him. So I sent him to his uncle's in India and told him not to return until the girl is married. I was dreaming that my sons would one day take responsibility for the family and I would enjoy peaceful old age but now all my dreams are gone'. (HHH north urban)

A girl (13) and boy (17) went to the park together until 8,30 pm. Fearing it was late to return they stayed at the boy's sister's house. The girl's employer (the UP member) heard about this and sent three men to forcibly bring her home. Next morning they held a meeting to discuss the punishment for the pair and insisted that these two should marry. The girl continues to be very upset, 'We were just neighbours and friends and studied together at primary school. We do not love each other or have had any relationship. We went to the park purely for recreation. I will never accept him as my husband'. (Field notes, north peri-urban)

Several villagers told us of their concerns about mobile phones. From the older generation, we heard 'They all have porn movies in their mobile phones'. On one occasion we spoke to a girl in her late teens. She had just caught a male friend having nude pictures on his phone. The girl got very upset: she told her friend that she did not approve and made sure the pictures where erased. From some elderly we heard comments about 'mobile phone call girls' and houses where you can rent a room on an hourly basis. This, the elderly man said, is mostly happening elsewhere, outside of this village. He recently heard rumours about this. (Field report, south rural)

A girl (10) and boy (12) were caught engaging in sexual activity. The neighbours suggested shaving the boy's head, putting lime on his face and forcing him to walk around the village with old shoes hung round his neck. But others suggested they should marry. The UP member intervened saying, 'We will all have to go to jail if we do this as they are under-age'. He threatened the pair with a beating and people say this sort of behaviour among the youth has stopped as a result but the team members still observed youngsters meeting at night just as before. (Field notes, north rural)

A group of young adolescent girls in the peri-urban area tell us that they know of several teenage, unmarried young women who recently have had abortions. We learn about similar things in the rural area. Here, the local midwife tells us of how she now and then carries out abortions for young unmarried girls. We presume that these events easier become common knowledge in rural areas since girls who seek advice and help with abortion go to someone they know locally. In peri-urban or urban areas families can arrange for abortion in a more anonymous way. Pre-marital liaisons, it seems, are quite common. In the peri-urban area teenagers talk of rendez-vous with lovers in public places such as parks, where the couple would hide in a secluded area for a private moment. They also hear of couples using friends' houses, or occasionally rent a hotel room in the city. (Field report, South, peri-urban, rural)

'The worst disease in the world is the one called love- it results in sexual disease and abortions. Youth today are like kites without strings… they do whatever they like without any respect to their parents. They see things in films and think they can be the heroes. I treat boys as young as 14 years for STDs and advise about three unmarried women per month for abortions', a local kobiraj-cum-pharmacist tells us. He predicts it will get worse in the future and then says with a wry smile, 'but all this is good business for me'. (Field notes, central peri-urban)

Elderly. More people tell us that they have had to continue working into old age when they had expected to retire as their families have left home and are not necessarily supporting them. The report that their incomes are low and they do not receive Government social security. A mini survey of forty five boys aged 16–22 years in the south peri-urban study area indicated that 70 % were employed in Dhaka or Chittagong. While some send money home others do not. Elderly people told us that they worry about their futures and continue to work into their eighties to support themselves, something they had not expected would be needed.

TECHNOLOGY

There are now 82,4 million mobile phone subscribers in Bangladesh an increase of 24 % over 2010[3]. There are twenty national TV channels and six national radio stations. Most of our study families have at least one mobile phone and people spend increasing time on the phone with little apparent concern about the costs.

Wherever there is electricity there are TVs and in the rural north we noticed the first solar panel powered TV this year. We noticed an increase in privately-owned TVs and also public provision in tea stalls which attract customers throughout the day and become a focal point in the evenings. Our study families who have TVs spend increasing time watching it particularly as there are more channels to enjoy.

Queuing for water is time consuming in the north urban area

ENVIRONMENT

Pollution. We noticed this year that more people were attributing their ailments to the effects of pollution. In the central rural area there are five new brick fields which generate huge quantities of dust and force people to wear masks when passing and smothers vegetable and tree crops. In the north rural area the air is often thick with stone dust from crushing stones in nearby quarries and workers frequently suffer respiratory infections. Nurses in the Sadar hospital in the central urban area told us that respiratory ailments are increasing due to smoking, dust and factories. They said *'there are always people admitted suffering with asthma'*. Stomach problems are increasingly attributed to the over-use of pesticides and fertilisers.

In several areas people complained about the decrease in river fish and blamed river pollution and electric net fishing. Although there is paid access to drinking water in the north urban study area, water for all other purposes is taken from the river and the high incidence of skin diseases is attributed to bathing and washing clothes in the polluted river water. There continue to be open drains in the central urban study area which overflow and in the north urban study area women complain that they *'cannot go out of the house because of the stagnant water and blocked drains'* which have to be cleared each day by householders.

Natural disasters. The south study area has been spared natural disasters this year and has more or less recovered from the aftermath of Cyclone Sidr in 2007. The south and north rural areas nevertheless suffered from water-logging which on one hand increases access to fish but on the other reduces agricultural productivity and the possibility to graze goats which do not like wetlands.

Environmental degradation. In the north peri-urban area there has been extensive unregulated destruction of hillsides by outsiders for residential plots. In the rural north study area, people are concerned about the destruction of the forests for firewood and for agricultural land (for example a landowner had recently planted 300.000 palm oil trees in the north peri-urban study area).

Alternative income generation initiatives to firewood collection are being established such as a new mushroom cultivation project in the

3 October 2011, 82,4 million subscribers compared with 66,5 million in November 2010. Source: Bangladesh Telecommunications Regulation Commission, www.btrc.gov.bd accessed December 29th, 2011.

Slums often have open litter dumps like this one in the central urban area which has been there throughout the five year study

New public latrines have been installed in the north urban study area to replace these old ones but improper construction means they drain out into the nearby open space

Children showed us the 'smelly places' in their neighbourhood which included badly maintained latrines and open defecation sites

north peri-urban area. Although the income from this is less, women told us it is *'less laborious'* and are keen to continue.

Trees have been intensively cut in the south peri-urban study area and there has been no replacement planting. We hear often that people prefer to plant wood trees rather than fruit trees as they generate a good income: *'After 6 or 7 years a fruit tree would start to blossom but by this time you can sell a wood tree for between Tk4000–10.000.... but we are losing our local fruit species'.* (south rural)

Sanitation. Open defecation seems to have increased in some areas partly because latrines have become damaged, are poorly maintained and become unusable or because *kutcha* latrines are filled up. In the south rural study area we noted that many of the latrines are full and badly maintained and people fail to use sufficient water when using them despite the long involvement of a NGO in water and sanitation in this area. One HHH in the peri-urban north is permanently infested with flies and emanates a very bad smell because their latrine has cracked due to soil erosion and they are unable to replace it. In the central study area we had always noted that the courtyards were kept clean but now cow dung and other animal faeces accumulate and are rarely swept up. Asking about this change, the families said it was because they were busy income earning and studying.

Ring slabs were distributed to every household about seven years ago but they have never been installed and make good containers for cow feed

Main Findings in Health

Many of our findings this year are similar to previous years and we have confined the discussion below to significant changes[4].

Increasing demand for profit margins. Over the five years of the study we have seen a burgeoning of health service providers and an increase in profit motivation among all providers. Where previously subsidised or low cost treatment would have been provided for people living in poverty by pharmacies and informal service providers (e.g. *kobiraj, polli* doctors) people tell us this rarely happens now. For example, in the south rural study area the opinions about the two previously well-respected homeopathic and *polli* doctors have changed this year. In the past they were praised for offering a service to the community and charged very little sometimes even waiving fees but now people complain that the quality of service is going down and they charge more and more.

Despite higher profit margins being charged, the preference for pharmacies still persists. Five years ago there were two pharmacies in the small market in the south urban area and now there are ten. The numbers of pharmaceutical representatives continues to increase and pharmacies tell us they get 4–5 visits every day, a testament to the competitive nature of this business. *'If you take four tests you will need eight medicines'* an elderly man told us in the south urban area echoing what others tell us about the practice of over-prescription. Some tell us that they are increasingly confused about the plethora of medicines and worry about being cheated with fake medicines. *'We take medicines and get no result. Sometimes the pharmacist gives an alternative to the one the doctor has prescribed saying it is the same. Fake factories are promoting their fake medicines to exploit the poor. How can the government be silent about this?'* asked teenage girls in the south peri-urban area.

Use of diagnostic centres. For the first year we did not notice any new Diagnostic centres but existing ones continue to do good business it seems, for example a diagnostic centre in south peri-urban study area says that profits have doubled this last year. In previous reports we noted that patients preferred diagnostic centres to government facilities because they were open long hours and provided immediate results but the trust is declining as people say that they feel unnecessary tests are completed purely with a profit motive. People are beginning to be wary as the following exemplifies:' It is more technical... but more costly and time-consuming' (urban central) and does not necessarily, they feel, lead to better outcomes.

Resorting again to self medication. As a result of increasing medicine costs, many have returned to self-medication so they can control the costs: *'If I have gastric problem I take ranitid, if I have fever I take napa or napa extra. If I have a fever with a headache I take paracetamol. If I have toothache I take a red tablet – I don't know the name but can recognise the packet'.* (FHH, urban south)

"We have more doctors and more medicines but are we any healthier?" (Elderly man, south urban)

"Most of time you would encourage the patient to buy one medicine and then offer them another saying that if you take this second one the first one will work even better. People are innocent and they don't know if this is right. This is how pharmacists play tricks on them". (Pharmacist, south urban)

"Before we would have had a fever and taken paracetemol and got better. Now we have tests and take lots of medicines" (Woman central urban)

"This year we have only had to spend Tk.150 on medical services so it is a good year". (HHH, south rural)

"My doctor prescribed me these many months ago and so I ask for these from the pharmacy. I decide the dose based on the severity of the pain - if it is low I take one and if it is high I take two more frequently... I know this could be harmful if I take too much but we cannot afford the frequent cost of transport and treatment so I take it this way to reduce my pain". (Woman with high blood pressure, urban north)

4 A summary of issues covered in previous years is provided on www.reality-check-approach.com

GOVERNMENT HEALTH FACILITIES

The use of government health facilities at any level can be largely divided into two main categories; emergencies and collection of free medicines (see Box 6 and photos on page 17). Improved roads have made a considerable difference to the accessibility of government hospitals but if more than about five miles away they are still only used in emergencies. The experience in the rural north study area demonstrates how the condition of the road affects choice of health provider as the cost for transport on the much deteriorated main road and the costs of accommodation in town are now considered prohibitive and villagers will not use the district hospital except in very serious cases. In 2008, they would also have travelled to the UHC which used to be quite busy but this has largely ceased because of the cost of transportation and the unpredictability of doctors and medicine supplies. In general only those who live close by use major hospitals for less serious conditions resulting in UHC, sadar and district hospital out-patients operating rather like large-scale community clinics.

District and Sadar hospitals. There have been some notable improvements in both the district and sadar hospitals in the north study area this year some of which may be attributable to a series of local and national media exposures of poor management. One of our north peri-urban FHH said of her recent experience at the district hospital, *'When we arrived at 9,30 am there were doctors in the out-patients. It only took about one hour to be seen whereas last year it took half the day. The hospital was clean and there were plenty of nurses'*. As a result there has been some shift in health-seeking behaviour away from pharmacies to these two institutions.

However, the district hospital in the central study area continues to struggle mainly because after eight years it is still officially a project hospital and so does not have the full complement of staff. The Government order to restrict deputation put this hospital into particular difficulties as it depends on deputised staff. We visited all four wards and found no staff at all in three and only one nurse sitting at her desk in the children's ward. Patients told us that they had been admitted three days ago but still had not been seen by a doctor.

The RMO of the south urban Sadar hospital tells us that his main concern is the attitude of the doctors. Young doctors start well and are willing to serve patients and share the workload but gradually they loose this commitment and think only about money. They come only between 9am and 1pm after which he is left on his own.

Upazila Health Complexes (UHC). The experience in the UHCs is mostly worse than before. One person referred to the rural south UHC as the *'sheshpital'* (a play on the Bangla words for 'end' and 'hospital') explaining that *'this is not a hospital, it is the last destination in life'*. Similarly, standards seem to be slipping even in the previously relatively good UHC in the south peri-urban area. Under-the-table payments for better treatment have re-started. There was no budget to fully equip the new extension and beds are old and broken furniture was piled up on the verandah. The hospital was not clean. As observed so many times before in the five years of the study this change in opinion coincides with the appointment of a new boss this year. We met him and he was defensive and evasive, demanding an official letter before agreeing to talk with us.

"There are no rules, no control, nothing is good here but we have no option but to see the doctors here and this is why we come. We only come because we have to. It only makes us unhappy and gives us grief" (patient in ward of UHC, south peri-urban)

When probing people's good experience of government facilities where they have not been required to pay, nepotism is often uncovered and explains this preferential treatment. For example, our HHH in the central urban has spent several weeks 'bed rest 'in the MCWC in both 2009 and 2011 and enjoyed good food and good care both times. We found out his year that she facilitates the profit-making menstrual regulation activities of the nurses. Similarly, one HHH in the south peri-urban study area does not need to pay for better treatment at the UHC as they have built relationships with the nurses there.

Casualties. Most hospitals are not set up to deal with the alarming surge of casualties from road accidents and fights. Last year we noted that typically more than three quarters of the in-patients at any time in the central district hospital are victims of road accidents. The RMO this year told us that they cannot cope with these large numbers and need a dedicated 20-bedded trauma unit. In the south district hospital a nurse said *'We have been invaded by patients with injuries from road accidents and assaults'* and others suggested a similar three quarters of admissions here were injuries sustained in road accidents especially motorbike accidents. We observed that the hospital was indeed busy; for every two beds there was another mattress on the floor. At the central rural UHC, nurses are left to deal with emergencies.

"Despite having nine doctors' quarters all are empty except one where the RMO stays sometimes. The nurses said they can never raise him at night and have to manage on their own for all emergencies". (Central rural UHC)

The supply of medicines in government health facilities had mostly improved this year. The nurses in the central sadar hospital said that this was the first year in a very long time that they felt the medicine supply was *'adequate'*. Where there have been increases in patient numbers as in the north district hospital because people feel it is giving a better service, medicine supply has not kept up. A new tele-medicine initiative has been started at this hospital providing prescriptions by SMS for minor health problems but we were told that the doctor who is supposed to run this comes irregularly and there had not been enough publicity. The room was locked when we visited.

"We wish we always had enough medicine so people do not have to buy from outside. We hate asking them to do this". (Nurse, central urban)

Cleanliness the biggest problem. The biggest problem throughout the study areas is the lack of cleaning staff in the government hospitals. In the central sadar hospital there is one cleaner for two or three wards and they only work between 7am and 2pm so there is no coverage for the rest of the day or overnight. A ward sister explained that they hire cleaners from outside often paying out of her own pocket. *'I am responsible for the ward so have no choice'*. Nurses in the central rural UHC calculated that as cleaners are paid Tk. 7.000 per month, for the cost of one nurse four cleaners

Two beds are occupied in this UHC, but only one is the patient. Nurses said it is in their interest to claim high bed occupation rates

When people heard that the community clinic was open, they dropped what they were doing and rushed to get any free medicines they could

could be employed whereas they only have one per shift for the entire hospital now. They said the Civil Surgeon had told them when they tried to raise the issue, *'you have to manage with one cleaner. This is the system and you have to get on with it'*. In the central peri-urban UHC nurses said they undertake a thorough clean every Friday themselves because they too only have one cleaner on duty. They supply cleaning materials from home. They say that the most important improvement that should be made is improved cleanliness and the doctor-on-duty agreed: *'Hygiene is a must in a hospital'*. In the south district hospital there are only three cleaners out of an allocation of ten. Since 2006 there is a continuing court case about temporary staff having rights to permanent positions which has never been resolved and prevents further recruitment.

Security continues to be a problem in many hospitals and some arrangements started last year to hire in security firms or use *ansars* have ceased. As a ward sister told us, *'There are just too many people milling around all the time'* (Central urban). At the central MCWC, there were large numbers of visitors including children sleeping on unoccupied beds despite notices restricting visiting hours to 5–7 pm. We were told that funds for the security had run out two months ago.

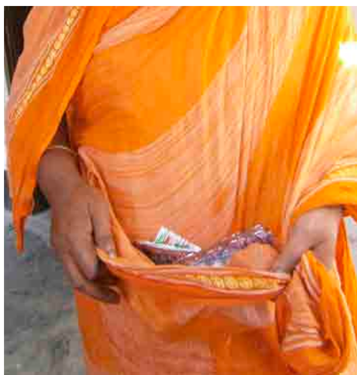
Box 6: Misuse of Government facilities

The UHC dispenser explained that probably a third of the out-patients are what he calls 'regulars' who are not ill but come for free medicines often three times a week. He acknowledges this is a huge waste of resources but thinks that doctors do not want to waste time trying to stop this as it is problematic. The most popular medicine is rantidine which only costs Tk. 2 outside. He says people also come for medicines for their animals, tetracycline being popular for poultry. We watched him dispense for some time and indeed, as he said, high numbers were not ill. (Field notes, central peri-urban)

One woman quickly stuffed four different medicines she got for the FWA at the community clinic in her sari. We asked her what they were for and what advice the FWA had given her about dosage. She replied 'I will manage', hid her medicine more tightly in her sari and scurried off. (Field notes south peri-urban)

People seemed to decide there and then when they saw the clinic open to pop in for some medicines. They asked for them by name; vitamins, calcium, iron tablets and oral saline. One man said, 'I am feeling feverish since yesterday.... I think I will have a fever' and demanded four medicines including antibiotics in advance. One of our HHH refers to this as 'stealing as they do not need the medicines' and feels the money should be saved for other purposes. (Field notes, south rural)

We have observed throughout the five years of the study an indulgent attitude to admission to the wards of the UHC. Some requiring 'bed rest' or 'some sympathy' are accommodated. Last year the nurses pointed to a 'regular who comes in for some good food and care but is not really ill' and this year one woman with a well-healed foot wound was allowed to stay. 'Of course she could go home and the health assistant could remove the stitches but she likes to stay here and feels happier that doctors will remove the stitches so we let her stay', one nurse told us. Another woman had been beaten by her neighbour and had no injuries but the nurses said, 'she is here only because she wants some attention'. Yet another with a gangrenous foot had her mother and daughter staying with her, 'we have beds so we can let them stay' the nurses explained.(Field notes, central peri-urban)



This lady collected medicines for her entire family from the community clinic to 'keep in stock'

The clinic staff confirmed that both the men in the photo (left) and the woman in the photo (right) were typical of many, were probably not ill but the staff hand out the medicines to avoid confrontations.

Box 7: Mysterious allocation of resources

The UHC initially covered two upazilas and so historically maintains a double complement of staff even though it now only covers one. Its official allocation of 22 doctors far exceeds the need. But there are only 10 currently posted and apparently several are on deputation and others simply 'do not bother to come' according to the administrative clerk. (Field notes, south rural)

As in previous years the UHC wards are less than half occupied. The hospital now has its full complement of 10 nurses making a patient to nurse ratio of 4:1. The nurses sit around with very little to do. The construction of the new extension which has been ongoing for four years has ceased but we question the need for this as the wards have never been more than half-full in all the years we have visited. (Field notes, central peri-urban)

As this hospital is staffed as though it were a fully functional 50-bedded one even though the extension is now closed (see Box 9) the current patient to nurse ratio is 6:1. The nurses would like more cleaners and less nurses.(Field notes, central rural)

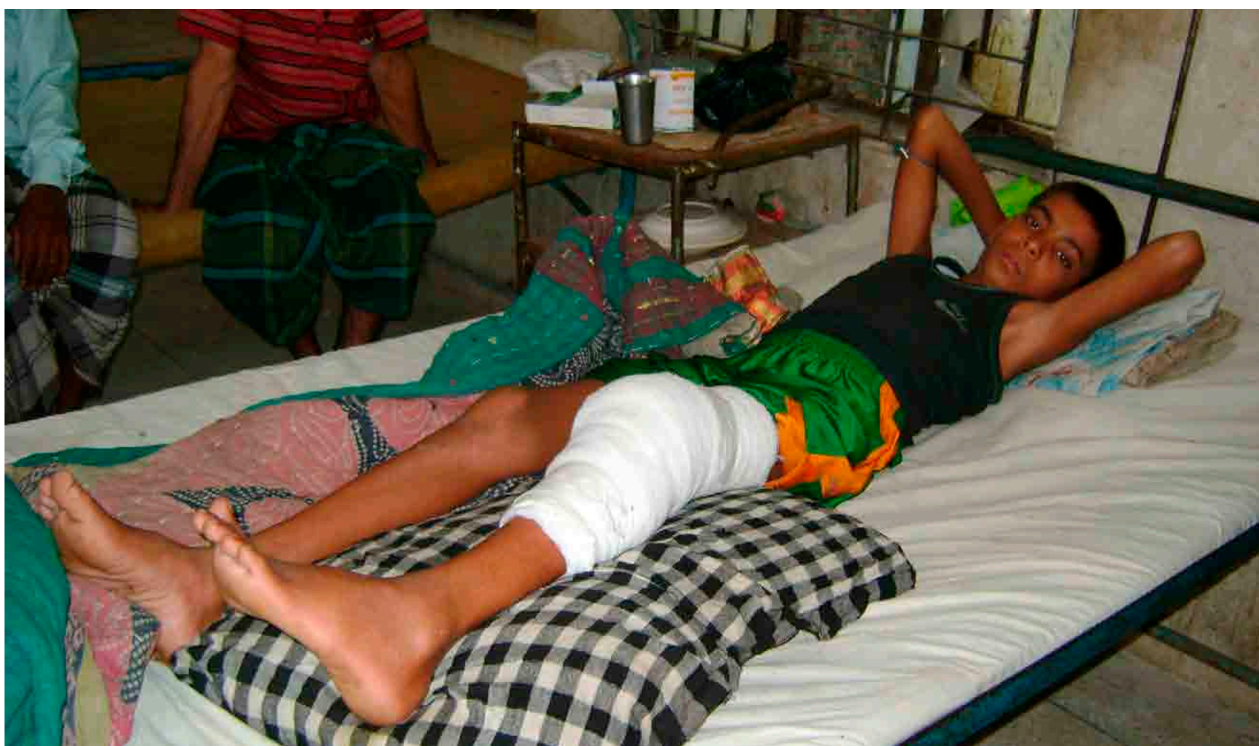
After much effort the UH & FPO had finally managed to get a dentist chair for the UHC this year, but the dentist has left and not been replaced. (Field notes, south peri-urban). In the district hospital however there is no dentist chair and no proper light for the dentist to conduct even minor operations. (Field notes, south urban)

The X-ray machine which was out of order for four years is finally replaced but there is no film so the X-ray operator continues to help out with the out-patients. (Field Notes south peri-urban)

Box 8: Our study families' poor experiences of government health facilities

I went to the Sadar hospital with a patient from our peri-urban area. At the registration he was asked what the problem was and he replied 'taap' (fever). He was directed to room #17 and was surprised to find dentistry chairs and three staff. One asked him which teeth he had problems with and he said he did not have problems with his teeth but frequently suffered 'taap' (fever). The staff rudely asked him why he was there and sent him to another room where once again he had to queue. It turned out that the registration clerk had written 'daat' (teeth) on his treatment slip. Eventually he was given three different medicines with no advice on dose or timing. We finally left three hours later. (Field Notes, north urban)

Pushpa accompanied a child to the UHC and brought with her the prescribed medicine for injection. But she noticed that the nurse administered somebody else's medication to the child. She complained to the doctor and he shouted in English to the nurse. 'That is what they do; speak in English to each other when something goes wrong with the patients'. (Field Notes, south rural)



This boy fell on some glass while playing in a paddy field. His father has had to take a loan of Tk. 4,000 from friends and relatives for his private treatment as no doctors were available at the UHC or the district hospital on the Eid holiday. They then were advised to admit him in the UHC for further care. An uncle stays with the boy but rues the fact that he is losing his day labourer income for these days.'

Our HHH has always been cheerful but has had a heart condition for which she has been taking daily medication costing Tk.40 per day. She had to stop taking the contraceptive pill because of these medicines and got pregnant twice despite not wanting any more children. A few months ago she started to feel very unwell and put on excessive weight. She went to see a specialist doctor and was told she has never had a heart condition but a gastric condition which requires daily tablets costing only Tk.4 per day. She is completely rejuvenated and the family is so much happier but how could this have been so completely misdiagnosed for so long? (Field Notes south urban)

The elderly man told us about his wife's stroke this year. She suddenly collapsed while cooking. They called an ambulance which arrived in 30 minutes and went to the district hospital where they waited for more than an hour before being seen. 'One test was taken' and they were left without any information for four hours during which time they had witnessed two other patients dying. They left for a private hospital and got immediate attention and information and were able to leave the same day. They have since returned there for follow up. (Field notes, south urban)

The HHH father accompanied his neighbour taking their sick baby to the UHC and were asked to pay Tk. 100 by the doctor. They only had Tk. 50 and so the doctor simply told them to go back home for some more money. The family is disappointed that the new woman doctor is also asking for under-the-table money, 'I believed a woman doctor would not do that' and noted that junior doctors are also asking for bribes. (Field notes, south peri-urban)

'I went to the UHC but the doctor did not even examine me and prescribed only cheap medicines. He gave another patient better prescription when he gave him Tk. 100. I am poor and cannot spend long time queuing or fees to see the doctor so what is the use of going to the UHC?' (HHH, north rural)

Box 9: Construction woes

The extension to the UHC was started in 2007 when we first visited. In 2008 the final completion was halted with no clear explanation and in 2009 a little more progress had been made but it was not yet open. It finally opened mid- 2010 and we visited the new men's ward although there were few patients there. This year the iron gate is locked across the whole extension and it is closed until further notice. We heard that the drains had backed up and caused serious knee-deep flooding in the wards. Speculation suggests that they were blocked with cement during construction. While closed, further maintenance work was being carried out and we were rather shocked at the seriousness of maintenance needs just one year after opening (broken windows, paint peeling of the walls, plaster falling off). The male in-patients are accommodated in the old wing and the verandah has been pressed into use, which is too hot in the sun in the day and too cold at night. (Field notes, rural central)

The new ward constructed on the top floor of the district hospital two years ago is now closed because it is too hot. Patients in plaster developed sores. The ward is now back where it was originally on the ground floor and this ward is empty. (Field notes South urban)

Community clinics. More Community clinics have opened this year and others have been painted and tidied up. However the opening times and services to be provided have not been well publicised and we encountered a lot of confusion and frustration as well as people shrug-

Going, going, gone...the demise of a basin in the only toilet in the outpatients department of the district hospital. (Central urban)

ging their shoulders having no knowledge at all about them. Men often tell us that there are no services for men at these clinics. Some say that these are just political places which will close with a change in Government.

New community healthcare providers have been appointed in October/November. HAs and FWAs knew about these appointments and had mixed understanding of their role although all knew that they would have laptop computers and be responsible for keeping clinic records. *'We have not been informed how it will work. We are concerned that there are only two rooms (at the clinic) but think the CHCP will be keeping the records only and getting doctors to prescribe through the computer'* (FWA, central peri-urban). Some felt these were political appointments and *'we don't expect much from them'* (FWA, central rural). The community healthcare providers themselves often apologised for not knowing exactly what their job would be but they are yet to receive the promised three months training. Some speculated that they would be *'in charge of the clinic'* and ensure it opens every day. As we observed they are pressured by patients to dispense medicines when the HA and FWA are not there.

"Interest and resources (for the community clinic) may quickly disappear when there is a change of government". (HA, community clinic south rural)

The success of the community clinic seems to largely be due to personal initiative. For example the clinic in the north peri-urban study area seems to operate quite well and is open four days a week as the HA has her own profit motive (see Box 10). Where the opening and services are unreliable people seem disinterested. As a man who went to the clinic in the central peri-urban area a while ago said, *'I went because my relative suggested it but I would not go back. If it is not open or well resourced there is little point'.*

With nothing provided to dispense the skin lotion, they use improvised bamboo sticks and scoop it onto banana leaf. (Community clinic, central rural)

The community clinic had been shut for the past two weeks and nobody knew why. (Central peri-urban)

Box 10: Observation of Community Clinics

I visited the community clinic at 9,30 am according to the advertised opening time and it was locked. Three women turned up and went away again. The health assistant, whom I had met before, arrived at 10,30 and I asked her why she was late. 'I had urgent work at home to do'. Last year people did not know about the clinic which is poorly situated in the middle of a paddy field. But people are beginning to use it now. The most common ailments are fever, gastric pain, cough, colds and skin diseases. 'We do not get enough medicine for skin diseases'. The HA collects the medicines herself and charges patients Tk. 5 to cover these transport costs and the electricity bill as she has arranged a connection to the neighbour. She has also bought her own blood pressure and blood sugar testing equipment and charges patients Tk. 5 which she regards as her own profit. She tells me that usually 30–40 patients come every day but during my half day observation only six women and a man come for treatment. The doctor who used to phone almost every day last year no longer contacts her. Apparently she stays at the new FWC which is more than 5 km away. (Field Notes, north peri-urban)

It took me over an hour to find the community clinic as nobody was quite sure where it was. It was a Thursday morning and all three staff were there including the newly appointed CHCP. There were a few patients and the HA was telling the CHCP what medicines to give them after cursory diagnoses. There were two huge packages of medicines labelled Community Clinic Project in one corner of the room. Apparently the HA had been on sick leave for several weeks and so the medicines had remained unopened. Word spread quickly that there was a good stock of medicine and people started to flock in. As confirmed by themselves and through the clinic staff, these were not patients, but there to stockpile free medicines and the HA was generously obliging. (Field notes, central rural)

A seven month pregnant mother arrived after walking some distance only to find the clinic shut. She had come two days before but it had run out of the tetanus vaccine she needed. She has diabetes and was very worried about taking the vaccine on time. She waited for two hours at the nearby tea stall. After trying to contact the HA by phone she finally got a reply saying that he could not open the clinic today as he had an emergency meeting. (Field notes, south rural)

The clinic was never open throughout our four days in the community and we were told it has not been open for the last two weeks. There was no information about when it might open again. People told us 'It is closed because there is no medicine... that's all they do is give out medicine'. (Field notes, central peri-urban)

Box 11: Unqualified advice at Community Clinics

The HA told patients coming in to the community clinic with fever to take antibiotics until the symptoms stop and then 'keep the rest in stock for next time'. She said all cases of diarrhoea were due to excessive meat eating over Eid and advised metronidazol for children although this should not be given to children. She suggested neomycin for scabies which is wrong and scooped out benzoic acid lotion liberally for all other skin complaints using a rough piece of bamboo. (Field Notes, central rural)

The FWA was on duty this day and was providing medicines to general patients. She gives a strip of ten antibiotics to a young boy and explains to us: 'He has been suffering with a temperature of 102 degrees for two days so he should get antibiotics'. (Field notes, south rural)

The almirah at the community clinic was filled with medicines and there were two further unopened cartons of medicines on the desk. I asked the FWA how she manages with all the different medicines. She says that 'It is a problem for me as I am not trained. But I have no choice but to give these medicines to the patients. I use my own personal experience and have been observing the HA giving out medicines too' (Field Notes, south peri-urban)

FAMILY PLANNING AND MATERNAL HEALTH

"My husband wants a boy but we already have two girls which is enough... so I continue taking the injection without telling him" (young mother, central urban)

"We go to the satellite clinic for injections. People think we are going for immunisation and we quickly run there and hide behind the pillars" (woman north rural)

There were notable new NGO programmes with outreach workers in several of the study areas but we have seen ebbs and flows before based on project cycles and people are concerned about the sustainability of such services.

As noted before, there continues to be a growing preference for the injection method of contraception. For example, an NGO clinic in the north urban study area indicated that more than two thirds of women who seek their advice get injections because they are covered for three

months and do not have to remember to take the pill daily. There is also the possibility to hide the use of injection from husbands and in-laws. But some men said they do not like their women to take the injection as it *'makes them skinny*[5]*, irritable and nagging because they do not have menstruation'* (central urban). As reported before, women also say that they feel less feminine when they do not menstruate and periodically take a break from using the injection method but it is clear that there is a high risk of unwanted pregnancies and very little advice about this practice.

Talking with four men at the pharmacy in the central rural study area, we established that they knew very little about different kinds of contraceptives. One said that his wife *'knows what to do'*. I said that I had heard that men do not get information.

Man 1: *Yes that is right. We should know more.*
Man 2: *I don't know anything at all.*
Me: *So who should make the decision in the family about this?*
Man 1: *We should make the decisions together. It is important to discuss this.*
Me: *So should counselling be done together?*
Man 1: *Yes, it is much better because we will both understand. At the moment women are told to communicate with their husbands and they tell us things we do not understand. These counsellors never suggest we should meet together. This would be much better and would prevent a communication gap.*

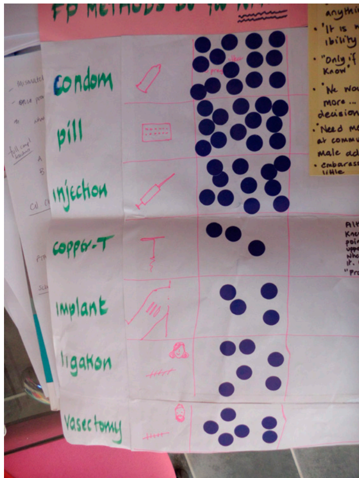
Other men told us that they think it is a matter for women and they should take responsibility for contraception (*'Men do not use family planning as they think this is the role of women'* (UP member, north rural)) as she will *'bear the burden of the pregnancy'* (men, central urban) but nevertheless criticised the fact that programmes are only directed at women.

If men are targeted it is for vasectomy (*'which we are afraid of doing'* (urban north)) rather than providing information about the range of choices. Women too continue to be concerned about vasectomy saying things like *'it will make my husband weak... his sexual power will be reduced... and he may need to marry after my death and will need to produce more children'* (north urban). An FWA in the central rural study area is promoting what she refers to as male injection (she says it is non-scalpel vasectomy) which men accept more readily. She has successfully persuaded thirteen men to have vasectomies by this tactic. Condom use is low because of the *'disposal problem'* in crowded housing situations, men say *'it feels uncomfortable'*, *'causes irritation'*, *'reduces pleasure'* and *'can't be bothered when feeling tired at the end of the hard working day.'* In the north rural study area we were told that some re-use condoms after washing.

"Women know much more than us (about family planning) this is true all over Bangladesh. Girls are more mature; by about 11 or 12 they start to ask older women about this and can talk freely. But the changes which happen to boys are more gradual and they don't ask about it like girls". (Young men, central urban)

Young people face problems getting information about family planning: *'We do not know whom to ask as we might be branded as bad boys practising illegal sex'* (boys, urban north), *'I asked a male family planning worker at a clinic and he told me to meet with him after I got married not now. I felt embarrassed and left.... maybe we do not have a right to know'* (boy north urban). In several locations two team members sought contraceptive advice as 'about to be married' young women. Box 12 provides an example of the typical experience.

5 Although more women tell us that they feel they gain weight on the injectible contraceptives.



Discussion with 18 men at a tea stall resulted in this diagram which shows which family planning methods they had heard of (dots).

Box 12: Getting family planning advice before marriage

Our team member (26) went to the NGO clinic to ask for family planning advice as she was to be married soon. The outreach worker told her not to take the pill because it would make her fat and cause her headaches and dizziness. 'You should only take for 4–6 months and then change to another pill'. She advised that she was too young to take the injection as she might 'lose her fertility'. She concluded that she should get her new husband to use a condom. The team member was then called to meet the paramedic whose first question was 'are you married?' and was reluctant to provide any advice to an unmarried person even though it was impressed on her that she was soon to marry. She recommended taking Femicon the night before the marriage. The MBBS doctor who saw her next told her to get her husband 'to use a condom because you will want a child. The Pill will make you gain weight and most women complain about this. Marvelon is best but quite expensive but you can manage this. After marriage you and your husband must decide what to do. Condoms are not always very successful'. (Field notes, central urban)

'Try to make your husband use condoms by complaining that the pills make you feel ill. Get the condoms from me as the ones supplied by the UHC are small and slippery', advised the FWA but others at the clinic told me: 'No, no your husband will not like condoms and they are difficult to use properly..You should get low-dose pills from the UHC. Those from the pharmacy are high dose and will have side-effects. There is another option that you could ask your husband to release his sperm outside... but no he will not enjoy that so it is better to take the Pill'. (Field notes, south rural)

As this experience illustrates there is little counselling or advice given but rather value-driven or incentives-driven instruction. The following Box 13 provides further examples of this problem.

A small roadside shop in the central rural area prominently displays condoms. The woman owner was taken aback when we asked if adults ever buy them and explained they were only for children to buy with their pocket money for use as balloons.

Box 13: Inappropriate family planning advice

I met a couple, the wife of which had had two Caesarean sections and had nearly died on one occasion. As a result the couple had decided that they did not want to risk having any more children but when they asked for a ligation after the second Caesarean the doctors refused saying: 'One of your boys might die and you will want another child.' The wife is taking a herbal contraceptive which her nurse sister-in-law advised and which she gets from the pharmacy at Tk. 45. She is very worried whether it works and would like to get more advice but does not know where to get it. (Field notes, central rural)

The FWA said that with newly-married couples: 'No method is best because they should have a child as soon as possible. But if they insist I can offer them condoms'.(Field notes, central rural)

The FWA advised a woman who was using the injection method and was worried about amenorrhoea that she had 'blood accumulation' and suggested she took a rest from the injection until her menses returned. She gave no advice on contraceptive cover over this period. (Field notes central rural)

'The FWA never told me about the risks of forgetting to take the pill. As a result I became pregnant twice and had to have an abortion both times.I paid a government nurse Tk. 800 each time to do this at her home'. (HHH, north urban)

The NGO outreach worker pressurises women to take the injection telling them they will get fat and have headaches on the Pill. Her enthusiasm for injection is to fulfil targets and to get her incentives (Field notes, central urban)

The FWA refuses to give pills to mothers with three children and puts pressure on for ligation. She earns Tk. 600 for every referred ligation. (Field notes, south rural)

The 14 year old girl who was hastily married to preserve the family's reputation was menstruating at the time of the marriage so they did not consult the NGO clinic until 8 days later (on an earlier visit they had been told to wait until after the marriage). The paramedic told her she was too young to go on the pill as she might lose her fertility and advised her to get her husband to use a condom. Four weeks later she realised she was pregnant and she and her family wanted a termination because they felt she was too young and they wanted her to continue her education. But the NGO clinic refused saying she was too young and it was risky. When we were there she was just about to give birth. She was very unhappy and her grandmother said, 'this is the time to play not become a mother... she needed her education to become independent... the clinic should not have refused her'. (Field notes, central urban)

'The NGO clinic ran out of injections so I did not use anything and became pregnant. They could easily have suggested to me to go to a pharmacy to get an injection or pills for that period but they didn't'. (FHH, north peri-urban)

The wife of our FHH gave birth in December 2010 to her third child but was concerned that she did not have a period a month after. She asked the FWA who told her there was no chance she could be pregnant and said there was no need to take contraceptives yet. Her sister-in-law said she should start the pill but the woman felt the FWA was the expert after all. She went to the UHC to have Norplant inserted but was refused because she has three children already. The nurses told her that Norplant was only for newly-married women and women with two children. 45 days after giving birth the woman was pregnant again and when she went to the UHC she was told it was too late for a termination. (Field notes, south peri-urban)

People tell us that the incidence of MR is increasing. Nurses who have been officially sanctioned to take on private work are seemingly 'cashing in' on this demand from unmarried girls and families who do not more children. *'People use it as a method of family planning nowadays'* (dai, central urban). Women prefer using the services of the nurses as it is often cheaper than the government services and more discrete as it takes place at their home or a rented place in town. An FWA in the rural south study area discussed frankly that there is an increase in unmarried girls seeking abortions and '*they prefer to come to me because I live in an isolated area and that helps them to maintain privacy. It takes only 20 minutes and I give them painkillers and antibiotics'*. Most are girl students who willingly participated in sexual activity with their partners. Although she refers those with pregnancies over four months to the Mother Theresa home. A neighbour of one of our HHH had an abortion at the UHC after five months costing Tk. 800.

People suggested that there should be more media publicity about family planning (particularly on TV in the evenings), more counselling for couples, special services for men and more male family planning workers.

OPPORTUNITIES FOR CITIZEN PARTICIPATION

"Whom do we complain to? The doctor taking money in hospital hours is the chief doctor. If we complain nothing will change and the doctor will refuse to treat us" (HHH, north rural)

Earlier attempts to provide information and clarify services in government health facilities have largely been abandoned. The Information Booth in the south district hospital no longer functions and boards displaying current stocks of medicines or doctors on duty are not maintained here or in other hospitals. Citizens Charters were either absent or posted in inaccessible places. Where present, the title, 'Citizens Charter' is given as a phonetic translation of the English so means nothing to the reader. Type face is often too small and dense to read and the text contains a lot of medical jargon and acronyms which cannot be understood. Caveats to service provision such as medicines will be provided free but may have to be bought from outside prevent the Charter being used to hold duty-bearers to account.

Even some members of the medical profession also felt it was impossible to complain "If I speak up I will be blamed" (RMO, south urban)

Although most of the Community Clinic Committees are weak and rarely or never meet there are exceptional ones which are trying to function but face bureaucratic barriers to working in the interests of the community. For example in the rural south the committee has provided equipment and suggested that the clinic advertises its opening times. But although willing, they have not taken initiatives over repair of the tubewell and latrine and electricity connections because they cannot communicate directly with the *upazila* administration and fear litigation if something they do goes wrong.

We came across Transparency International workers in the south study area who were helping hospitals and schools to erect sign boards to explain services and provide information as well as identifying the public's rights and the service providers' deficiencies. These are pilot projects and too early to assess any impact.

DIET

'We have almost forgotten the taste of meat as we haven't had it for a long time', (HHH father, north urban). The quote sums up the fact that it is now very rare for families to eat meat in any of our study locations except at Eid when the meat may be gifted to them or occasionally bought. An exception is the urban central area where incomes have increased over the last five years and chicken or chicken skin is often eaten. The main protein source is fish but this year we noticed an increase in egg consumption which may be because flocks have now regained sufficient size following the Avian Flu epidemic and concomitant preventative measures in 2008. Despite rising food prices, most of our study families indicate that they eat a little better than they did five years ago.

Often fish is bought in bulk by neighbours and the cleaning and preparation is a shared activity as here in the urban central area.

Most of the study families cook only once per day, although they may have cooked more often before. This is both to save fuel (which is more costly) and time. In the north study area, families indicated that they had reduced their daily intake because of spiralling food prices

but, like in other places, families have developed new priorities and want to be able to pay for mobile phones, *tiffin* for their school-going children and other educational costs.

As vegetable prices have escalated this year, there has been a shift towards taking more potato, the only vegetable which has not seen an increase this year. It is common for families to eat only rice and mashed potato in various forms in place of fish. The limited nutritional value of potato is not understood as the following quote which is typical in all three study areas suggests: *'What is the need to take other vegetables if we are taking potatoes everyday?'* (HHH, north urban). Another HHH said: *'We have poor knowledge about the food value of different vegetables and nobody tells us about this'* (urban north) and teachers say that this is not covered in the school text books any more (urban north). We are told that vegetables in some areas are considered *'poor persons' food'* and others simply say they don't like eating vegetables e.g. *'If I have Tk.30 in my hand I will not buy spinach but will buy chicken skin as it is more tasty'* (FHH central urban). In the central urban study area we rarely saw children eat vegetables at all partly because they say they don't like them but also because the only affordable vegetable other than potato is bitter gourd and this is not given to children. People say they are not motivated to grow vegetables at their homesteads because it will get *'eaten by goats and chickens'*, the courtyard is *'too shaded by trees'* or they *'cannot be bothered'*. But in the north rural study the high price of vegetables has motivated people to grow beans, onions, aubergine and leafy vegetables for the first time. Although families eat three meals per day the first meal of the day may be quite meagre comprising *moori* (puffed rice) or *ruti* and tea.

"Children will not go to school if we don't give them Tk. 5 for snacks. They do not understand our difficulties to pay Tk. 5 every school day" (peri-urban north)

"We cannot keep pace with the demand from children snacking all the time" (snack vendor, central urban)

Outside the school children spend their daily pocket money on pickles and sweets.

HYGIENE

As noted in the context section, environmental cleanliness is declining in some areas. Open defecation has resumed in some places as latrines have filled up or have become unusable through lack of maintenance. Even where there are properly installed and maintained latrines families adopt a liberal attitude to managing babies' and toddlers' faeces often scooping them up and throwing in the bush and wiping bottoms

Hands up who gets more than Tk. 5 pocket money everyday.

This is the new toilet of one of our HHH cost Tk10,000 and represents the new trend in this area which has not been prompted by any local sanitation programmes. The family had a kutcha toilet five years ago. They tell us they have seen toilets like this on TV. 'You will see the toilets round here have toilet tissue and soap ... it is everywhere now but do they care about their children's faeces? Even my daughter-in-law just throws her baby's faeces into the bush and she is well educated.' (Pharmacist, central rural)

with saris and *ornas*. There is a persistent belief that these faeces will not cause diseases like adult faeces.

Spitting continues to increase including inside the house; *'don't worry it will soon be absorbed by the mud'* (HHH father, north rural). Children particularly delight in spitting and tell us it has become a *'habit'*. We talked at length with an elderly much-respected pharmacist about our observed increase in spitting and he agreed it had increased a lot: *'Although people are more educated these days they seem less aware of these problems'* and pointed out that was one factor in the increase in colds and coughs. Another man added: *'If you tell people to stop spitting they aggressively ask: 'Who are you to tell me this?''* (central rural)

Main Findings in Education

As with the main findings in health, we have confined our findings for education to newly emerging ones and refer the reader to www.reality-check-approach.com for issues which have changed little this year. The most significant finding this year is the concern among parents and teachers alike regarding falling standards in primary education for which most blame the introduction of the Class 5 terminal exam and the emphasis on memorisation.

"I asked my niece who scored A+ in the last terminal exam to do some translations for me. You will not believe it but she could not do any and I was so shocked! Now all they need to do is memorise the answer. They do not know what they are writing" (father, south rural)

Although defensive of any choice of education made for their children, parents often confide that they prefer private schools[6] as teachers are *'more committed, they know they might lose their jobs if they are not accountable to guardians... in a government school the teachers know they are in service and have a guaranteed salary. They don't care'* (young mother, central rural). Parents know that the teachers in private schools do not have certificates in education but tell us that their children learn more and like the young teachers[7]. The one overriding difference noted everywhere is that private school classes (and indeed coaching classes) are small and children get more attention.

"Government primary schools would be the best if only the teachers taught in the same way as in private schools" (HHH, south peri-urban)

There is a prevailing notion that RNGPS are inferior to full GPS (e.g. in the rural south study area it was described as *'the son of the step mother'* implying it was not fully recognised as GPS are). There is however a feeling that admission into government schools is important so that students are part of the recognised system. The most important change people would like to see in government primary education is for teachers to be committed, punctual and provide all the necessary education within class time so that extra lessons and coaching would not be necessary. There is also room for more exciting and stimulating lessons, people told us, something which private schools are said to do better. Some, particularly in the rural south study area where they had experienced good quality supervision in the past, felt that more frequent supervision of Government schools by *Upazila* Education Officers would go a long way in improving standards and ensuring teacher discipline. Where Government schools have small classes, full complement of teachers and motivated Principals, parents say they are less likely to prefer private schools.

Private schools are not necessarily better resourced than government schools but parents like them because of the small classes and committed teachers

Staffing of Government Schools. The most significant change this year is seen in attempts to fully staff the Government primary schools. 85 % of the GPS schools in the study areas have for the first time a full complement of staff. But a few schools still struggle with

6 It needs to be made clear that these charge in the region of Tk. 300–600 per month. Parents say this is often little more than coaching costs which they consider essential if their child goes to a Government school. They argue that this is more cost effective as privately schooled children do not need coaching and it is better for the child as the school day is shorter.

7 Who are often young graduates or Masters students using the job to help pay for their education.

inadequate staffing for example the school in the rural north which has one full-time teacher-cum-principal and one part-time teacher only (for 273 students) and the school in the rural central study area which has three temporary teachers and no principal (for 170 students).

Box14: Some glimmers of turnaround in GPS

The Principal (of the GPS) is delighted as, for the first time in the five years of the study, it has a full complement of six teachers (128 students). This is partly due to the new policy which enables teachers to return to their home upazila for employment and partly due to new recruitment. But he says: 'The teachers are lazier now... we managed to get all our students through the terminal exam with only two teachers before and were singled out by the Education Office for demonstrating what can be done with few resources. Now we have more teachers but are less diligent'. (Field notes, central rural)

In the south urban GPS there are thirteen teachers now and all but one are young women. There is a lively and friendly atmosphere with teachers joking with each other and students coming into the staff room in a relaxed way. The classroom walls are covered with posters. The staff room has lots of teaching materials which are clearly in frequent use. (Field notes, south urban)

'There are new teachers who are much better... it is turning into a better school'. (teenager, former student of GPS central urban)

THE TERMINAL EXAM

Useful construction has taken place in many government primary schools during PEDP2, but there is little attention to health and safety.

This is the third year of the class 5 terminal exam and children were just about to sit the exam while we were staying with their families. Most of the primary schools in our study areas claimed that they achieved 100 % pass in the terminal exam held in November 2010 and everyone agrees that the exam is easy to pass. Those who fail have usually missed an exam paper or fail in maths or English. There is considerable pressure felt by teachers from the education department to achieve high pass rates and there are various strategies adopted by teachers to ensure this (see Box 15).

Box 15: Strategies to ensure high pass rates in the Class 5 Terminal exam

'We manipulate the roll numbers in the model test so weak students sit next to strong ones. These roll numbers are then replicated in the public exam. We encourage students to help each other in the exam as long as they do it quietly. In the past we could easily provide school certificates for children to enter class 6 even if they were a bit weak. So this is no different – we do it this way for them now. If we don't do this, drop out will increase'. (Teacher RNGPS, central rural)

The school is better organised to provide intensive exam preparation for its students than in previous years. The teachers have prepared a package of possible exam questions which the students learn by rote. They hold a monthly exam to test these. The teachers believe that the exam has created a competitive climate among students and fostered attention to attendance and home work. (Field notes, south rural)

Teachers explained that they are more likely to hold students back in Class 4 than before as it was 'not possible to get weak students ready for the exam in one year'. This also ensures that they will not repeat in Class 5 which 'looks bad for the authorities'. (Field notes, central rural). Twenty children had been held back in Class 3 (in the RNGPS) because they were not ready to start preparation for the terminal exam. (Field notes, central urban)

Both GPS and RNGPS hold compulsory coaching before school costing Tk.250 and Tk.200 per month respectively. (Field notes, central urban)

Children and parents are much more relaxed about the exam than in the previous two years. The evening study we noted in 2009 has largely stopped. Some have dropped coaching as they know they will pass without it (e.g. north rural). Even children who scored poorly in the model test are confident that they will pass the real exam. Some schools

Children preparing for the class 5 exam.

are nevertheless requiring compulsory coaching towards the Terminal Exam for which they charge. This can result in a student studying for nine hours per day and children increasingly tell us this is repetitive and boring. *'The exam seemed like a good idea as teachers and children became more serious.... but now I am realising that the kind of learning is not very helpful as it is all memorisation and teachers are helping the children in the exam. Quality is definitely going down and I am worried for the future'.* (Man, central rural).

"They even memorise the maths calculations. When I changed the numbers the children could not do it" (Field notes, north urban)

The low standard required to pass the exam worries some parents (see quotes at the beginning of this section) and some teachers: *'Before it was hard to pass and students were carefully recorded by merit. Now we are forced to get the children through. Teachers are sometimes surprised, even shocked, when weak students actually pass – when we get together we laugh about this. Children ask me why they need to learn anything as they only need to pass the exam'.* (Principal private primary school, central peri-urban)

"Students are becoming lazy. They memorise everything ... and student and teachers become dependent on guidebooks. We sell many different guidebooks and get a very good commission from selling and pass on some discount to some teachers" (Booksellers, north peri-urban)

Makmuda (speaking in English): *My name is Makmuda, I am 10 years old. My mother is a teacher. My father is a farmer'.*

Me (speaking in Bangla): *But, Makmuda your mother is not a teacher, she works in a garment factory. And your father is a rickshaw driver.*

Makmuda (speaking in Bangla): *I know, I know but this is the right answer. If I say anything else the teacher will mark it wrong.*

Although most people supported the idea of having only one exam per day instead of two as practised in 2009 and 2010, some families incur high costs as a result. In the central rural study area the exam centre is 8 km away and the return fare cost Tk.100. Assuming they share rickshaws the minimum cost for children to attend six days of exams is Tk.300. We were also told that rickshaw drivers cash in on this and charge hiked *'porikha bara'* (exam fares) and there is loss of earnings for those who have to accompany the children. Children in the rural north and central peri-urban study area faced similar costs and although the costs were not so high there were also complaints in the south peri-urban area too. Schools which host the exams and provide invigilators feel that the longer time is a burden and disrupts their work with other classes.

DROP-OUTS

"Some weak students cannot follow what the teachers say in class and the teachers do not give them time. There is no time to play any more because of coaching. Some are older and feel shy to sit with us. The new Principal does not visit the homes of absent students and their parents do not know that they are not in school" (Class 5 students, north peri-urban)

Several Principals were concerned that holding children back (an increasing trend to ensure high pass rates in the terminal exam – see Box15) creates a problem as 'old for year' children are embarrassed to continue. This was highlighted in the 2010 report (p 44, Box 14). Mahmuda (14) in the central rural study area is an example of this. She now lives with her brother in town and says she *'does nothing all day'* but left school in Class 3 last year because she *'felt awkward'*. Her friend (13) has missed years of schooling and is now in Class 2. She will be 16 when she reaches Class 5 and family and teachers think it is unlikely she will stay in primary school but *'will not be able to take the Class 5 exam anywhere else'* so her education will stop. A private school principal in the central urban study area voiced her concerns that the exam put too much pressure on children and those who could not keep up with the memorisation and miss school often will drop out: *'Their school life is finished then as there is no way to continue'*. She said the system fails to take account of the fact that children develop at different rates. Some parents continue to be concerned that if they cannot afford what is regarded as 'essential coaching to pass the exam', their children will fail and so take their children out of school in year 3 or 4.

The calculation of drop out rates at the RNGPS

The calculation of drop-out observed in one school in the central urban study area seems wrong (see photo and translation in table below) and we understand that all the schools under this Education Office have been told to calculate it this way. The percentage drop-out is based on the original intake at class 1 and is not adjusted for those who have transferred to another school or those who are held back. In this example, the drop out rate was calculated as 12,5 %, calculated as 11 students who dropped out from the 88 students who originally enrolled. However since 20 students were held back and 24 transferred to other schools, the actual drop out rate is 11 out of 44 students which is a more worrying 31 %.

5th Class enrolled students		Year	Number of Drop-out		Year	Drop-out percentage
Enrolled in class 1 (1416 Bangla year)	Failed in class 5 final exam (2010)	Repetition in class 2–4 (1416 Bangla year)	Repetition in class 5 (2010)	Transfer/ readmitted to other school	Total drop out	
88	33	20	0	24	11	12,50

As noted before interruptions in education even for short periods can result in the child wanting to drop-out. This is particularly apparent with the current emphasis on memorisation as losing a few days can mean that a whole passage from the text book has not been learned. For example a girl in class 6 in the rural south study area had to look after her little brother in hospital with pneumonia. She only lost nine days but felt de-motivated when she returned and asked her parents to hire a coach to help her catch up. They could not afford this and the girl has chosen to stay at home. We have also heard of two cases where the cumbersome process of securing transfer papers has hindered enrolment in a new school (rural south and peri-urban south). Time and substantial bribes were required resulting in the drop-out of a girl who had

always done well in school and de-motivation of the boy as he felt he will lag behind when he finally joins the school.

Some parents continue to put pressure on their children to help at home as well as go to school. For example a young girl in the south peri-urban area goes off to school as early as she can to avoid her mother's requests to look after her younger siblings and one HHH mother was criticised by her brother-in-law for constantly giving her daughter more chores to do and never sitting down with her to read or acknowledge she needed to study (south urban). In the urban north study area the shortage of drinking water since the nearby pump went out of order means that children are kept home to queue for water at another pump further away. Schools with lunch breaks complain of *'post lunch drop out'* with as many as 50 % not returning after lunch.

"Nowadays you will find even rickshaw pullers have SSC pass" (HHH, south peri-urban)

Frustration has increased over the lack of jobs for young people with education. We met a group of drop-out boys in the south peri-urban study area who have no intention to return as they say there are *'no jobs in the area for people with average results... you need high marks and costly additional skills training'*. Similarly, *'there is no point going back to school. I cannot get a job with my SSC qualification so what is the point of spending more money on education? I would rather spend money getting a drivers licence'*. (Boy, south rural).

"What is the point of getting a class 7 pass? What can a girl do with that? Only be a maid" (Teen girl, central urban)

Girls in the central peri-urban and in south peri-urban study areas have good prospects of employment locally in garment factories, fishing net and electronics factories if they get an education while boys have plenty of opportunities in construction, manufacturing and transport without the need for education. Girls in the south peri-urban study area complained that even getting a good degree did not guarantee you a job as *'you will need to pay Tk. 3 lakh (bribe) to get a job as a teacher'*. We felt that in some areas parents desire to keep children at school, particularly older children who are not doing well, is reducing compared to five years ago partly because they see no future employment benefits and partly because the costs of education (with mandatory coaching costs) are increasing. For example, boys of 13–15 years can earn Tk. 200 per day pushing rickshaws up the slope of the bridge in the north urban area and enough for snacks and mobile phone use from working in the new brick fields in the central rural study area. In both the urban and peri-urban locations in the north frequent migration by families chasing work opportunities was cited as another reason for drop-out.

Box 16: Changing view of education

The father told us there is 'no benefit from having passed SSC. Many boys and girls have SSC and HSC but are jobless and frustrated. The boys are being recruited by politicians and becoming a nuisance'. Before this family had been very keen on education and were disappointed when their boys decided to drop-out. Now the boys have work in Dhaka even without education. They say that girls with education can get married with less dowry. 'She will be able to support her own children through education without having to pay for coaching'. (Field notes, south peri-urban)

'Illiterate girls never get good husbands these days – families look for good-looking and literate girls for their sons'. (FHH, central urban)

Some older girls who are failing at school see starting relationships with boys as a way out of continuing with school. They know their parents will worry about their reputation (see Box 5) and will agree to get them

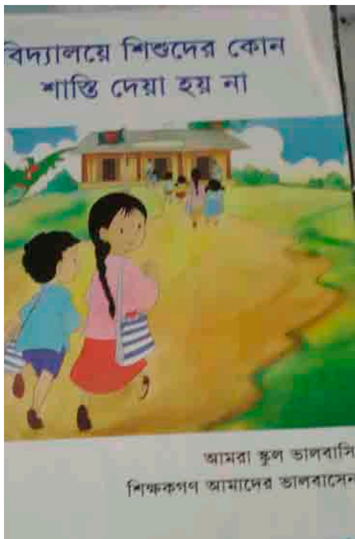
married. This is seen not only as way to get out of school but to achieve independence.

In the central peri-urban study area, people spoke of being very fortunate that primary, secondary and tertiary level institutions are available in the community. This, they say, makes a difference to continuing education as social pressure expects cohorts to continue with each other throughout the system.

CORPORAL PUNISHMENT

"We beat our children so why shouldn't the teacher? She does it for the benefit of the child" (Parent, central urban)

The new High Court Ruling early in 2011 making corporal punishment in schools an offence has worried many teachers. *'It is not possible to control fighting and children hurting each other without a stick in our hands. Ideally the teacher should be like a magician and motivate children so very little punishment is needed but this is not possible all the time.'* (RNGPS teacher, rural central). One teacher who had ceased all kinds of punishment felt that negative results were already apparent as the *'naughty students were not performing well at all'* (rural south). Most teachers told us that they needed to retain the threat of punishment at least. Some said they were confused by the Meena campaign (see photo) and were not sure if this meant that they could not use any form of punishment including raising voices, getting children to clean the classroom or providing extra work for bad behaviour. *'We used to carry a stick not to hit the children but to hit the table to make a noise and get order... now we cannot do that either'*. (GPS teachers, central urban). We observed several teachers who carry scale rulers instead of sticks fearing being accused of corporal punishment.



The UNICEF produced Meena poster states: 'School children will not get any punishment – We love school and the teachers love us'. Some schools have refused to display it and others find it a problem as if the teacher so much as raises her voice the students will point at the poster.

Students told us *'our teacher has to beat us to make us quiet. We only have one teacher in the school and sometimes we make a lot of noise when he is not in our class. He has to use a stick to control us'*. (Rural north). Though some parents felt it was right that teachers should be able to punish in this way some said it was 'unacceptable'. (HHH, south rural). But more felt it was nevertheless needed: *'Children are becoming more unruly, attendance is falling. Even children in higher classes are skipping school. You find them riding motorbikes instead. They are out of parent's control. Now teachers will not punish either. The children know this because they have seen the advertisements on TV about a teacher being handcuffed for violating the punishment policy. Children are now free from fear and the nation will see the consequences'*. (Man, south rural). *'There are so many children in the class. What would you do? Kiss them or beat them? If you look at how things work at home you will see poor people cannot control their children so rely on teachers to instil discipline'*. (Man, south peri-urban). *'If teachers are no longer allowed to punish children it shows they do not care. They don't care they are mis-behaving and therefore do not care if they are doing well either'*. (Parent, south urban).

Teachers and parents all felt that there should not be corporal punishment for academic inadequacies and that it should be reserved for bad behaviour or non-attendance.

Box 17: Punishment dilemmas

The Principal told us about a recent incident when one boy stabbed another in the wrist with a pen. The Principal threatened to confiscate his books and told him she would need his parents to come and collect them. The boy wanted to avoid this so agreed to behave better. But the Principal was concerned that even this sort of action might be considered wrong and guardians might complain against her. The Court verdict makes them feel very worried. (Field notes, central peri-urban)

The teachers told us about a situation where a boy threw another child's tiffin against the wall. The Principal did not know what to do and called in the mother and demanded she pay for the tiffin. This response was felt to be inappropriate as the boy took no responsibility for his actions. The main problem seems to be that teachers are confused and do not know what they can and cannot do. They have little orientation to alternative ways of dealing with indiscipline. (Field notes, central urban)

PRE-SCHOOL

Government intended for all GPS to start pre-school classes from January 2011. Where space and teachers are available this has been complied with within our study areas. In some areas the lack of space has led to incorporating the pre-school with Class 1. At the GPS in the north peri-urban study area the teacher said they have 320 students in the combined class 1 and pre-school with only two teachers. She said: *'It takes me 40 minutes to take the register'.*

We met several teachers who had attended the one week pre-school teacher training at their Local Resource Centres held mid year and they indicated that they found this useful: *'It was better than the whole year of Certificate in Education training. I learned a lot and it was very practical so I could apply what I learned'.* (Teacher, central rural)

The pre-school in the north urban study area uses the school verandah. Only 13 children come regularly despite 30 enrolled. There are few resources and the older classes continually disturb them.

Box 18: Observation of government pre-schools

The young woman teacher had the pre-school training manual with her and based her session on it. The children and the teacher sat on the floor completely engaged despite the two visitors (us) sitting on the floor at the back. They got up to do some fun exercises to a song, sat to do some writing skills practice and then played some interactive word games. The session was enchanting and the best example of pre-school interaction we had seen anywhere. The only problem was that the children arrived at 9,15 am and class did not start until 9,50 am. (Field notes, central rural)

We observed the pre-school session but although the teacher had received the one week training she seemed to find it hard to put into practice what she had learned theoretically. She tried hard to engage the students but concentrated only on a few, leaving others out. For example, she invited one child to the blackboard and focused on her while the others were messing about. She used no visual aids in the lesson. (Field notes, south rural)

There were 30 enrolled students but only a third present. It was originally held on the verandah according to the instructions of the Upazila Education Officer but parents objected. They now sit with the Class 1 students. he situation is chaotic as there are more than 300 children in this class. The pre-school children are forced to stand for long periods because the Class 1 children occupy the benches. (Field notes, north peri-urban)

There were 45 children enrolled but only 23 had turned up (all but 5 were girls). The class started 15 minutes late and ended 15 minutes early 'because the children are ready to go home and don't want to stay any longer' (teacher). The teacher had been on the one week training programme. She engaged them well, involving them in coming up to the board, clapping along to songs and poems, reading a story and getting children to repeat it. She used resources well such as demonstrating addition by using pencils. She encouraged the children to share and help each other. However, she had to leave the cleaner in charge while she dealt with some administrative matters. The cleaner used a scale ruler to beat the children on the back when they made too much noise. (Field notes, central urban)

The children in this government pre-school were completely engaged in the fun activities the teacher organised based on her training earlier this year.

We came across this little group of children surrounded by their school books late one afternoon. They are all pre-school children. We asked them what they were doing. 'Private' they shouted back in English meaning they were playing at having private coaching (central peri-urban).

There is only an old mat on the floor for the pre-school students to sit on in the verandah. The teacher says they are often disturbed by the students of other classes who make rude noises, chant songs or throw rolled-up paper at the children while they try to recite rhymes. Some children are accompanied by older siblings which makes teaching difficult. Some urinate on the mat and the teacher has to clean it up. Others fall asleep. (Field notes, north urban)

OPPORTUNITIES FOR CITIZEN PARTICIPATION

Like the health facilities, few schools have Citizens Charters and if they do they are rarely publicly visible. In the south primary schools, the charters are hand-written and teachers were not clear about what the purpose was and had never spoken to parents about the contents. *'When we first put it up the supervisor checked it but nothing else has happened... after some time nobody will ask about it any more... there was no budget for activities around the charter... but we have never made it public which is our fault.'* (Teachers GPS, south peri-urban)

Few schools have active SMCs and fewer have effective PTAs. In the rural north school the ex-Principal told us: *'We have to do everything as instructed by the education office, so for the sake of providing the right documentation we prepare a list of different members of committees and keep this on file in case we are asked to show it.'* Teachers in other schools complained about the lack of support from SMCs, e.g. *'All they think they need to do is come to meetings and put their signature on minutes'*, (GPS teachers, south peri-urban) and *'the SMC members say they do not have the time to attend meetings so ask us to conduct the meetings and send them the minutes to sign'*, (teachers, north peri-urban). By contrast the SMC at one of the south urban GPS is regarded as very active. Re-elected last year, they hold regular meetings and constantly ask the Principal what she needs. The Chair donated Tk. 60.000 for refurbishment and other members donated fans. They are currently planning for a garden in front of the school. A good SMC is usually equated to one which can provide donations rather than one which effectively helps with school management.

Only one school in our study areas had established a student council. This is a GPS model school in the north peri-urban study area. They held elections in June 2011 with forty nine contestants. The elections were run along the lines of local elections and they even borrowed the official ballot box. But since this nothing has happened and teachers said they had had no instructions about what the student council was set up to do.

"We received a copy of the Citizens Charter but were never asked to display it, so it is on file" (Principal GPS north peri-urban)

Teachers expressed frustration at not having a voice. It was interesting to note that two teachers in the north urban study area who had previously been obstructive in sharing information were very open this year and the reason, they explained, was that they were both planning to take early retirement. Teachers in the south rural area told us about their dissatisfaction with a recent seminar in Dhaka to which they were invited but hushed up by authorities when they *'suddenly decided the rules of what could or could not be raised during question time'*.

There was much concern expressed in private schools about the new Government regulations proposed for operating private schools. Teach-

ers were angry that the 28 page policy was prepared without any consultation with private schools. The elements particularly objected to are the proposals to include a GPS teacher on the SMC, the enforcement of Government pay scales[8], and the exclusion of the use of books which are not on the Government curriculum list. This latter is particularly contested as the use of alternative textbooks and supplementary materials is often regarded as one of private schools main strengths. *'If private schools cannot use their own text books, what will be the use?'* (Principal RNGPS, central urban)

8 Private teachers' salaries are often much less than Government schools and the schools consequently attract young graduates who are prepared to work for Tk. 3.000 per month but produce good exam results.

Conclusions

Examples of unheard voices: Families living in poverty say…

"Rather than free medicines in out patients, we need subsidised treatment for in patients"

"Corruption in government health provision must stop"

"Men and young people need to get family planning and sexual and reproductive health advice"

"Schools and health facilities need better supervision"

"Primary education standards are going down"

"Education must be geared to getting better jobs"

Every year of the study we have commented on the need to promote mechanisms for the users of services and local providers to influence public services (i.e. for greater **participation**[9]). Although there have been some attempts to create such mechanisms, the Reality Check regularly finds little or no evidence either that these mechanisms exist on the ground, or if they do, that anybody uses them. This is perhaps ironic in a society in which complaining is well documented as an act of resistance (see Wilce, 1998). There are perhaps both supply and demand reasons for the lack of turning complaints into actions seeking redress. In a blame culture people are reluctant to raise criticisms and high 'power distance' in terms of unequal status inhibits voice. On the supply side, the arrangements that are set in place to facilitate participation may not work properly. For example, local committees are often captured by vested interests and this further excludes dissent. We note that the media exposure in the north study area had an impact on the quality of the services in the main government health facilities, but official opportunities to comment on service provision are either absent or controlled in terms of who is invited and what is discussed. Locally elected representatives are not currently viewed as conduits for making demands on behalf of constituents and anyway seem to have less interest in health and education than infrastructure, relief distribution and dispute resolution (the traditional means to acquire money and status).

Key to the lack of participation is an overwhelming absence of information about what is supposed to happen in terms of rights and duties in relation to public services (**transparency**). The Transparency International work to raise people's expectations of public provisioning that we observed in the south study area has potential, as do other projects which take a rights-based prospective, to build a demand for accountability. Nevertheless there will continue to be a need to gather opinions through informal means where people feel able to share experiences openly and without fear of reprisals. This five year Reality Check Approach has provided one informal and trusted means to convey the voices of ordinary people to policy makers and others need to be considered and supported.

As we have also highlighted each year the fact that **accountability** within the SWAPs appears to operate purely upward (rather than downward to people) and heavily emphasises the achievement of quantitative targets with little critical reflection on the possible negative consequences which may accrue. This perpetuates the illusion that service provision in health and education is performing well, when our 'bottom up' perspective shows repeatedly that there are areas of failure of provision, 'systems losses' or falling standards. Each leads to further distorted response to needs. Distribution of free medicines, manipulation of dropout and registration and attendance data (noted in earlier reports), conveyor belt promotion through primary terminal exams and the provision of new classroom

9 The Participation, Non-discrimination, Transparency and Accountability (PNTA) framework adopted by Sida forms the basis of this conclusion.

or health facility space without consideration of need are symptoms of a prevailing supply-led culture rather than a responsive and demand-driven one.

Furthermore, there seems to be an unwillingness for policy makers to question certain development or cultural dogmas. For example, the problem we have identified since Year 1, which recent statistics are beginning to confirm, of boys dropping out of school in greater numbers than girls because they do not find it stimulating, education often does not enhance their earning potential and they feel intimidated by successful and sponsored girls is yet to be embraced as an issue yet the families in poverty with whom we interact in the study have been worrying about their boy school refusers for several years. Knowing as we do that public forums are not the best platforms for people to air their opinions for reasons mentioned above, there is a worrying level of confidence in information generated in this way. Received wisdom continues to suggest that children only drop out of school because of poverty and the ignorance of parents, that traditional birth attendants are incompetent, that domestic violence is primarily gender-based, that women usually eat less than men and that men never care about contraception. Listening and immersion in the lives of people in poverty provides evidence that the real situation is much more complex and nuanced.

The quantitative target bias among current donor practices may also reinforce **discrimination**. When a child drops out of school from a poor family we have observed fewer efforts made by the school to encourage them back than before the introduction of the terminal exam because of the pressure to show high pass rates. Choice, for example for contraceptives, is constrained by service provision targets rather than consideration of the couple's needs. Information and explanations are denied to people living in poverty leaving them vulnerable to malpractice and inefficiencies which the perpetrators know will not be complained about. Much still needs to be done to tackle the issues around discrimination based on poverty to challenge patronising behaviours and practices.

Each year, one of our most striking findings is that people living in poverty are constantly making choices and trade-offs to optimise their scarce resources. They often continue to use and prefer private health facilities because they better meet their needs, but they also recognise that a functioning state provision would be preferred. But they are not going to make long journeys and wait in long queues for services which they ultimately find are sub-standard or require under-the-table payments to bring up to standard. Rationalisation of government health services in any given geographic area would ensure that rather than trying to provide a range of services ineffectively, some facilities would be guaranteed to have the necessary resources for particular problems (e.g. either the sadar or the district hospital would have full dentistry facilities but perhaps not both). Where resources were tight, full medicine provision for in-patients but cuts for out-patients (which would also have the effect of minimising time-wasters) and better and holistic co-ordination with NGO, private and some informal providers would promote complementarities rather than duplication.

Although the community clinic initiative is taking shape, there remains a lack of information about what these are intended to provide

as well as suspicion of political motivations in their operation. As we noted in the 2010 report their potential is phenomenal but not as long as their main function remains distribution of free medicines. What people want from these facilities is first line advice and support with ongoing conditions and needs (such as family planning counselling) to avoid expensive and time consuming expeditions to town centres.

The study reveals that there is a gap in understanding how behaviours have changed and adapting public health messages and services in response to these changes. There needs to be a response to the issues of taking excessive salt and chillies, increased snacking, unexplained increase in spitting, evidence of increased open defecation and increased drug abuse. There needs to be a response to increased violence in the community and family and recognition of the health demands made as a result of more social and sexual freedoms.

There is evidence that the drive to recruit and train new teachers so that government schools can provide better education services is having some impact but there is little consistency between schools and quality is primarily dependent on the energy and commitment of the Principals. With those that can afford it continuing to prefer private schools and the recognition that even those living in poverty will sacrifice other expenditures to meet these costs, government schools need to continue to address deficiencies, which fuel this preference. As with health services, payment for private services is seen to confer greater downward accountability and parents feel more able to engage with the school. Small classes with caring, punctual and committed teachers are key elements but increasingly we hear the appreciation that private schools provide what is needed to pass exams within the school day negating the need for additional coaching making them increasingly better value for money.

The pressure to achieve better results in the terminal exam each year is having a number of negative results including increased retention of students in classes 3 and 4, focus on memorisation of model answers to the exclusion of a wider educational experience and perceived falling standards. With targets for exam performance, there seems to be less concern about encouraging weaker students as excluding them from the register is an easier option to preserve the school's reputation. Coupled with the frustration that education does not necessarily equate to better income earning opportunities the challenges of the terminal exam for those who are irregular in school and struggling may contribute to increasing drop out before completion of primary education, an issue parents worry about.

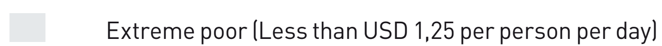
The early indications of pre-school initiatives which on the whole appear to engage pre-school children well indicates that much can be achieved with short focused teacher training and this approach could be taken to help teachers with other aspects of their role, for example helping them with alternative strategies to discipline without recourse to corporal punishment.

Finally, the Reality Check Approach has established over the years that useful up-to-date insights into why people make choices and behavioural changes can add value to large programmes such as the health and education sector wide programmes in Bangladesh by flagging up issues, explaining conundrums and putting faces and voices to the statistics. A full evaluation of the effectiveness of the approach to convey the reality of people living in poverty to policy makers and encourage greater responsiveness will be conducted in early 2012.

Annex 1. Host Household Changes 2007–2011

Households	WB Poverty Classification					Changes in Income				
	2007	2008	2009	2010	2011	2007	2008	2009	2010	2011
Urban areas										
North Urban HHH1						→	↘	↘	↘	↘
North Urban HHH2						→	↗	↘	↗	↗
North Urban HHH3						→	↗	↘	↗	↘
Central Urban HHH1						→	↘	↗	↘	↘
Central Urban HHH2						→	↗	↗	↗	↘
Central Urban HHH3						→	↗	↗	↗	↘
South Urban HHH1						→	↗	↗	↗	↘
South Urban HHH2						→	↗	↗	↘	↘
South Urban HHH3										
Peri-urban areas										
North Peri-urban HHH1						→	↗	↘	↘	↗
North Peri-urban HHH2						→	↗	↘	↘	↗
North Peri-urban HHH3						→	↗	↘	↘	↗
Central Peri-urban HHH1						→	↗	↗	↗	↗
Central Peri-urban HHH2						→	↗	↘	↗	↗
Central Peri-urban HHH3						→	↗	↗	↗	↗
South Peri-urban HHH1						→	→	↗	↗	↘
South Peri-urban HHH2						→	→	↘	↘	↘
South Peri-urban HHH3						→	→	↘	↘	↘
Rural areas										
North Rural HHH1						→	↘	↘	↗	↗
North Rural HHH2						→	↘	↘	↘	↘

Households	WB Poverty Classification					Changes in Income				
	2007	2008	2009	2010	2011	2007	2008	2009	2010	2011
North Rural HHH3						→	→	↗	↘	↗
Central Rural HHH1						→	↗	↗	↗	↘
Central Rural HHH2						→	→	↘	↗	↗
Central Rural HHH3						→	↗	↗	↘	↘
South Rural HHH1						→	↗	↗	↗	↗
South Rural HHH2								→	↘	↘
South Rural HHH3						→	↘	↗	↘	↗


Extreme poor (Less than USD 1,25 per person per day)

Poor (Less than USD 2,00 per person per day)

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

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

North	Central	South
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 school teacher	• Head masters from GPS and Kindergarten • Teachers (men and women) from GPS, Kindergarten and BRAC • Parents and students, (GPS, Kindergarten, NGO schools, primary and secondary level) • NGO teacher • Chairman of school committee, Kindergarten

Annex 3. Methodological Approach

SUMMARY OF THE BASIC METHODOLOGICAL APPROACH USED FOR THE REALITY CHECKS (FROM THE REALITY CHECK REPORT 2007)

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

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

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

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

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

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

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

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

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

LOCATION SELECTION

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

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

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

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

Annex 4. SWAp Programme Summaries

HEALTH, NUTRITION AND POPULATION SECTOR PROGRAMME (HNPSP)

Goal

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

Priority Objectives

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

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

Duration

Original – July 2003 to 2006, Revised-2003 to 30 June 2011.

Total Cost

Approved taka 94.100 million, GOB (Dev 14.000m + Rev 48.100m) PA 32.000m
Revised taka 324.503m, GOB (Dev 54.297m + Rev 162.271m) PA 107.935m

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 1.161m (63,9 %) and 654m (36,1 %) from 10 multilateral and bilateral organisations.

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

Acronyms

ANC	Ante Natal Care
BRAC	Building Resources Across Communities (formerly Bangladesh Rural Advancement Committee)
BTV	Bangladesh Television
CI sheet	Corrugated Iron Sheet
CNP	Community Nutrition Promoter
CTG	Care Taker Government
CS	Civil Surgeon
C/S	Caesarean Section
DOT	Direct Observation Treatment
DPHE	Department for Public Health and Environment
EPI	Expanded Programme for Immunisation
FHH	Focal Household
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
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 2012):

Tk. 100 = USD 1,22
Tk. 100 = SEK 8,44
Tk. 100 = GBP 0,79
Tk. 100 = EUR 0,94
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

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 contributed to Action Aid's immersion programme. She has also led Reality Check Approach Studies in Indonesia, Mozambique and Nepal.

Enamul Huda MSc is the team leader for the North sub-team and overall co-ordinator in Bangladesh. He has been working for over 37 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 as a short term consultant with the Food and Livelihood Security Programme of the European Union, the Food Security Programme of the Canadian Foodgrains Bank, the Maternal and Child Health Programme of German Doctors in Bangladesh and the Child Centered Community Development Programme of the Baptist World Aid Australia.

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 has worked in ICDDR,B 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. She is currently working as a lecturer in a private medical university in Malaysia since 2008, where she is doing her PhD in behavioural science using the Reality Check Approach as the qualitative research methodology.

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) for the Local Government Engineering Department (LGED).

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.

Amir Hossain MSS, MBA has over 22 years experience working with participatory training, research and monitoring and evaluation in Bangladesh. He worked with different INGOs and donor agencies. He has undertaken extensive field work all over the country and has been working with PromPT since 1995. He has specialised facilitation skills for community needs assessments on health, agriculture, education and analyzing the economic situation of communities. He is currently engaged with a few short time assignments under Action For Enterprise, DRRA and WCPF.

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. Recently he facilitated training sessions with for a wide range of participants in Bangladesh, Sri Lanka and Thailand.

Dil Afroz MSc has over 20 years of working experience with training, development research and development studies. She works with right based development organizations and the NGO sector in Bangladesh on right based approaches. She specializes in the use of participatory approaches and is associated with four research and training institutes in Bangladesh.

Shuchita Rahman MSS is a development professional; currently working as a Field Research Officer in the Qualitative Research Team at the International Food Policy Research Institute (IFPRI). She is doing her M.Phil thesis on food security issues from an anthropological perspective. She has been involved in a number of research studies and evaluations, involving qualitative data collection, coding 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. His most recent book is 'Bangladesh: Politics, Economy and Civil Society' (2011).

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, funded by a range of international development agencies in the capacity of project director, manager and consultant.

Nurse:	*‘You have been coming here for five years, what is your most important observation?’*
Me:	*‘That policy makers don’t know the reality’.*
Nurses (in union)	*‘Absolutely!’*
Nurse:	*‘They don’t see for themselves and they don’t listen.’*
District nurse:	*‘If they do what you do the policies would be very different.’*
MLSS:	*‘Yes like the Civil Surgeon says we can manage with one cleaner. He does not see for himself how impossible this is with the patients and numbers of visitors... but it is clear for you.’*
District nurse:	*‘Their eyes are closed and their ears are blocked.’*

(Conversation at the central rural Upazila Health Complex)

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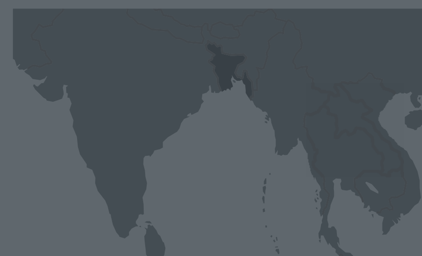
Reality Check Bangladesh – Year 5

BANGLADESH

The Reality Check Bangladesh is an initiative 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 fifth year of the Reality Check Approach as well as implications for policy development.



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