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# Baseline Survey of Caregivers' KAP on Early Childhood Development in Bangladesh

## By READ for UNICEF Bangladesh

# Baseline Survey of Caregivers' KAP on Early Childhood Development in Bangladesh


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# Abbreviations

| | |
|---|---|
| AHI | Assistant Health Inspector |
| ANC | Antenatal Care |
| BDHS | Bangladesh Demographic and Health Survey |
| CHT | Chittagong Hill Tracts |
| ECD | Early Childhood Development |
| EPI | Expanded Programme on Immunization |
| FGD | Focus Group Discussion |
| FHA | Female Health Assistant |
| FPI | Family Planning Inspector |
| FP-MCH | Family Planning - Mother and Child Health |
| FWA | Family Welfare Assistant |
| GO | Governmental Organization |
| H&FP | Health and Family Planning |
| IMPS | Integrated Multi-Purpose Sample |
| KAP | Knowledge, Attitude and Practice |
| NGO | Non-Governmental Organization |
| ORS | Oral Rehydration Solution |
| ORT | Oral Rehydration Therapy |
| PNC | Postnatal Care |
| READ | Research Evaluation Associates for Development |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid |
| UH&FPO | Upazila Health and Family Planning Officer |

# Executive Summary

## Introduction

Early childhood development (ECD) is the cornerstone of human development. It is a continuous and individualized process of change in which a child learns to handle ever more complex levels of moving, thinking, speaking, feeling and relating to others. Development includes both physical growth and mental development. Physical growth refers primarily to the integrated growth of the human organs, while mental development refers to cognitive, social and emotional development. Children's development does not depend solely on their levels of access to food and health care. It is also critically influenced by the quality of care they receive and interventions made on their behalf, which promote their cognitive, emotional and social advances. Bangladesh faces serious challenges in ensuring the development of its young children.

UNICEF is working with the Government of Bangladesh to implement a comprehensive early childhood development project during the period 2001-2005. The overall objective of the project is to develop activities designed to empower caregivers of children aged 0 to 5 years to promote children's integrated and holistic development. Childcare practices are divergent and multitudinous, varying by geographical area (rural, urban and CHT) and socio-economic status (non-poor/poor, education/no education, and aware/not aware of measles vaccines). In preparation for designing interventions under the new ECD project, it was considered essential to investigate the processes and factors that determine the quality of child care within the socio-cultural context of Bangladesh. Keeping this in view the study was carried out to achieve following objectives:

- assess the knowledge, attitudes and practices of caregivers regarding the care of young children (from conception to 5 years) focusing on their cognitive, emotional and social development;
- identify the key persons who are acceptable and credible to parents/caregivers as a source of information on child development; and
- examine media reach on matters relating to early childhood development.

## Study Methods and Sampling

READ conducted this nationwide study and data were collected during October and December, 2000. It was designed to examine the childcare practices of caregivers in terms of frequency and quality of care given to the child from conception to the age of five years. Both qualitative and quantitative methods of investigation were used to collect information from respondents from diverse cultural backgrounds across different areas, including tribal areas. Qualitative methods provided insight into the intricate and culture-based processes of child care, while quantitative methods gave estimates of the rates of childcare practices.

An Integrated Multi-Purpose Sample (IMPS) design was adopted. For rural and urban areas of Bangladesh, excluding Chittagong Hill Tracts, a nationally representative sample of 88 clusters at 95 per cent level of precision was estimated: 66 rural and 22 urban. CHT was treated as a separate sample with 12 clusters, which adequately represent the CHT population. A cluster refers to a *mouza* in rural areas and a *mohalla* in urban areas with 110 households per cluster. Using a systematic random sampling technique, a total number of 9680 sample households were selected for the rest of Bangladesh (rural and urban areas), and 1320 households for CHT. Sample categories were proportionally distributed by primary caregivers (55 per cent) comprising wives, mothers with children, pregnant women and newly-married non-pregnant women; and secondary caregivers (45 per cent) comprising fathers and husbands, married men

with children, newly-married men with pregnant/non-pregnant wives, siblings, older guardians, and household helpers. The proportional distribution of caregivers was determined taking multiple factors into account.

**Data Collection**

Intensive supervision was undertaken by READ professionals to ensure data quality during data collection which, on completion, achieved the following status:

- Survey interviews: 1075 out of 1320 interviews for CHT and 9663 out of 9680 interviews for the rest of Bangladesh;
- FGDs for community/opinion leaders: 100 out of 100;
- FGDs for adolescents: 26 out of 26 (12 female, 14 male);
- Household-level observation: 298 out of 300 households; and
- Intensive interviews: 295 out of 300 interviews with caregivers - mothers (144), fathers (50), sisters (42), brothers (20) and grandparents (39)

**Design of Analysis of Data**

Analysis of findings includes discussions on caregivers' (males and females) role and influence on the physical growth and mental development of children aged 0 to 1 year, > 1 year to 3 years, and > 3 years to 5 years. Analyses have been undertaken integrating the findings obtained from the surveys, intensive interviews, FGDs and direct household-level observation of caregivers' childcare practices. One section separately compares caregivers' influences on the mental development of a child by their socio-economic status, i.e. comprising being non-poor/poor, having education/no education, and being aware/not aware of measles vaccines. A word of caution: several answers given during qualitative investigations suggest a high level of awareness about measures and influences concerning the mental development of a child. These responses were mainly provided by a few caregivers during intensive interviews and FGDs, and should not be construed to reflect the true level of awareness of caregivers in general.

**1. Socio-economic and Demographic Characteristics**

Study areas comprise six divisions and CHT, covering 33 districts and 100 clusters in 96 upazilas. There is hardly any difference in the mean age (28 years) of caregivers across different areas. The findings of the study confirm the recent statistics on overall national literacy rate of the country at 60 per cent. Most of the female caregivers are housewives while males are engaged in various different occupations. The mean monthly family income reported by caregivers for rural areas and CHT (Tk.4265-4829) are comparable, while the mean monthly family income reported for urban areas is Tk.6803. On average, a family owns about two minor electronic/mechanical items, which include a radio. Almost all the households have parents, while in more than three-quarters of households, there is a brother or sister. But in only a little over half of the rural households there is an older relative (grandparent/uncle/aunt), while in CHT in more than two-thirds of households, there is an older relative. In urban areas, however, nearly one-third of households has an older relative. The reported average family size both in rural areas and in CHT is 5.5, while for urban areas it is 5.4.

**Household Environment**

Household environment was investigated in terms of 'cleanliness' (presence of dirt in and around the house), 'quality of surroundings' (status of openness of the area and presence of light) and 'security' (any exposure to danger). Results show that in rural areas, more than half of households are assessed as clean, while in urban areas more than half (61 per cent) are not clean. In CHT the majority (64 per cent) of households are clean. Surroundings of only one-third

of households in urban areas and less than half in rural areas are assessed healthy, while in CHT, surroundings of nearly two-thirds of households are healthy. Judging the status of security of households, nearly 40 per cent of households in CHT were considered safe with a comparable proportion (37 per cent) of rural households also considered safe, while a little less than one-third of households in urban areas were considered safe.

**2. Care during Pregnancy**

The vast majority of caregivers stated that they knew that pregnant women need care during pregnancy which included 'eating nutritious food during pregnancy, followed by 'avoiding heavy work', 'having TT immunization', ' eating extra food' and 'taking short rest'. Awareness on ANC/PNC was observed to be very low. All the caregivers identified parents and in-laws as the primary source of care during pregnancy, followed by husbands (>70 per cent), siblings (7 to 41 per cent) and neighbours (7 to 15 per cent). As regards support for care during pregnancy from outside the family, one-third to one-sixth of caregivers identified health workers followed by health facilities. In rural and urban areas the majority of caregivers (45 to 66 per cent) and in CHT about one-third (33 to 39 per cent) identified mass media as the most credible source of information on care during pregnancy followed by 'doctor/nurse', 'Health and FP workers', and 'relatives, neighbours and friends' in that order. Very few mentioned private clinics. Awareness about the impact of psychological or physical abuse on the outcome of pregnancy is very low.

**3. Preventive Childcare Measures**

About one-sixth of female and one-quarter of male caregivers in rural and urban areas, and about one-third of both male and female caregivers in CHT are not aware about the preventable childhood diseases. The majority of caregivers (78 to 86 per cent) reported fully immunizing their children. The overwhelming majority of caregivers, females (75 to 80 per cent) and males (68 to 75 per cent), said that they give ORS, followed by taking the child affected by diarrhoea to doctor (23 to 37 per cent), giving liquid frequently (10 to 43 per cent) and continuing to feed the child normal food (5 to 18 per cent). Observation at household level revealed that children in rural and urban areas usually suffer from common colds, fever, eye and ear infections, scabies, accidents/injuries and diarrhoea/dysentery. In most cases, treatment was hardly sought, except sometimes when the father took the children to the doctor or brought some medicines from the pharmacy. In many instances, home-based treatment was given, like washing head with cold water, massaging oil, rubbing/rinsing with cotton, applying Savlon, etc. The majority of caregivers are not aware about optimal breastfeeding practices including the need to feed colostrum. Bottlefeeding practices were observed more frequently in urban areas.

**4. Child Care for Physical Growth and Mental Development**

A child is generally given warm physical care and love till the age of 1 or a little more; by the age of 2, the child is more or less left alone. According to the estimates of mean time spent on child care in a day (24 hours), the primary caregivers (mothers) spend about 4.1 hours, while all the secondary caregivers combined spend 3.1 hours. More than 60 per cent of caregivers believe that childhood extends up to the age of 2 or at 3 years. Caregivers were in broad agreement that the most important measures to ensure a child's healthy physical growth were feeding nutritious food, keeping the child clean and taking a sick child to the doctor. There was an overwhelming acceptance of the need for affectionate and warm behaviour to promote children's healthy mental development. The majority of caregivers in rural and urban areas stated that they were not aware of any specific obstacle to mental development. Malnutrition and sickness were identified as primary impediments to physical growth, while sickness and neglect were mentioned as important factors impeding emotional development. The physical movement and growth of a child were identified as primary indicators of physical growth and happiness as an important indicator of mental development.

Opinion leaders from urban and rural areas mentioned height, weight, movement and feeding habits as indicators of the physical growth of a child, while keeping happy, imitating others' behaviour and asking questions were mentioned as indicators of mental development. In intensive interviews, caregivers identified measuring child's body structure, build and growth, eating habits and appetite, movement e.g. walking, frequency of playing, observing the behaviour and manners of others and self-expression as indicators of child development. Traditional practices, such as conversing with a child, giving loving care, engaging the child with toys are followed to some extent to stimulate a child's curiosity. Punishment of a child after he or she does something wrong ranges from negligence to beating.

**5. Care of Children with Disabilities**

The majority of caregivers (77 to 85 per cent) said they were not aware of discriminatory behaviour, either mental or physical, towards a child with disabilities. The overwhelming majority (66 to 89 per cent) of caregivers who described different types of discriminatory behaviour said that children with disabilities are neglected/teased/avoided, while 10 to 34 per cent mentioned that they get less care or love. The findings of the intensive interviews confirmed the opinions obtained through the survey. The responses suggest that the child with disabilities is given inadequate food, scolded and neglected, not sent to school, not allowed to play, beaten, mocked, and considered a liability of the family. Caregivers from CHT mentioned the need to mobilize the entire society to establish institutional (training) facilities on health and educational care for children with disabilities.

**6. Development of Learning Skills: Process of Socialization**

The first behaviour initiated by a child is his or her capacity to see which occurs from immediately after birth up to less than one month. The next series of behaviours initiated by the age of six months are feeling hungry, recognizing and hearing. By the age of 12 months crawling is added. Behaviours initiated in the next phase, from 12 to 24 months, are walking, speaking, learning, feeling, understanding and mixing (interacting) with others. According to caregivers and opinion leaders, the most complex behaviours reflecting intense mental efforts, such as smelling, thinking, acquiring knowledge and being curious are initiated after 24 months. The majority of caregivers in rural and urban areas, expressed the view that fathers play no role in the learning process of the child. In CHT, however, around half of caregivers recognized the role of fathers in providing emotional support in the child's learning.

**7. Discriminating between Girl and Boy Child**

About two-thirds of caregivers from rural and urban areas and 90 per cent from CHT reported that they are unaware of any behaviour discriminating between boy and girl children. Findings from the intensive interviews indicated that a large number of caregivers are unaware (don't know) about discrimination between boy and girl children. The reasons cited by caregivers for discriminating against the girl child are that girls require dowries during marriage, boys live with parents while girls leave the parental home, and boys are earning members of the family. A very low proportion of caregivers (1 to 6 per cent) stated that they do not discriminate against girl children at all.

**8. Emotional Development, Curiosity, Confidence-building**

The overwhelming majority of caregivers (64 to 88 per cent) are unaware of any steps that can be taken to stimulate a child's feelings. Levels of awareness on this point are lowest in rural and urban areas and highest in CHT. A child's first day at school is perceived to be a very important event. However, the overwhelming majority of caregivers from both rural and urban areas and the majority of female caregivers from CHT said that they were not aware of any need to

prepare the child for this experience. By contrast, the majority of male caregivers from CHT identified the need for such preparation. The majority of caregivers (69 to 80 per cent) in rural and urban areas do not understand the meaning of self-confidence in relation to a child. The level of understanding among caregivers in CHT is comparatively higher (60 per cent among male caregivers and 39 per cent among female caregivers). Being able to act independently was highlighted by caregivers as an important benefit of self-confidence in a child. Around two-thirds of caregivers in rural and urban areas and over half of caregivers in CHT believed that a self-confident child was an independent child.

**9. Impact of Violence: Physical and Mental**

Caregivers are aware of some harmful effects of exposing a child to violence. Around one-third to one-half of caregivers mentioned that a child becomes scared or aggressive if exposed to violence. Regarding use of physical violence, three degrees of violence were described: a mild act of violence, severe beating with stick, and no use of violence. Approximately 30 per cent of parents revealed that they used some kind of (mild or severe) of violence against the child, while the remainder stated that they did not use any violence. The vast majority of caregivers (80 to 91 per cent) perceived the negative impact of violent behaviour inflicted by parents on the child. Household-level observation and intensive interviews reveal that parents, older sisters/brothers and other older relatives abuse (by rebuking or beating) small children.

**10. Socialization Skills**

The vast majority of respondents said that they take part in games with children using different play materials, such as dolls, a toy car, ball or rattle. Caregivers identified playing and participating in games with others as providing good opportunities for socialization. There was a consensus that participation in games and play impacts on a child's physical and emotional development.

**11. Media Influences: Use and Exposure**

Television is the medium to which caregivers are exposed most frequently, with a mean score of 5 for caregivers in all areas (except males in rural areas, mean score 4). Television is followed by radio, with a mean score of 4-5, except for female caregivers from urban areas (mean score 3). Cinema and newspapers are ranked the same with a score of 3, followed by other print media (posters, booklets, leaflets). The subjects covered in messages transmitted through the mass media (in order of frequency) were 'Child care information on preventive measures, e.g. EPI and ORS', followed by 'Child feeding focusing on breastfeeding and supplementary feeding', 'Cleanliness' and 'Maternal care'. Messages dealing with 'Good behaviour with children' were very rarely mentioned.

**12. Comparative Analysis of Caregivers' Practices by Socio-economic Status**

Segmenting caregivers by non-poor / poor, education / no education and aware / not aware of measles vaccines, significant differences were observed ($x^2$–test) regarding their awareness on selected childcare variables, such as the six childhood diseases, importance of a child becoming curious and aspects of a child's emotional development. Those who are economically better off (non-poor), have had more education, and have a greater awareness of measles vaccines showed higher levels of awareness on all the variables.

**Logistic Regression Analysis for ECD**

The results of the logistic regression indicate that rural mothers are less likely than urban mothers to spend time on child care. The age of the mother is also an important correlate of child caring. The coefficient is negative, demonstrating that the lower the age of the mother, the higher the likelihood of her spending time on child care. Similarly, the higher the level of

education of the mother, the lower the probability of her spending more time caring for her children. The poor economic condition of the mother is also negatively associated with child caring. The findings of the regression analysis may be considered as conditional, since co-factors such as parity and members present in a family were not entered in the regression model. Hence, the influence of these and other similar variables on the conclusions has not been established.

**Conclusion and Implications**

Overall, no substantive differences in caregiving practices were observed between urban and rural areas A particularly striking finding in these areas was the generally inadequate knowledge and practices regarding emotional care. The situation in CHT on this issue was, however, much better. Behaviour demonstrating a child's independence, inquisitiveness and self-reliance is frequently seen as indisciplined, disobedient and argumentative. For example, children are sometimes punished when they try to wash their own clothes or when they argue with their father in order to learn something. Games and play are encouraged by caregivers. Many parents mentioned that they play with children. This is a positive behaviour, which may be further encouraged through community initiatives where parents and children get together to participate in games and sports. A number of cultural and religious practices are observed to be an integral part of the value system recognizing a child and promoting his/her development. These include name-giving and feeding ceremonies.

The mother is the focal point for child care in a family. During the first year of life, a child is mainly looked after by the mother and she is the sole teacher of social and survival skills. Fathers are involved in the care of children mostly aged 3 and above, to whom they provide company and teach socialization skills. Children learn about the environment and acquire socialization skills mainly through games with siblings and other children. It was observed that a child quite often tries to help the mother with household chores and in this way acquires survival and socialization skills. Grandparents occasionally provide loving care and company to the child, which is valued as a child care practice in Bangladeshi society.

Caring practices that discriminate between girl and boy children have been recognized to some extent. Study findings observed that caregivers of low income (poor) or educational (no education) status or who are unaware of measles vaccines are relatively less conscious of the factors influencing a child's mental development. Future programme interventions, while targeting all caregivers, may give relatively greater emphasis to these groups in order to raise their awareness.

The above findings have important implications for future programming. The current study has generated a large body of data on the childcare practices of different categories of caregivers. The data on adolescents, male caregivers and caregivers from CHT may be further analyzed as part of separate secondary analysis to determine the strengths and weaknesses of current caring practices related to psychosocial, emotional and cognitive development. Child care is highly valued in Bangladeshi society, but the quality of existing practices could be significantly strengthened if initiatives were launched to improve the awareness and practices of caregivers on different aspects of cognitive and emotional development.

# I. Introduction

## Rationale and Background

Early childhood development (ECD) is the cornerstone of human development. It is a continuous and individualised process of change in which a child learns to handle ever more complex levels of moving, thinking, speaking, feeling and relating to others. Development includes both physical growth and mental development. Physical growth refers primarily to the integrated growth of the human organs, while mental development refers to cognitive, social and emotional development. Cognitive development involves strengthening the base of knowledge and information, social development the improvement of interaction skills, and emotional development the intensification of levels of interest, inquisitiveness, feelings and warmth.

Children's development does not depend solely on their levels of access to food and health care. It is also critically influenced by the quality of care they receive and interventions made on their behalf, which promote cognitive, emotional and social advances.

Bangladesh faces serious challenges in ensuring the development of its young children. UNICEF is working with the Government of Bangladesh to implement a comprehensive early childhood development project during the period 2001-2005. The overall objective of the project is to develop activities designed to empower caregivers of children aged 0 to 5 years to promote children's integrated and holistic development.

In preparation for designing interventions under the new ECD project, it was considered essential to investigate the processes and factors that determine the quality of child care within the socio-cultural context of Bangladesh. Childcare practices are divergent and multitudinous, varying by geographical (rural and urban) area and socio-economic status (poor and non-poor). Many of the practices have a cultural basis and have been passed down from generation to generation.

This study, conducted by READ on behalf of UNICEF, has been designed to examine the childcare practices of caregivers in terms of both frequency of care given and quality of care. The former refers to the incidence of contact between caregiver and child, while the latter refers to the type and intensity of care supporting the child's development. Childcare practices are initiated from the time of conception up to the age of 5. The study has been conducted nationally and includes population groups from diverse cultural backgrounds across different areas, including tribal areas. When determining the levels and types of care given to a child in a family, it is necessary both to observe the child and to establish the relevant knowledge, attitudes and practices of the primary and other (secondary) caregivers. The ultimate aim is to identify the levels of cognitive, emotional and social development of a child, including his or her acquired (manifested) characteristics, and the factors influencing such development.

While families already play a positive role in supporting children's physical growth, they are much less involved in their children's mental development. This study, combining quantitative surveys and qualitative in-depth investigations, focuses on identifying and understanding existing childrearing beliefs and practices. In order to develop an integrated plan to design interventions for a comprehensive ECD programme, it is necessary to investigate the existing practices, deficiencies and the factors influencing the quality of child care within the socio-cultural context of Bangladesh.

Identification of the deficiencies in childrearing practices will, in turn, aid the design of programmatic interventions to strengthen the ability of caregivers to support young children's development, especially of a cognitive, social and emotional kind. The baseline data obtained will also enable implementers to measure the impact of interventions.

## Objectives of the Study

The primary purpose of the study was to generate information on the current knowledge, attitude and practices of caregivers regarding ECD. Parents, grandparents and older siblings are all involved in the care of young children; the sample was determined so as to focus on childcaring processes.

The objectives of the study were to:

- assess the knowledge, attitudes and practices of caregivers regarding the care of young children (from conception to 5 years) focusing on their cognitive, emotional and social development;
- identify the key persons who are acceptable and credible to parents/caregivers; as a source of information on child development and
- examine media reach on matters relating to early childhood development.

# II. Study Methods and Sampling

Both quantitative and qualitative methods of investigation were used in the study. The former gives an estimate of the rates of childcare practices by varying standards and levels of quality, while the latter provides insight into the intricate and culture-based processes of child care. Qualitative methods included observation of childcare practices at family level, intensive interviews with selected caregivers and focus group discussions (FGDs) with selected opinion leaders (having influence in the community) and adolescents.

## Sampling

In order to obtain the necessary quantitative and qualitative information, a nationwide study was conducted with a diverse study sample, including parents, grandparents and older siblings involved in the care of young children. The sample was determined in such a way as to permit an in-depth and comprehensive investigation of childcaring practices and processes. Moreover, to capture regional and cultural variations and other characteristics of the population – such as the poor, slum population or floating population – it was also considered by different income classes.

An Integrated Multi-Purpose Sample (IMPS) design was adopted to determine the sample size. The IMPS covers 372 sample clusters (253 rural and 119 urban) drawn from all over Bangladesh following a scientific sampling procedure. On average, an enumeration area consists of 268 households and 1375 population according to the listing and mapping operation. Previous survey findings revealed that about 13 per cent of children were under 5 years. For rural and urban areas of Bangladesh (excluding Chittagong Hill Tracts) a nationally representative sample of 88 clusters (66 rural and 22 urban) at 95 per cent level of precision was estimated. CHT was treated as a separate sample with 12 clusters, which adequately represent the CHT population. In subsequent references, the samples are broadly classified as 'rest of Bangladesh', covering rural and urban areas, and 'CHT'. A cluster refers to a *mouza* in rural areas and a *mohalla* in urban areas. From each cluster, 110 households were selected using a systematic random sampling technique. Thus, in CHT the total number of sample households was 1320 (110x12), while for the rest of Bangladesh the total number was 9680 (110x 88). The sample households for different categories of caregivers were estimated on the assumption that approximately 75 per cent of households were rural and 25 per cent were urban. The sample households selected for the study (including in CHT) were distributed according to the following proportions:

*Primary Caregivers: 55%*

- Wives and mothers with children (36 per cent)
- Pregnant women (13 per cent) and
- Newly-married non-pregnant women (6 per cent)

*Secondary Caregivers: 45%*

Fathers and husbands: 20 per cent

- Married men with children (12 per cent)
- Newly-married men with pregnant/non-pregnant wives (8 per cent)

Siblings: 10 per cent

- ♣ Sisters (6 per cent)
- ♣ Brothers (4 per cent)

Older guardians: 10 per cent
- ♣ Grandmothers and aunts (6 per cent)
- ♣ Grandfathers and uncles (4 per cent)

Other caregivers: 5 per cent
- ♣ Female helpers (3 per cent)
- ♣ Male helpers (2 per cent)

The proportional distribution of caregivers set out above was determined taking multiple factors into account, namely:

- Time spent per child per day weighted against the proportional availability of a caregiver in a household. The estimate of proportional availability of caregivers and time spent per child within a household were investigated and information obtained through a house-to-house census conducted in four villages in two upazilas (sub-districts) during the pretest. The proportional distribution of caregivers in the completed interviews (survey) matches almost completely the estimates obtained during the pretest.
- Considerations of meeting adequate sample size requirement per category of caregiver corresponding to availability of the given caregiver in the household, such as pregnant women, newly-married men and women.
- Assumed comparative importance of caregivers in influencing a child's life, especially his or her emotional state, for instance, the impact of a sibling versus the father

# III. Data Collection Management

## Study Personnel

The following categories of personnel were recruited for data collection:
- Team Leaders: 8
- Moderators/Observers: 16
- Interviewers: 54 (14 male, 40 female)

Two additional categories of personnel were recruited as:
- Local Observers - a literate woman from the cluster was engaged full time (from 7 am to 6 pm) to assist the observers from READ to observe childcare practices at household level; and
- Interpreters - to provide assistance to the interviewers from READ (who were residents of Rangamati district of Chakma origin) in the interior of Khagrachhari and Bandarban districts, where Marma and Tipra dialects are spoken.

Study personnel were recruited through advertisement in associated research agencies and educational institutions (to recruit tribal students for CHT interviews). A total of 150 applications were received. The target number of personnel (as specified above) were recruited through interviews by a selection board. The criteria fixed for recruitment of interviewers was the length of their field experience together with academic qualifications at least to graduation level. Some interviewers (10) dropped out during training and during data collection due to sickness or other family obligations. The vacancies created were immediately filled from among READ's pool of trained interviewers.

## Training of Study Personnel

The training of the study personnel took place between 12$^{th}$ and 30$^{th}$ September 2000. Training comprised 13 days' institute-based orientation and 2 days' intensive fieldwork combined with pre-tests. Training methods included: explanation of ECD concepts, discussion of techniques of interviewing in interpersonal and group situations; and quantitative and qualitative methods of data collection. During training sessions intensive group participation was encouraged through questions and answers focusing on four different data collection instruments, namely, structured survey questionnaire, guidelines for intensive interviews and FGDs and checklist for household-level observation. In addition, trainees took part in role-play sessions followed by intensive field practice, which helped to clarify confusions regarding language and the format for presentation and recording. Pre-testing of all the data collection instruments was combined with field practice. Thereafter, an intensive review of the instruments was carried out to improve the quality of the format and language of the questionnaire, guidelines and checklist.

## Data Collection Instruments and Methods

### Core Principles/Issues

Data collection focused on twelve core principles which are central to the development of young children:
- Critical period for ECD: Conception to 5 years
- Life in the womb: During pregnancy support from fathers and other family members is critical

- Interactive care: Interaction between caregiver and child is an important prerequisite for learning
- Inclusion: All children deserve to be nurtured well
- Participation: Encouraging active participation of children
- Multiple ways of learning: Encouraging child to learn through different kinds of activity
- Bonding: Breastfeeding and bonding with mother is an important practice
- Role of the family: Parents and family members are a child's first teachers
- Role of the father: Father's involvement in caregiving makes babies healthier and more emotionally secure
- Self-confidence: Building self-esteem of children irrespective of gender and ability
- Modeling: Significant adults teach children good behaviour and morals
- Negative influences: Violence, stress and neglect have a negative impact on a child's development.

**[CHECK – Which of the multiple versions of the core messages do we want to include here – the one provided to READ when they started the research, the one refined in collaboration by Cassie Landers, or some other? A relevant factor in this decision is whether we believe that this list should accurately reflect the principles that informed the research (the right approach?) or whether we want it to serve an educational purpose in this report.]**

In addition, information on the following media-related issues was collected:
- media use/preferred media
- frequency of exposure to each media
- likes and dislikes regarding selected messages relating to mother and child care.

**Methods and Instruments**

Quantitative and qualitative methods and instruments were used for data collection, as described below.

*Quantitative*

- **Survey Interview** Household-level interpersonal interviews with sample caregivers were conducted by trained interviewers using a structured questionnaire consisting of 15 sections with 75 major and 85 sub-questions targeted for 1320 interviews from CHT and 9680 from rest of Bangladesh and total interviews being 11,000.

*Qualitative*

- **Household-level Observation** Childcare practices of caregivers in relation to a specific child (aged 0 to 1 year, >1 to 3 years and >3 to 5 years) were observed at household level for a whole day (7 am to 6 pm). Observation particularly explains how a given behaviour is performed; the data derived from observation thus allow an assessment of the quality and strength of a given practice. A standard guideline (checklist) was used consisting of 16-22 items (depending on the child's age group). The total time for observing and recording caregivers' childcare practices was divided into three distinct periods: morning (7 am to 12 pm); noon (12.00 to 3 pm); and afternoon (3 to 6 pm). Only one child was selected for observation per household. A total of 300 households were targeted. Caregivers' behaviour towards boy and girl children was observed. A team of two persons, one selected from the

neighbourhood (preferably a FWA, female health assistant, volunteer or NGO female field assistant) and a READ professional (usually senior interviewer), carried out the observation.

- **Intensive Interviews** A target was set of 300 intensive interviews (three per cluster) with caregivers at household level (mothers, fathers, sisters, brothers and grandparents).
- **Focus Group Discussions (FGDs)** FGDs were conducted for local community/opinion leaders and adolescents (boys and girls). The target was 100 (one per cluster) for FGDs with opinion leaders and 26 for FGDs with adolescent boys (14) and girls (12).

## Status of Data Collection

Data collection was completed as follows:

- Survey interviews: 1075 out of 1320 interviews for CHT and 9663 out of 9680 interviews for the rest of Bangladesh;
- FGDs for community/opinion leaders: 100 out of 100, with an average of 7 participants per group;
- FGDs for adolescents: 26 out of 26 (12 female, 14 male), with an average of 6 participants per group;
- Household-level observation: 298 out of 300 households; and
- Intensive interviews: 295 out of 300 interviews with caregivers - mothers (144), fathers (50), sisters (42), brothers (20) and grandparents (39).

Four out of the 100 clusters were replaced in consultation with the sampling adviser for the following reasons:

- Mirzapur was replaced by Magura Gopinathpur due to devastating flood in the area during the survey.
- Surail was replaced by Roshulpur due to non-existence of a cluster by the name of Surail.
- Barahajachhari was replaced by Baradum due to non-existence of a cluster by the name of Barahajachhari.
- Daldali mouza was replaced by Dhalia due to political disturbance in the area.

In addition, Shonagazi upazila was replaced by Chagolnaiya upazila due to political unrest during that period; Chardarbesh cluster was consequently replaced by Pathan Nagar. However, the replacement of clusters did not affect the quality of sampling, since the clusters selected for replacement were from a comparable geo-cultural setting: replacement clusters were selected from areas adjacent to the old clusters.

Intensive supervision was undertaken during data collection by senior professionals from READ to ensure the quality of data. During the supervisory visits, specific instructions were given to all the teams in the field to improve their interviewing performance, including the following major points:

- to record correctly caregivers' relationship with the targeted child;
- to record relevant responses to questions numbered 8,11 kha, 13, 16, 20, 21, 42, 48 and 74 having understood the meaning and implications of these questions; and
- to follow specific guidelines on probing, skipping and recording.

Analysis of the status of completed interviews shows that data for survey interviews were collected almost in accordance with the targets for each category of the study population conforming to the sample stratification (rural, urban and CHT). Table 1 shows the distribution of completed interviews by targets assigned in the sample and by specific categories of caregiver (female and male).

**Table 1: Distribution of completed survey interviews by categories of respondent and geographical area (in per cent and actual number)**

| Category of respondent | Rest of Bangladesh | | | | | | Chittagong Hill Tracts | |
|---|---|---|---|---|---|---|---|---|
| | Urban | | Rural | | Total | | | |
| | Target | Completed | Target | Completed | Target | Completed | Target | Completed |
| Mother | 880 (36%) | 886 (36.5%) | 2640 (36.4%) | 2642 (36.6%) | 3520 (36.4%) | 3528 (36.5%) | 480 (36.4%) | 472 (44%) |
| Pregnant woman | 330 (13.6%) | 332 (13.7%) | 990 (13.6%) | 987 (13.6%) | 1320 (13.4%) | 1319 (13.7%) | 180 (13.6%) | 119 (11.0%) |
| Newly-married women | 154 (6.4%) | 155 (6.4%) | 462 (6.4%) | 469 (6.5%) | 616 (6.4%) | 624 (6.5%) | 84 (6.4%) | 53 (4.9%) |
| Sister | 154 (6.4%) | 154 (6.3%) | 462 (6.4%) | 461 (6.4%) | 616 (6.4%) | 615 (6.4%) | 84 (6.4%) | 55 (5.1%) |
| Grandparent | 154 (6.4%) | 159 (6.5%) | 462 (6.4%) | 466 (6.4%) | 616 (6.4%) | 625 (6.5%) | 84 (6.4%) | 86 (8%) |
| Female helper | 22 (0.9%) | 29 (1.2%) | 66 (0.9%) | 47 (0.6) | 88 (0.9%) | 76 (0.8%) | 12 (0.9%) | 5 (0.4%) |
| **Subtotal: female** | **1694 (70%)** | **1715 (70.6%)** | **5082 (70%)** | **5072 (70.1%)** | **6776 (70.0%)** | **6787 (70.2%)** | **924 (70%)** | **790 (73.6%)** |
| Father | 286 (11.8%) | 290 (11.9%) | 858 (11.8%) | 858 (11.9%) | 1144 (11.8%) | 1148 (11.9%) | 156 (11.8%) | 154 (14.3%) |
| Newly-married man | 198 (8.2%) | 195 (8.0%) | 594 (8.2%) | 590 (8.2%) | 792 (8.2%) | 785 (8.1%) | 108 (8.2%) | 45 (4.1%) |
| Brother | 110 (4.5%) | 110 (4.5%) | 330 (4.5%) | 333 (4.6%) | 440 (4.5%) | 443 (4.6%) | 60 (4.5%) | 31 (2.7%) |
| Grandparent | 110 (4.5%) | 110 (4.5%) | 330 (4.5%) | 332 (4.6%) | 440 (4.5%) | 442 (4.6%) | 60 (4.5%) | 54 (5%) |
| Male helper | 22 (0.9%) | 10 (0.5%) | 66 (0.9%) | 48 (0.6%) | 88 (0.9%) | 58 (0.6%) | 12 (0.9%) | 1 (0.9%) |
| **Subtotal: Male** | **726 (30%)** | **715 (29.4%)** | **2178 (30%)** | **2161 (29.9%)** | **2904 (30.0%)** | **2876 (29.8%)** | **396 (30%)** | **285 (26.4%)** |
| **Grand total** | **2420 (100%)** | **2430 (100%)** | **7260 (100%)** | **7233 (100%)** | **9680 (100%)** | **9663 (100%)** | **1320 (100%)** | **1075 (100%)** |

On average, interviewers completed three survey questionnaires in a day, taking roughly 2.40 hours per interview. In rural and urban areas, 99.8 per cent of the target survey interviews were completed, compared to 81.4 per cent of the target in CHT. The reasons for failing to complete such a large proportion of the interviews in CHT (especially of pregnant women and newly-weds) were:

- non-availability of specified categories of respondent
- difficult terrain
- non-availability of accommodation for interviewers in cluster impeding search for respondents
- political in-fighting between rival groups.

Chart 1 shows the status of targeted and completed interviews by major categories of sample population/respondent and by area. The bar chart below compares the targeted and completed interviews separately for 'Rest of Bangladesh' and CHT by caregivers.

**Chart 1: Bar chart showing targeted and completed interviews for rural and urban samples**

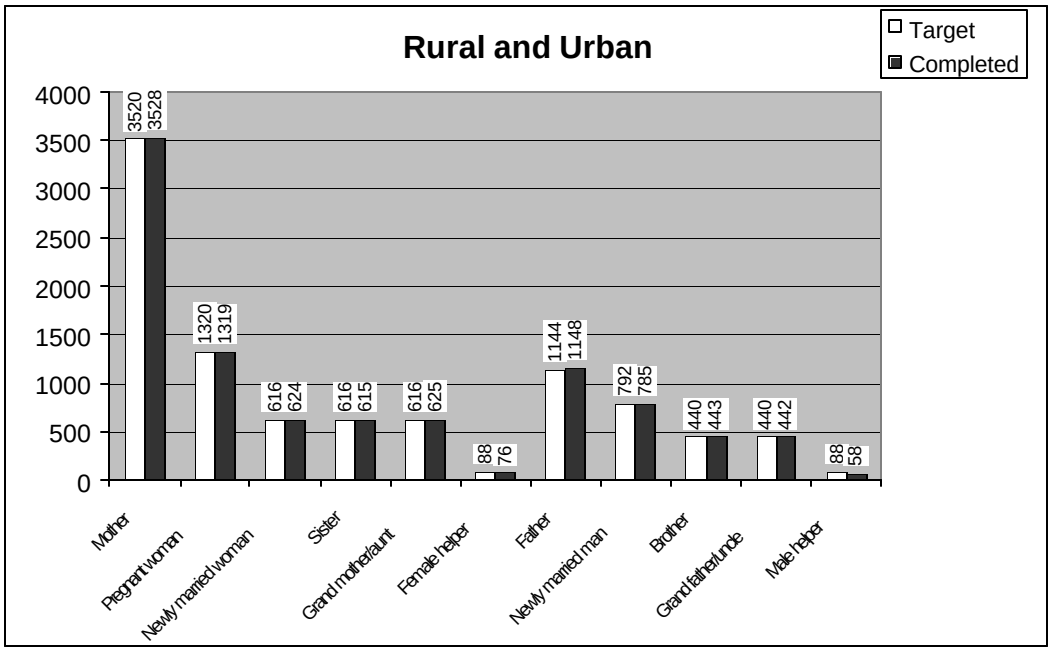
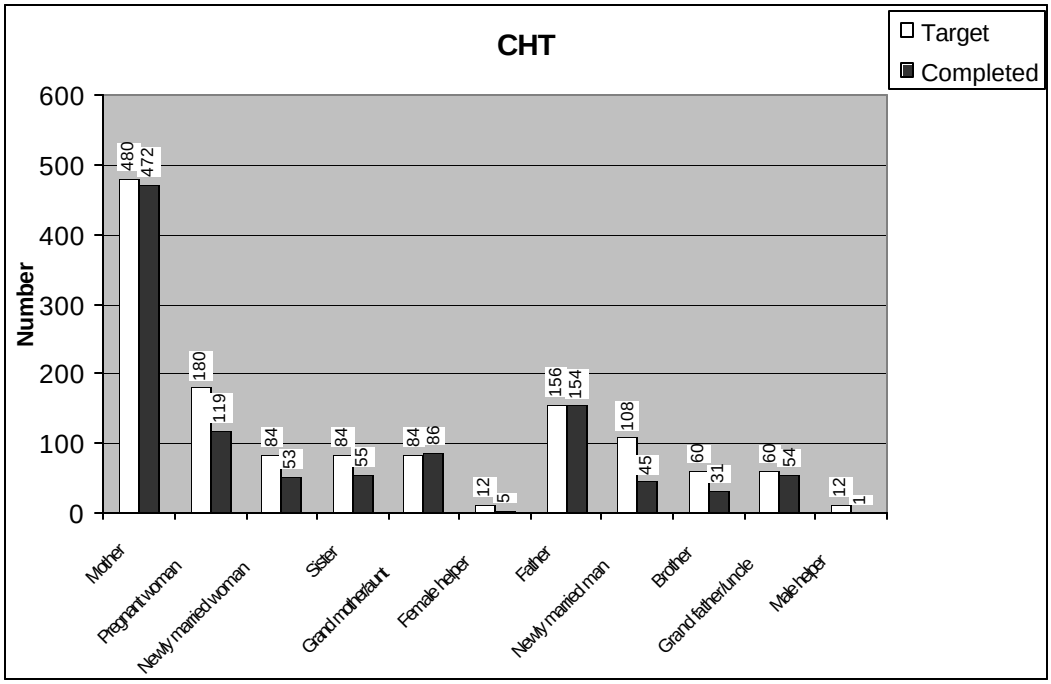



Chart 1a: Bar chart showing targeted and completed interviews for CHT sample



The distribution of intensive interviews by caregiver and area is shown in Table 1a below.

**Table 1a: Distribution of intensive interviews by caregiver and by area**

| Category of caregiver | Rest of Bangladesh | | | CHT |
|---|---|---|---|---|
| | Urban | Rural | Total | |
| Mother | 31 | 95 | 126 | 18 |
| Sister | 9 | 28 | 37 | 5 |
| Grandparent | 3 | 32 | 35 | 4 |
| **Subtotal: female** | **43** | **155** | **198** | **27** |
| Father | 9 | 35 | 44 | 6 |
| Brother | 5 | 14 | 19 | 1 |
| **Subtotal: male** | **14** | **49** | **63** | **7** |
| **Grand total** | **57** | **204** | **261** | **34** |

The target for intensive interviews was three per cluster. Accordingly the targets for 'Rest of Bangladesh' and CHT were 264 and 36 respectively. The completed intensive interviews thus fall short of the targets by 3 interviews for 'Rest of Bangladesh' and by 2 interviews for CHT.

One FGD was conducted in every cluster. The distribution of FGDs is shown in Table 1b below.

**Table 1b: Distribution of FGDs by categories of participant and by area**

| Category of FGD participant | Rest of Bangladesh | | | CHT |
|---|---|---|---|---|
| | Urban | Rural | Total | |
| Community/opinion leaders | 22 | 66 | 88 | 12 |
| Adolescent boys | 5 | 7 | 12 | 2 |
| Adolescent girls | 3 | 7 | 10 | 2 |
| **Total FGDs** | **30** | **80** | **110** | **16** |

One hundred per cent of the target for FGDs was completed both in the 'Rest of Bangladesh' and in CHT. The participants in the FGDs for community/opinion leaders included:

- teachers (male/female), influential leaders, private practitioners, village doctors, TBAs, land owners
- union parishad chairpersons/members (male/female), religious leaders, NGO leaders (male/female), microcredit leaders (male/female)
- FPI/AHI, health assistant (male/female), FWA.

Table 1c below shows the distribution of children observed to assess caregivers' child care practices at household level by age group and area.

**Table 1c: Distribution of children observed in households by age and by area**

| Child observed by age group | Rest of Bangladesh | | | CHT |
|---|---|---|---|---|
| | Urban | Rural | Total | |
| 1 day - 1 year | 23 | 67 | 90 | 14 |

| | | | | |
|---|---|---|---|---|
| > 1 - 3 years | 23 | 67 | 90 | 11 |
| > 3 - 5 years | 22 | 64 | 86 | 7 |
| **Total** | **68** | **198** | **266** | **32** |

Caregivers' childcare practices were observed in respect of a total of 298 children, on the basis of one child per household. The distribution of children observed is almost equal among the three age groups included.

**Problems Encountered during Data Collection**

- Survey interview took more than 2.5 hours in some cases, which disturbed respondents;
- A few clusters in the sample could not be located;
- Travel within the clusters was sometimes difficult due to riverine and difficult/hilly terrain;
- Newly-wed and pregnant women samples were sometimes difficult to locate;
- Floods in Satkhira were a serious constraint to conducting interviews;
- Stormy weather commencing on 27th October 2000 in Kathalia impeded interviews;
- Serious political clash occurred on day of interview in Matiranga (CHT), which impeded progress of interviews;
- Female interviewers faced problems concerning accommodation in Bandukbandha and Suvalong within CHT;
- There were shortages of male and female helpers' samples in rural areas;
- Number of households in Sagardighi Road cluster, Seminal was far less than assigned target; and
- Initially interviewers encountered difficulties in explaining some ECD concepts to respondents.

## IV. Design of Analysis of Data

The main purpose of the study is to investigate caregivers' behaviour relating to early childhood development, including children's physical growth and mental development. The primary focus is on ECD at the household (family) level. Here, caregivers include both males and females, who are further sub-divided into 11 categories, namely mother, pregnant woman, newly-married woman, sister, father, newly-married man, brother, female grandparents, aunt, male grandparents, uncle, and male and female household helpers. **[CHECK – this is 14 categories!]**

Caregivers' childcare practices have been analyzed by three distinct age groups of children (0 to 1 year; > 1 year to 3 years; and > 3 years to 5 years). Five years has been taken as the cut-off point for two reasons: first, because the period from conception to 5 years fits an accepted definition of early childhood; and, second, because this period represents the whole time that a Bangladeshi child spends at home before he/she starts school (at 6 years). Survey findings and data obtained through qualitative investigations are discussed in an integrated manner.

Survey data provide rates and frequencies of childcare practices by age and caregivers of the child, while the qualitative data obtained through in-depth studies, such as intensive interviews, household-level observation and FGDs, provide insight into the factors influencing caregiving practices. Such factors are rooted in socio-cultural beliefs, values and practices. Findings from the intensive interviews provided in-depth information regarding individual caregivers' knowledge, attitude and practices, while FGD findings presented the opinions and insights of community leaders and adolescents. Observation at household level was conducted to identify and assess the actual childcare practices of caregivers with reference to a targeted child. Major areas, such as rural, urban and tribal (Chittagong Hill Tracts) configurations present findings of the study. **[CHECK – don't understand this last sentence]**

Analyses have been undertaken integrating the findings obtained from surveys, intensive interviews, FGDs and direct household-level observation of childcare practices by caregivers. A discussion on these findings has been organized and is presented in the following sections, which cover different childcare practices relating to early childhood development.

1. Socio-economic and demographic characteristics
2. Care during pregnancy
3. Preventive childcare measures: immunization, ORT, breastfeeding
4. Child care for physical growth and mental development
5. Care of children with disabilities
6. Development of learning skills: process of socialization
7. Behaviours resulting in exclusion: discriminating between girl and boy child
8. Emotional development, curiosity, confidence-building
9. Impact of violence: physical and mental
10. Socialization skills
11. Media influences: use and exposure
12. Comparative analysis of caregivers' practices by income level, educational status and awareness of measles vaccines.

In Section 12, an analysis has been carried out comparing three independent variables, namely, income, education and awareness of measles vaccines with five dependent variables mostly reflecting the mental development of a child.

The operational criteria classifying the independent variables are as follows:
By income status, caregivers have been divided into two groups:

- Poor (48 per cent): family income up to Tk.4999 per month (equivalent US$ = 93.00); and
- Non-poor (52 per cent): family income Tk.5000 and above per month.

By educational level, caregivers have been divided into three groups:

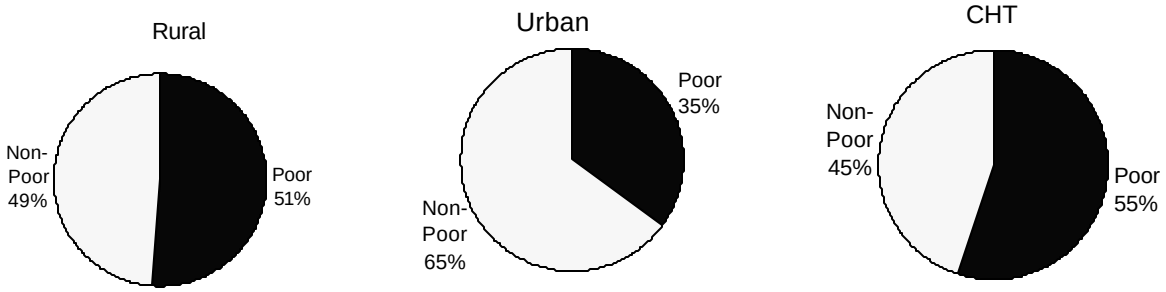
- No education: 40 per cent
- Completed primary: 26 per cent
- Above primary: 34 per cent

By levels of awareness on measles vaccines:

- Aware about measles vaccines: 55 per cent
- Not aware about measles vaccines: 45 per cent

Chart 2 shows the distribution of caregivers by their socio-economic status.

**Chart 2: Distribution of families by socio-economic status and by area (in per cent)**




The selected dependent variables reflecting the status of mental development are:

- measures influencing emotional development of child;
- six childhood diseases (used only with income and education)
- the need and importance of a child becoming curious
- the need and importance of a child having a special skill/quality
- the role of parents in the emotional development of the child.

The analysis is done also with a view to finding out/identifying childcare practices on the basis of:

- Age of child: infant (up to 1 year), toddler (1 to 3 years) and child (3+ years);
- Categories of caregivers: primary and secondary;
- Urban, rural and CHT areas;
- Religious and socio-economic groups, gender;
- Special areas: Chittagong Hill Tracts;
- Type of care/activities and interventions by knowledge, attitude and practices of caregivers;
- Levels and access to media and information;
- Choice/preferences of model caregiver's role;
- Quantitative and qualitative data/findings; and
- Influence of cluster and community groups.

The concluding chapter contains a detailed discussion on programmatic interventions in the form of recommendations. These have been framed on the basis of identified deficiencies in existing childcare practices relating to holistic child development.

# V. Findings: Quantitative and Qualitative Data

The findings are discussed and presented in 12 sections analyzing the data obtained through surveys, intensive interviews, FGDs and household-level observation on child care.

## Section 1: Socio-economic and Demographic Characteristics

### Distribution of caregivers by sample areas

Study areas comprise seven units including six divisions and CHT covering 33 districts and 100 clusters in 96 upazilas. In a cluster, interviews have been conducted at household level selecting one caregiver as respondent per household. Of the total survey interviews (10,738), 1075 (10 per cent) are from Chittagong Hill Tracts. Of the rest (9663) of the interviews, 7233 (75 per cent) are from rural areas and 2430 (25 per cent) are from urban areas. Table 2 below shows the distribution of the respondents of the survey interviews by rural, urban and tribal (CHT) locations.

**Table 2: Distribution of caregivers by area (in per cent and number)**

| Type of caregiver | Rest of Bangladesh | | | | | | Chittagong Hill Tracts | |
|---|---|---|---|---|---|---|---|---|
| | Rural | | Urban | | Total | | | |
| | n | % | n | % | n | % | n | % |
| Mother | 2642 | 36.5 | 886 | 36.5 | 3528 | 36.5 | 472 | 44.0 |
| Pregnant woman | 987 | 13.6 | 332 | 13.7 | 1319 | 13.7 | 119 | 11.0 |
| Newly-married woman | 469 | 6.5 | 155 | 6.4 | 624 | 6.5 | 53 | 4.9 |
| Sister | 461 | 6.4 | 154 | 6.3 | 615 | 6.4 | 55 | 5.1 |
| Grandparent and aunt | 466 | 6.4 | 159 | 6.5 | 625 | 6.5 | 86 | 8.0 |
| Female helper | 47 | 0.6 | 29 | 1.3 | 76 | 0.8 | 5 | 0.4 |
| **Subtotal: female** | **5072** | **70.0** | **1715** | **70.7** | **6787** | **70.2** | **790** | **73.6** |
| Father | 858 | 11.9 | 290 | 11.9 | 1148 | 11.9 | 154 | 14.3 |
| Newly-married man | 590 | 8.2 | 195 | 8.0 | 785 | 8.1 | 45 | 4.1 |
| Brother | 333 | 4.6 | 110 | 4.5 | 443 | 4.6 | 31 | 2.7 |
| Grandparent and uncle | 332 | 4.6 | 110 | 4.5 | 442 | 4.6 | 54 | 5.0 |
| Male helper | 48 | 0.5 | 10 | 0.4 | 58 | 0.6 | 1 | 0.9 |
| **Subtotal: male** | **2161** | **30.0** | **715** | **29.3** | **2876** | **29.8** | **285** | **26.4** |
| **Grand total** | **7233** | **100** | **2430** | **100** | **9663** | **100** | **1075** | **100** |

Of the total survey respondents, about 30 per cent are males, with a slightly lower proportion in case of CHT (26 per cent). Of the total caregivers, the majority (57 per cent) are mothers/wives, followed by fathers/husbands (20 per cent), siblings (11 per cent: brothers and sisters), while the rest are other older relatives and helpers.

**Demographic, Socio-economic Characteristics: Age, Education, Family Income, Occupation**

The mean age of the respondents by type of caregiver and by location are shown in Table 3 below.

**Table 3: Distribution of caregivers by their mean age, age range and by area**

| Type of caregiver | Rural | Urban | CHT | Mean age for all areas | | |
|---|---|---|---|---|---|---|
| | | | | Mean age | Age range | |
| | | | | | Minimum | Maximum |
| Mother | 26 | 26 | 27 | 26 | 15 | 50 |
| Pregnant woman | 24 | 24 | 23 | 24 | 14 | 40 |
| Newly-married woman | 18 | 18 | 20 | 18 | 12 | 35 |
| Sister | 15 | 15 | 17 | 15 | 8 | 25 |
| Grandparent | 51 | 51 | 48 | 51 | 35 | 90 |
| Female helper | 20 | 20 | 16 | 20 | 10 | 38 |
| **Subtotal: female** | **26** | **26** | **27** | **26** | **8** | **90** |
| Father | 35 | 35 | 33 | 35 | 20 | 65 |
| Newly-married man | 25 | 25 | 27 | 25 | 17 | 40 |
| Brother | 16 | 16 | 17 | 16 | 12 | 25 |
| Grandparent | 53 | 53 | 51 | 54 | 40 | 98 |
| Male helper | 21 | 21 | 70 | 22 | 11 | 70 |
| **Subtotal: male** | **27** | **27** | **33** | **31** | **11** | **98** |
| **Grand total** | **31** | **31** | **28** | **28** | **10** | **98** |

There is hardly any difference in the mean age of caregivers across areas, while there is distinct difference in mean age between mothers and fathers by 9 years, which is slightly less in CHT (6 years). Absence of difference in mean age between rural and urban sample is not unexpected, as people migrate from the rural to urban areas at a relatively young age in the pursuit of jobs. Besides early marriage is a common practice in both rural and urban areas.

The age range (minimum and maximum age) as shown in Table 3 shows a justifiable range for all categories of caregivers. The lower limit of mothers' age at 15 years and that of pregnant women at 14 years evidence the incidence of early marriage, pregnancy and childbirth.

**Table 3a: Distribution of caregivers by level of education and by area (in per cent)**

| Type of caregiver | No education | | | Grade I-V primary completed | | | Above primary | | |
|---|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT |
| Mother | 49 | 33 | 49 | 27 | 26 | 17 | 23 | 41 | 35 |
| Pregnant woman | 43 | 33 | 51 | 30 | 25 | 13 | 27 | 41 | 35 |
| Newly-married woman | 23 | 19 | 26 | 28 | 30 | 26 | 49 | 51 | 47 |
| Sister | 10 | 16 | 16 | 40 | 35 | 18 | 50 | 49 | 66 |
| Grandmother/aunt | 74 | 59 | 64 | 17 | 21 | 8 | 9 | 21 | 28 |
| Female helper | 83 | 79 | 100 | 11 | 21 | 0 | 6 | 0 | 0 |
| **Subtotal** | **45** | **33** | **48** | **28** | **27** | **16** | **27** | **40** | **37** |
| Father | 50 | 35 | 25 | 23 | 22 | 20 | 27 | 43 | 55 |
| Newly-married man | 36 | 19 | 20 | 29 | 26 | 31 | 35 | 55 | 49 |
| Brother | 14 | 12 | 13 | 32 | 33 | 19 | 55 | 56 | 68 |
| Grandfather/uncle | 40 | 33 | 37 | 22 | 16 | 22 | 38 | 52 | 41 |
| Male helper | 77 | 60 | 100 | 17 | 40 | 0 | 6 | 0 | 0 |
| **Subtotal** | **40** | **27** | **26** | **26** | **24** | **22** | **35** | **49** | **53** |
| **Grand total** | **43** | **31** | **42** | **27** | **26** | **17** | **30** | **43** | **41** |

By educational level, the caregivers from both urban and CHT areas have achieved higher levels of education compared to those in rural areas. By contrast, for all other categories, irrespective of gender and area, a lower proportion of caregivers has achieved primary education compared to those with no education or education above primary level. Besides, historical differences in the educational levels both by geographical area and by gender seem to have been narrowing down. The overall proportion of caregivers with no education in rural areas is 43 per cent in rural areas, 31 per cent in urban areas and 42 per cent for CHT. This finding confirms the recent statistics on the overall national literacy rate being 60 per cent.

**Table 3b: Distribution of caregivers by occupation and area (in per cent)**

| Type of caregiver | House wife/ Domestic Work | Farmer | Service | Business | Laborer | Intermediate Tech. Occupations* | Profess-ional Occupations ** | Student | Unem-ployed |
|---|---|---|---|---|---|---|---|---|---|
| **Female** | | | | | | | | | |
| Rural | 82 | 1 | 1 | 2 | 2 | 1 | 0.4 | 8 | 3 |
| Urban | 76 | 0.1 | 3 | 3 | 5 | 2 | 0.3 | 8 | 3 |
| CHT | 76 | 2 | 4 | 2 | 3 | 2 | 1 | 7 | 3 |
| **Male** | | | | | | | | | |
| Rural | 3 | 35 | 5 | 20 | 8 | 8 | 1 | 12 | 8 |
| Urban | 5 | 1 | 19 | 33 | 8 | 14 | 1 | 11 | 8 |
| CHT | 4 | 32 | 13 | 19 | 6 | 8 | 1 | 11 | 6 |

*** Driver, mason ** Doctor, teacher, lawyer**

Most of the female caregivers are housewives engaged in domestic work, while most of the males are engaged in various different occupations. Males in both CHT and rural areas are engaged mostly in farming and business, whereas in urban areas they are engaged in business

and service. Interestingly, the distribution of caregivers who are students or unemployed is comparable across areas. However, by gender, there are differences between the caregivers falling in these two categories. A substantial proportion of male caregivers irrespective of area are engaged as laborers and in the intermediary technical occupations.

Table 4 delineates the respondents by their status of mean (family) monthly income for rural, urban and CHT areas.

**Table 4: Distribution of mean monthly family income (in Taka) estimated by the caregivers by area**

| Type of caregivers | Rural | Urban | CHT |
|---|---|---|---|
| Mother | 3797.5 | 6310.13 | 4877.55 |
| Pregnant woman | 3962.3 | 5834.80 | 3812.72 |
| Newly-married woman | 4882.2 | 7451.22 | 3930.02 |
| Older sister | 3869.4 | 6583.56 | 4854.74 |
| Grandmother/aunt | 5974.1 | 9455.53 | 5770.48 |
| Female helper* | 8155.6 | 11153.70 | 10420.00 |
| **Subtotal: female** | **4180** | **6715.7** | **4785.27** |
| Married man with children | 3651.6 | 6278.60 | 4739.05 |
| Newly-married man | 4251.8 | 5976.96 | 4908.89 |
| Older brother | 4403.4 | 8046.36 | 3183.87 |
| Grandfather/ uncle | 6437.28 | 9586.02 | 6625.49 |
| Male helper* | 8163.23 | 8292.00 | 7800.00 |
| **Subtotal: male** | **4460.9** | **7007.1** | **4949.5** |
| **Total** | **4264.9** | **6802.7** | **4828.7** |

The mean monthly family income estimated by caregivers for rural and CHT areas are comparable, while the mean monthly family income reported for urban areas is higher by 60 per cent. The estimated income cited by the Helpers in all locations was much higher than other caregivers, as helpers are usually employed by rich families. However, the average family income represents median value, which is not affected by outlier values such as the family income cited by helpers.

The proportion of families that can be categorized as 'poor' is estimated to be 51 per cent in rural areas, 35 per cent in urban areas and 55 per cent in CHT. According to this data, nationally, the proportion below the poverty line would be around 50 per cent. The estimated distribution of all caregivers by their socio-economic status is in conformity with the findings of other recent studies.

The data collected on household possessions (items either in operational condition or in use) have been classified in the following three groups:

- Minor electronic/mechanical items: radio, cycle, watch, fan (any, some or all = one response; consider only the operational ones)
- Major electronic/mechanical items: television, fridge, motorcycle, baby taxi (any, some or all = one response; consider only the operational ones)
- Other: tree, boat, cupboard, bed, table, chair, bench, cabinet (any, some or all = one response; consider only the one being used)

On average a family owns about two minor electronic/mechanical items, almost no major electronic/mechanical items and roughly two other items (mainly furniture).

**Table 5: Distribution of mean number of household items by socio-economic status (poor and non-poor) and by area**

| Movable property | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Minor | 0.82 | 2.72 | 1.78 | 4.16 | 0.71 | 2.58 |
| Major | 0.03 | 0.25 | 0.29 | 0.86 | 0.06 | 0.45 |
| Others | 1.25 | 3.72 | 1.46 | 3.21 | 1.14 | 2.78 |

Possession and use of household items especially electronic media items (radio/television) empowers members of family to gain access to development information. Differences between poor and non-poor families regarding possession of 'Minor Electronic/Mechanical Items' are observed in all the areas. In rural areas and CHT, a poor family owns less than one of 'Minor Electronic/Mechanical Items', while a non-poor family owns almost three items. Similarly in urban areas a poor family owns less than two items of the said category compared to more than four items by a non-poor family.

**Distribution of Different Types of Caregivers in the Households**

The respondents have been interviewed in households with reference to a child (targeted child). In half (50 per cent) of households, the targeted child was aged 0 to 1 year, in about one-third (30 per cent) of households, the child was >1 year to 3 years, while in the rest (20 per cent), >3 years to 5 years. In the survey questionnaire, questions were asked about the number of caregivers available within a household according to their relationship with the targeted child. Table 6 below identifies the proportional availability of different types of caregiver within the households covered by the survey.

**Table 6: Distribution of caregivers in the families by relationship with targeted child and by area (in per cent) ***

| Types of caregiver by relationship with child | Rural | Urban | CHT |
|---|---|---|---|
| Mother/wives | 99 | 96 | 99 |
| Father/husband | 97 | 95 | 96 |
| Sister | 79 | 71 | 82 |
| Brother | 88 | 83 | 87 |
| Grandmother/aunt | 56 | 39 | 75 |
| Grandfather/uncle | 55 | 28 | 63 |
| Female helper | 1 | 4 | 2 |
| Male helper | 3 | 3 | 2 |

*** Multiple response**

Almost all the households have parents, while in more than three-quarters of households, there is a sibling. But in only a little over half of rural households there is an older relative, while in CHT in more than two-thirds of households, there is an older relative. By contrast in urban areas, nearly one-third of households have an older relative. Summary composition of the rural, urban and CHT families by kinship relationships is shown in Table 6a.

**Table 6a: Summary composition of families by kinship relationships and by area**

| Area | 90-99% | 71-88% | 55-75% | 28-39% |
|---|---|---|---|---|
| Rural | ✓ Parents with or without child | ✓ Parents with or without child<br>✓ Older children | ✓ Parents with or without child<br>✓ Older children and<br>✓ Other older relatives: grandparent, uncle/aunt | |
| Urban | ✓ Parents with or without child | ✓ Parents with or without child<br>✓ Older children | | ✓ Parents with or without child<br>✓ Older children and<br>✓ Other older relatives |
| CHT | ✓ Parents with or without child | ✓ Parents with or without child<br>✓ Older children | ✓ Parents with or without child<br>✓ Older children and<br>✓ Other older relatives | |

The reported average family size both in rural areas and in CHT is 5.5, while for urban areas it is 5.4. This means that in every family in rural areas or CHT, there are 3 to 4 additional members apart from the parents. The likelihood is that in rural areas and CHT, a family is composed of parents, their offspring (children: 2-3) and at least one additional member (older relative). This finding is in conformity with the latest report of BDHS (1999-2000) in which the average household size in Bangladesh is shown as 5.2 persons.

**Household Environment**

Household environment in terms of 'cleanliness' (both inside and outside of the house), 'quality of surroundings' (status of crowded or openness of the area) and 'security' (any hazardous exposure) was investigated. Investigators following set criteria identified these statuses.

**Operational Criteria Used by Investigators**

**Cleanliness:** If dirt or rubbish in the form of left-over food or any other items are not visible in and around the house, it is considered c**lean**; the opposite status is u**nclean.**

**Surroundings**: If the surroundings of a household are open, airy and with sufficient light, it is considered h**ealthy**; if the surroundings are congested and dark, it is considered u**nhealthy**.

**Safety:** If the household has a proper boundary and is protected from open ponds, rivers, canals, ditches or busy highways, it is considered s**afe**; if the household is situated beside a highway, etc. and without proper fencing it is considered u**nsafe**.

These three conditions are important for the safety and development of a child. A child primarily grows up within a household environment, which affects the child both physically and mentally.

**Household cleanliness**

This condition has been verified on the basis of four different alternative statuses.

**Table 7: Distribution of households by status of cleanliness and by area (in per cent)**

| Household cleanliness | Rural | Urban | CHT |
|---|---|---|---|
| Inside and outside clean | 59 | 49 | 64 |
| Inside and outside not clean | 28 | 32 | 22 |
| Inside clean but outside not clean | 12 | 18 | 13 |
| Inside not clean but outside clean | 1 | 1 | 1 |

In rural areas, more than half of households are assessed as clean, inside and outside, while in urban areas more than half (65 per cent) are not clean. In CHT the majority (64 per cent) of households are clean inside and outside.

**Quality of household surroundings**

Table 7a describes the status of the household in terms of openness, airiness and light.

**Table 7a: Distribution of households by quality of surroundings and by area (in per cent)**

| Household Surroundings | Rural | Urban | CHT |
|---|---|---|---|
| Healthy | 45 | 32 | 63 |
| Unhealthy | 55 | 68 | 37 |

The surroundings of only one-third of households in urban areas are healthy, while those of a little less than half of households in rural areas are healthy. In CHT by contrast, the surroundings of nearly two-thirds of households are healthy.

**Household safety**

The safety status of households has been assessed in terms of the degree of exposure to hazardous (accident) conditions.

**Table 8: Distribution of households by safety status and by area (in per cent)**

| Household safety | Rural | Urban | CHT |
|---|---|---|---|
| Safe | 37 | 30 | 39 |
| Moderately safe | 21 | 23 | 17 |
| Unsafe/hazardous | 42 | 47 | 44 |

Judging the status of household safety, nearly 40 per cent of households in CHT were considered safe with a comparable proportion (37 per cent) of rural households also considered safe, while a little less than one-third of households in urban areas were considered safe.

## Section 2: Care during Pregnancy

### Awareness of Specific Pregnancy Care

In response to a question about pregnant women's need for care during pregnancy, the overwhelming majority (>90 per cent in both rural and urban areas and 88 to 90 per cent in CHT) stated that they knew that pregnant women need care during pregnancy. Table 9 shows caregivers' awareness on the type of care needed during pregnancy.

**Table 9: Distribution of caregivers by level of awareness on type of care needed during pregnancy and by sex and area (in per cent)***

| Type of care during pregnancy | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Consume nutritious food | 82 | 85 | 86 | 85 | 60 | 66 |
| Consume extra food | 29 | 33 | 45 | 43 | 30 | 31 |
| Take rest: < 6 hours | 24 | 19 | 40 | 26 | 15 | 13 |
| Take rest: >6 hours | 3 | 6 | 5 | 7 | 5 | 5 |
| Avoid heavy work | 62 | 57 | 69 | 63 | 76 | 72 |
| Have regular check-ups: ANC/ PNC | 3 | 4 | 5 | 5 | 3 | 2 |
| TT immunization | 38 | 33 | 43 | 30 | 51 | 49 |
| Remain free from anxiety | 1 | .4 | 2 | 2 | .6 | 1 |
| Others | 4 | 4 | 4 | 5 | 4 | 3 |
| Do not know about any care | 7 | 4 | 3 | 5 | 10 | 12 |

*** Multiple response**

The majority of respondents (> 80 per cent in rural and urban areas and 60 per cent in CHT) know about the need to take nutritious food during pregnancy, followed by their knowledge on avoiding heavy work, having TT immunization, eating extra food and taking short rest (<6 hours). Awareness on ANC/PNC is observed to be very low, while awareness about remaining free from anxiety is still lower. Data in Table 9 reveal that respondents are aware to a certain extent of the care affecting a pregnant woman's physical health; but they are ignorant of measures promoting a healthy mental state during pregnancy which can positively affect the development of the foetus.

All caregivers identified parents and in-laws (Table 10) as the primary source of care during pregnancy, followed by husbands (> 70 per cent), siblings (7 to 41 per cent) and neighbours (7 to 15 per cent). As regards support for care during pregnancy from outside the family, one-third to one-sixth of caregivers identified health workers, while about one-quarter to one-tenth identified health facilities. Very few mentioned private clinics. A large number mentioned traditional sources of care ('Others': 16 to 26 per cent).

**Table 10: Distribution of caregivers by level of awareness on source of care during pregnancy and by sex and area (in per cent)***

| Source of assistance | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Husband | 73 | 73 | 73 | 89 | 85 | 73 |
| Father/mother-in-law | 100 | 89 | 39 | 100 | 100 | 32 |
| Sister, brother, sister/brother-in-law | 21 | 22 | 7 | 32 | 41 | 8 |
| Neighbour | 8 | 7 | 9 | 15 | 10 | 9 |
| Health worker | 29 | 21 | 32 | 21 | 17 | 39 |
| Government health facility | 10 | 24 | 12 | 4 | 10 | 10 |
| Private hospital/clinic | 1 | 5 | 1 | 1 | 1 | 0.4 |
| Others (including traditional sources) | 26 | 20 | 23 | 21 | 16 | 26 |
| Don't know | 0.3 | 0.1 | 0.4 | 0.2 | 0.4 | 0 |

* **Multiple response**

Table 11 specifies caregivers' awareness of steps needed during pregnancy to ensure delivery of a healthy child.

**Table 11: Distribution of caregivers by awareness of need for specific care to ensure delivery of healthy child by sex and area (in per cent)**

| Type of caregiver | Awareness of need for specific care to ensure healthy delivery | | |
|---|---|---|---|
| | Rural | Urban | CHT |
| Female | 73 | 74 | 30 |
| Male | 37 | 52 | 35 |

The level of awareness among male caregivers in rural areas and both male and female caregivers in CHT on how to ensure delivery of a healthy child is low (30 to 37 per cent). By contrast, the overwhelming majority of female caregivers in both rural (73 per cent) and urban (74 per cent) areas stated that they are aware of the steps needed to ensure delivery of a healthy child.

The specific steps/care needed to ensure delivery of a healthy child are listed in Table 12.

**Table 12: Distribution of caregivers by awareness of specific types of care needed to ensure delivery of healthy child, by sex and area (in per cent)***

| Type of care | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Take extra/nutritious food | 66 | 40 | 68 | 54 | 19 | 20 |
| Take rest/avoid heavy work | 50 | 26 | 51 | 35 | 18 | 23 |
| Have regular check-ups (ANC) | 30 | 18 | 48 | 32 | 15 | 21 |
| TT immunization | 29 | 17 | 32 | 23 | 19 | 20 |
| Check blood pressure | 1 | 1 | 1 | .3 | .3 | 1 |
| Monitor foetal movement | 21 | 5 | 21 | 4 | 2 | .4 |
| No physical violence | 1 | 1 | 2 | 2 | 1 | 2 |

| | | | | | | |
|---|---|---|---|---|---|---|
| No mental abuse | 2 | .4 | 2 | 1 | .4 | 1 |
| Others | 2 | 1 | 2 | .3 | 1 | 1 |

* **Multiple response**

Most caregivers in both rural and urban areas mentioned having extra/nutritious food (40 to 68 per cent) and rest during pregnancy (26 to 51 per cent) as ways of ensuring the delivery of a healthy child, while awareness of the need for TT immunization (17 to 32 per cent) and the need for ANC (15 to 48 per cent) are at a lower level. It is interesting to note that no caregiver mentioned the practice of family planning in this context. Awareness of the impact of abuse – physical and psychological – on the outcome of pregnancy is negligible. It is evident that programme interventions in the past have hardly attempted to raise caregivers' consciousness about the need to take care of the mental health of the mothers during pregnancy in order to ensure a positive outcome for the child.

**Sources of Information on Care during Pregnancy**

Table 13 lists caregivers' sources of information on care during pregnancy.

**Table 13: Distribution of caregivers by awareness of sources of information on care during pregnancy and by area (in per cent)***

| Source of information | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Mass media: radio, television, newspapers, books | 45 | 55 | 62 | 66 | 33 | 39 |
| Doctor/nurse | 17 | 26 | 28 | 32 | 32 | 28 |
| H & FP workers and TBA | 24 | 16 | 13 | 15 | 22 | 24 |
| Hospital/THC/satellite clinic | 1 | 1 | 1 | .3 | 1 | 1 |
| Private/NGO hospital/clinic/ pharmacy | 1 | 1 | 1 | 1 | 1 | 1 |
| Friends, relatives, neighbours | 13 | 10 | 7 | 9 | 9 | 7 |
| Mother, father, sister, brother, spouse | 7 | 7 | 6 | 7 | 5 | 3 |
| Other pregnant women | 1 | .1 | 1 | .3 | 1 | 0 |
| Institutions: school, college, university, club, samity | 5 | 8 | 5 | 7 | 12 | 14 |
| Others | 1 | 1 | 1 | 2 | 2 | 1 |
| Don't know | 6 | 8 | 5 | 8 | 14 | 14 |

* **Multiple response**

As sources of information on care during pregnancy, almost half or the majority of caregivers mentioned mass media (45 to 66 per cent) in rural and urban areas, while in CHT mass media were mentioned by only 33 to 39 per cent. The next most credible source identified is the 'Doctor/Nurse' and 'Health and FP workers'. About 10 per cent of caregivers mentioned relatives, neighbours and friends as a source.

Physical and emotional care considered essential during pregnancy are specified in Table 14.

**Table 14: Distribution of caregivers by type of physical and emotional care needed during pregnancy and by area (in per cent)***

| Type of physical/ emotional care | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **Physical care:** | | | | | | |
| Avoid physical exhaustion (heavy work) / seek assistance with domestic work | 100 | 100 | 100 | 100 | 100 | 100 |
| Take extra/nutritious food | 70 | 95 | 86 | 100 | 49 | 66 |
| Have regular check-ups/take vitamins/have TT | 26 | 28 | 35 | 26 | 22 | 23 |
| No physic violence | 6 | 12 | 10 | 12 | 9 | 9 |
| Don't know | 14 | 10 | 13 | 7 | 9 | 12 |
| **Mental care:** | | | | | | |
| Keep cheerful/ ensure loving care/no mental abuse | 48 | 55 | 65 | 69 | 77 | 84 |
| Keep company/take for walk | 13 | 16 | 23 | 26 | 30 | 26 |
| Provide mental support through counselling and advice | .3 | 1 | .3 | .4 | .4 | .4 |
| Others | 4 | 6 | 6 | 8 | 2 | 1 |
| Don't know | 48 | 42 | 31 | 26 | 20 | 20 |

* **Multiple response**

All the respondents mentioned that a woman must avoid heavy work/exhaustion during pregnancy. The majority of women recommended consumption of extra and/or nutritious food. About one-quarter of respondents recommended ANC check-ups including TT immunization. About 6 to 12 per cent of caregivers mentioned avoiding physical violence during pregnancy.

Almost half (42 to 48 per cent) of caregivers in rural areas and about one-third of the urban caregivers are unaware of the need for emotional care during pregnancy; but only one-fifth of caregivers in CHT did not realize the need for such care. Most caregivers mentioned that avoiding mental abuse, keeping the pregnant woman happy and ensuring loving care are essential, while about one-sixth (rural) to one-fifth (urban) and one-third (CHT) believe that giving companionship is important.

**Table 15: Distribution of caregivers by practice followed during pregnancy and by area (in per cent)***

| Type of care provided | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Take rest/Avoid heavy work | 65 | 79 | 80 | 58 | 83 | 75 |
| Give extra food/nutritious food | 52 | 62 | 39 | 58 | 57 | 56 |
| Ensure regular check-up ANC/TT in time | 22 | 26 | 25 | 12 | 14 | 26 |
| Provide loving care and avoid mental abuse | 3 | 4 | 3 | 2 | 5 | 4 |
| Avoid physical abuse/violence | 6 | 4 | 4 | 7 | 5 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| No care in the family | 12 | 6 | 6 | 18 | 9 | 3 |

*__Multiple response__

More than three-quarters of caregivers both in urban areas (79 to 83 per cent) and CHT (75 to 80 per cent) observed that in their households usually heavy work is avoided during pregnancy, while the majority (58 to 65 per cent) of the rural caregivers mentioned the same practice. In respect of consumption of extra/nutritious food, the majority of caregivers, except females in CHT, affirmed the same. More than one-fifth of female caregivers mentioned that they had seeking regular check ups (ANC) and TT injections during pregnancy. Very few caregivers both males (2 to 7 per cent) and females (3 to 6 per cent) mentioned the need for avoiding mental or physical abuse/torture.

The responses from intensive interviews identified the following kinds of physical and mental care during pregnancy.

**Table 16: Distribution of physical and mental care recommended during pregnancy and by area (findings of intensive interviews)**

| Type of care | Rural | Urban | CHT |
|---|---|---|---|
| Physical | • Take rest<br>• Take nutritious food<br>• Avoid heavy work<br>• Assistance with household work<br>• Move carefully<br>• Have medical check-ups<br>• Have TT immunization<br>• Ensure protection from harmful weather: cold | • Take rest<br>• Take nutritious food<br>• Avoid heavy work<br>• Assistance with household work<br>• Move carefully<br>• Have medical check-ups<br>• Have TT immunization<br>• Ensure protection from harmful weather: cold<br>• Check weight<br>• Take iron tablets | • Take rest<br>• Take nutritious food<br>• Avoid heavy work<br>• Assistance with household work<br>• Move carefully<br>• Have medical check-ups<br>• Have TT immunization<br>• Ensure protection from harmful weather: cold<br>• Take iron tablets<br>• Ensure cleanliness |
| Mental | • No expression of anger<br>• Keep cheerful<br>• Instill courage<br>• Keep company and take outside house<br>• Ensure good behaviour | • No expression of anger<br>• Keep cheerful<br>• Instill courage<br>• Keep company and take outside house<br>• Ensure good behaviour<br>• Keep free from anxiety<br>• Aid mental adjustment<br>• Avoid mental abuse<br>• Ensure caring behaviour | • No expression of anger<br>• Keep cheerful<br>• Instill courage<br>• Keep company and take outside house<br>• Ensure good behaviour<br>• Converse<br>• No response<br>• Provide entertainment: television, books |

Findings of the intensive interviews reveal that caregivers are aware of the need for a sufficient level of emotional and mental care during pregnancy. However it should be remembered that during the intensive interviews, the respondent is probed and given adequate time to ponder over an issue and respond. Awareness is often not an indicator of practice; the wide gap that can exist between awareness and practice is evident in Tables 14 and 15. Lack of proper education coupled with family level and social influences may inhibit practices providing emotional support. The responses from survey investigation did not reveal much of the behaviour leading to emotional care practices, which are only mentioned during intensive interviews.

In response to a question on the impact of caring practices during pregnancy (see Table 17), caregivers' responses varied between areas.

**Table 17: Distribution of caregivers' awareness of impact of caring practices on physical and mental development of child by area**

| Impact of care | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Positive impact | • No harm<br>• Do not know | • Healthy growth of child<br>• Adequate nutrition | • Do not know | • Do not know<br>• Healthy foetus<br>• Health of mother and child ensured | • Absence of organic defects<br>• No Injury during placental separation<br>• No physical complications after delivery<br>• Not affecting development of brain<br>• Not becoming physically weak | • No harm<br>• Do not know |
| Harmful impact | • Nothing mentioned | • Delivery complications<br>• Fatal consequences for mother and child | • Nothing mentioned | • Nothing mentioned | • Nothing mentioned | • Nothing mentioned |

Analysis of the responses in the table above obtained through intensive interviews reveals that:

- Females from both urban and rural areas are not aware of any positive impact of appropriate caring practices during pregnancy;
- Both rural and urban husbands are aware of healthy growth of mother and child as a positive impact. In addition, urban males mentioned the development of a healthy foetus.
- Female caregivers from CHT are sufficiently aware of the positive impact of appropriate caring practices during pregnancy as they mentioned five different benefits of care during this time.
- By contrast, male caregivers from CHT are ignorant of any impact.
- Regarding harmful impact, only rural males mentioned fatal consequences for mother and child and the possibility of delivery complications.

## Section 3: Preventive Childcare Measures: Immunization, ORT, Breastfeeding

The successful implementation of EPI has had a significant impact on child mortality in Bangladesh. The level of awareness about the six killer childhood diseases and the vaccines against them is an important indicator of ensuring the physical health of a child. In Bangladesh, the level of immunization under EPI is very high, which has been a major factor in drastically reducing the child mortality rate over the last few decades.

About one-sixth of female and one-quarter of male caregivers in rural and urban areas are not aware of the childhood diseases, while about one-third of both male and female caregivers are not aware of the same in CHT.

**Table 18: Distribution of caregivers by level of awareness about preventable childhood diseases and by area (in per cent)**

| Awareness about preventable childhood diseases | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| TB | 59 | 51 | 60 | 50 | 39 | 48 |
| Tetanus | 49 | 33 | 55 | 46 | 39 | 46 |
| Diphtheria | 23 | 19 | 35 | 27 | 20 | 24 |
| Whooping cough | 35 | 26 | 42 | 32 | 21 | 25 |
| Polio | 61 | 62 | 66 | 69 | 47 | 55 |
| Measles | 51 | 47 | 62 | 56 | 33 | 39 |
| Others | 5 | 8 | 5 | 3 | 2 | 3 |
| Don't know | 16 | 24 | 14 | 20 | 38 | 31 |

In general, the level of awareness about these childhood diseases is very low in CHT. Awareness about diphtheria and whooping cough is relatively lower compared to other diseases; There is little difference in the levels of awareness between males and females.

Table 18a specifies the preventive measures taken by caregivers to protect children against these childhood diseases.

**Table 18a: Distribution of caregivers by type of preventive measure taken against childhood diseases and by area (in per cent)**

| Preventive measure | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Full immunization | 83 | 78 | 86 | 79 | 80 | 85 |
| Took child to doctor | 3 | 1 | 3 | 2 | 1 | 3 |
| Given vitamin A | 0.4 | 0.3 | 0.3 | 0.3 | 0.1 | 0.4 |
| Others | 0.1 | 0.1 | 0 | 0 | 0.3 | 1 |
| Don't know | 14 | 20 | 11 | 19 | 19 | 12 |

The majority of caregivers (78 to 86 per cent) reported fully immunizing their children, while only a few reported visiting doctors (1 to 3 per cent). One-tenth to one-fifth of respondents (11 to 20 per cent) reported that they either took no action or did not know about it.

Table 18b describes the treatment given to children suffering from diarrhoea

**Table 18b: Distribution of caregivers by treatment given to children with diarrhoea and by area (in per cent)***

| Treatment of child with diarrhoea | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Give ORS | 79 | 73 | 80 | 68 | 75 | 75 |
| Take child to doctor/ health worker | 34 | 30 | 37 | 37 | 23 | 26 |
| Give liquids frequently | 29 | 33 | 37 | 43 | 10 | 17 |
| Continue normal food | 11 | 14 | 15 | 18 | 5 | 5 |
| Others | 2 | 2 | 1 | 1 | 1 | 1 |
| Don't know | 3 | 3 | 1 | 4 | 6 | 4 |

***Multiple response**

The overwhelming majority of caregivers, females (75 to 80 per cent) and males (68 to 75 per cent), said that they give ORS, followed by taking the affected child to the doctor (23 to 37 per cent), giving liquids frequently (10 to 43 per cent) and with continuing to feed the child normal food (5 to 18 per cent).

Findings from the direct observation of children at household level reveal the occurrence of the following health problems.

**Table 19: Distribution of childhood illnesses by age group, type of care given and by area (findings from household-level observation**)

| Age group | Rural | Urban | CHT |
|---|---|---|---|
| 1 day to 1 year (n = 104 children) | • Diarrhoea: taken to homeopathic doctor; given one drink (water) in course of day.<br>• Ear infection: no treatment. | • Fever with cough and cold: sister looking after child – no treatment; child taken to doctor in afternoon by father. | • Fever, cold and cough: no treatment.<br>• Eye infection: no treatment. |
| > 1 year to 3 years (n = 101 children) | • Child with fever: given drinking water, no medicine.<br>• Dysentery: fed soft rice; head washed with cold water. | • Injury: applied antiseptic (Savlon).<br>• Cold: no treatment.<br>• Fever: father bought medicine from shop. | • Eye infection, high fever/malaria: treated by quacks.<br>• Itching: applied local medicine. |
| > 3 years to 5 years (n = 93 children) | • Cough and cold: taken to homeopathic doctor.<br>• Diarrhoea/dysentery : water given 3-4 times during day; no other treatment given. | • Cold: mother gave massage with mustard oil. | • Itching: ointment applied by sister.<br>• Eye sore: cleaned by older sister using cotton wool. |

Observation of caregiving practices at the household level revealed that children in rural and urban areas commonly suffer from colds, fever, eye and ear infections, scabies, diarrhoea/dysentery and accidents/injuries. In most cases, treatment was hardly sought, but in a

few fathers took the children to see a doctor or they brought medicines from shops. In many instances, home-based treatments were given, such as washing the head with cold water, using mustard oil, Savlon, etc.

**Table 20: Distribution of caregivers by level of awareness of breastfeeding practices and by area (in per cent)***

| Breastfeeding practices | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Feeding colostrum | 42 | 33 | 50 | 34 | 39 | 28 |
| Exclusive breastfeeding up to 5 months | 16 | 18 | 26 | 26 | 17 | 9 |
| Supplementary feeding from 5 months | 21 | 15 | 30 | 21 | 18 | 12 |
| Discarding colostrum; feeding breastmilk only | 1 | 1 | 1 | 1 | 0 | 1 |
| Others | .4 | 1 | .4 | 2 | .4 | .4 |
| Don't know anything | 51 | 60 | 40 | 54 | 56 | 68 |

*** Multiple response**

The majority of caregivers from rural (female 51 per cent, male 60 per cent) and urban areas (female 40 per cent, male 54 per cent) and from CHT (female 56 per cent, male 68 per cent) reported that they are not aware of optimal breastfeeding practices. Between one-third and one-half of caregivers are aware of the importance and need to feed colostrum. Awareness regarding exclusive breastfeeding and supplementary feeding is still low.

The feeding practices observed at household level are described in Table 21 below.

**Table 21: Breast, bottle and other feeding practices observed in households by time period**

**a) For rural sample:**

| Time of day | Age of child | | |
|---|---|---|---|
| | **1 day-1 year** | **>1-3 years** | **>3-5 years** |
| Morning (7am – 12pm) | Child is fed:<br>• on demand<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• taking child on lap<br>• talking with child<br>• rocking child<br>• cuddling child<br>• showing affection to child (breastfeeding)<br>• singing rhymes. | Child is fed:<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• talking with child<br>• telling stories.<br>Self-feeding:<br>• child takes food while mother not watching. | Feeding by others:<br>• child is fed<br>• caregiver tells stories while feeding.<br>Self-feeding:<br>• child eats food by himself/herself<br>• child eats food using dirty hand<br>• child eats food while playing<br>• child eats food without washing hands.<br>Type of food eaten:<br>• leftover rice soaked in water<br>• orange/biscuit/rice/fish/vegetables/cooked mashed rice/boiled egg<br>• local pancakes (*pitha*). |
| Noon (12pm – 3pm) | Child is fed:<br>• when cries<br>• after bathing<br>• before putting to sleep.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• talking with child<br>• taking child on lap. | Same as morning | Same as morning |

| Time of day | Age of child | | |
|---|---|---|---|
| | 1 day-1 year | >1-3 years | >3-5 years |
| Afternoon (3pm – 6pm) | Child is fed:<br>• when cries<br>• after bathing.<br>Interactive behaviour at time of feeding:<br>• cuddling child<br>• taking child on lap<br>• singing rhymes. | Same as morning | Same as morning |

**b) For urban sample:**

| Time of day | Age of child | | |
|---|---|---|---|
| | 1 day-1 year | > 1-3 years | > 3-5 years |
| Morning (7am – 12pm) | Child is fed:<br>• on demand<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• taking child on lap<br>• talking with child<br>• rocking child<br>• cuddling child<br>• showing affection to child (breastfeeding)<br>• singing rhymes.<br>Bottlefeeding practices:<br>• child fed using clean bottle<br>• bottle boiled in hot water<br>• caregiver feeds child with bottle while carrying child and walking<br>• teat of bottle is overused<br>• mother touches bottle with dirty hand.<br>Other feeding practices:<br>• caregiver feeds child milk from bowl with spoon. | Child is fed:<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• talking with child<br>• telling stories to child.<br>Self-feeding:<br>• child takes food while mother not watching. | Feeding by others:<br>• child is fed<br>• caregiver tells stories while feeding.<br>Self-feeding:<br>• child eats food by himself/herself<br>• child eats food using dirty hand<br>• child eats food while playing<br>• child eats food without washing hands.<br>Type of food eaten:<br>• leftover rice soaked in water<br>• orange/biscuit/rice/fish/vegetables/cooked mashed rice/boiled egg<br>• local pancakes (*pitha*). |
| Noon (12pm – 3pm) | Same as morning | Same as morning | Same as morning |
| Afternoon (3pm – 6pm) | Same as morning | Same as morning | Same as morning |

**c) For CHT sample:**

| Time of day | Age of child | | |
|---|---|---|---|
| | **1 day-1 year** | **>1-3 years** | **> 3-5 years** |
| Morning (7 am – 12 noon) | Child is fed:<br>• on demand<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• taking child on lap<br>• talking to child<br>• rocking child<br>• cuddling child<br>• showing affection to child (breastfeeding)<br>• singing rhymes.<br>Bottlefeeding practices:<br>• father feeds child with bottle. | Child is fed:<br>• when cries.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• talking with child<br>• telling stories to child.<br>Self-feeding:<br>• child takes food while mother not watching. | Feeding by others:<br>• child is fed<br>• caregiver tells stories while feeding.<br>Self-feeding:<br>• child eats food by himself/herself<br>• child eats food using dirty hand<br>• child eats food while playing<br>• child eats food without washing hands.<br>Type of food eaten:<br>• leftover rice soaked in water<br>• orange/biscuit/rice/fish/vegetables/cooked mashed rice/boiled egg<br>• local pancakes (*pitha*)<br>• papaya/banana<br>• rice mixed with salt. |
| Noon (12pm – 3pm) | Child is fed:<br>• when cries<br>• after bathing<br>• before putting to sleep.<br>Interactive behaviour at time of feeding:<br>• patting child on back<br>• talking with child<br>• taking child on lap. | Same as morning | Same as morning |
| Afternoon (3pm – 6pm) | Child is fed:<br>• when cries<br>• after bathing.<br>Interactive behaviour at time of feeding:<br>• cuddling child<br>• taking child on lap<br>• singing rhymes. | Same as morning | Same as morning |

Breastfeeding is fairly common, while bottlefeeding is observed more frequently in urban areas. Children above the age of 2 years are usually left to eat on their own. At the time of feeding/eating, the mother and children's hands are often dirty. Feeding is frequently accompanied by warm interaction, such as talking, singing rhymes and patting their back.

Generally, children are given loving physical care up to the age of about 2 years, after which they are more or less left alone.

## Section 4: Child Care for Physical Growth and Mental Development

Child development depends on both physical growth and mental development, the latter encompassing the development of cognitive, social and emotional skills. Caregivers play a crucial role in supporting the child's optimal development through appropriate caring practices. The quality of caring practices may be measured by the amount of time spent by a caregiver with the child on a day-to-day basis and the type of support provided. This section describes specific caring practices of caregivers and their implications for child development.

### Time Spent on Child Care and Important Caring Practices

In the current study one of the methods of estimating proportional distribution of caregivers' sample was on the basis of time spent per child per day weighted against the proportional availability of a caregiver in a household. The table below gives the estimates of the weighted mean time spent per child per day by caregivers.

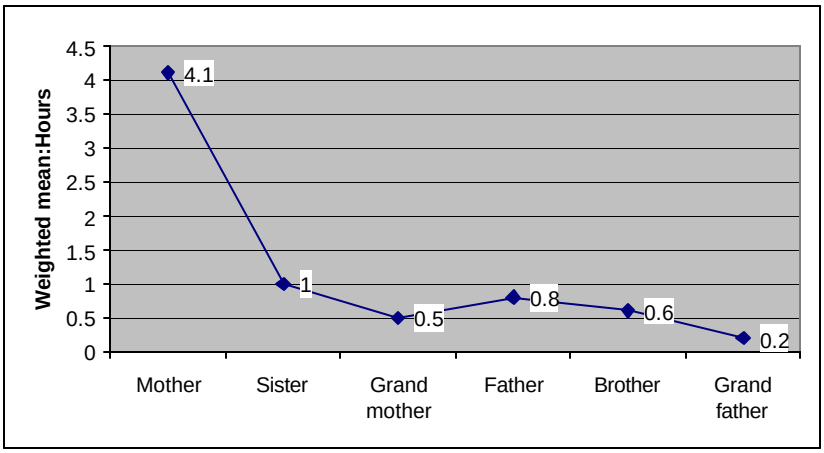
**Table 22: Distribution of mean time spent per child per day weighted against availability of caregivers in household**

| **Type of caregiver** | **Mean time spent per child per day** (in hours) | **Proportional availability of caregiver per child per day** (in hours) | **Weighted mean time spent per child per day** (in hours) |
|---|---|---|---|
| Primary caregivers: mother/wife | 4.25 | 0.969 | 4.1 |
| Secondary caregivers:* | 5.05 | 0.65 | 3.1 |
| Sister | 1.35 | 0.76 | 1.0 |
| Grandmother/ aunt | 1.4 | 0.39 | 0.5 |
| Father/ husband | 0.85 | 0.96 | 0.8 |
| Brother | 0.75 | 0.85 | 0.6 |
| Grandfather/ uncle | 0.7 | 0.29 | 0.2 |

*** Helpers' mean time not considered as proportion of helpers in completed interviews is barely 1 per cent.**

The mean time spent on child care by a caregiver has been estimated on the basis of a whole day (i.e. 24 hours). The total unweighted mean time spent per child per day is estimated at 9.3 hours, while the weighted mean time is estimated to be 7.2 hours. According to the estimates of weighted mean time spent, the primary caregivers (mothers) give about 57 per cent (4.1 hours) of the total time, while all the secondary caregivers combined give 43 per cent (3.1 hours).

**Chart 3: Line chart showing weighted mean time spent per child per day by availability of caregivers in household (in hours)**




The line graph above clearly shows that the mean time spent per child by different caregivers declines drastically in the case of secondary caregivers starting with sisters.

Table 22a shows the distribution of standard deviations calculated on the mean time spent per child by each category of caregiver.

**Table 22a: Distribution of standard deviations on mean time spent per child by caregiver and by area**

| Type of caregiver | Rural | | | | Urban | | | | CHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time spent for male children | | Time spent for female children | | Time spent for male children | | Time spent for female children | | Time spent for male children | | Time spent for female children | |
| | Mean | Std. Deviation | Mean | Std. Deviation | Mean | Std. Deviation | Mean | Std. Deviation | Mean | Std. Deviation | Mean | Std. Deviation |
| Mother/ Wife | 4.1 | 1.70 | 4.1 | 2.15 | 4.0 | 1.67 | 4.1 | 1.77 | 4.4 | 1.88 | 4.5 | 1.94 |
| Father | 0.8 | 1.46 | 0.8 | 1.52 | 1.2 | 1.72 | 1.0 | 1.98 | 0.9 | 1.72 | 0.6 | 1.46 |
| Sister | 1.2 | 1.80 | 1.4 | 2.07 | 1.3 | 1.75 | 1.4 | 1.98 | 1.6 | 1.91 | 1.0 | 1.94 |
| Brother | 0.6 | 1.26 | 0.7 | 1.23 | 1.4 | 1.75 | 0.8 | 1.62 | 0.3 | 0.84 | 0.4 | 0.95 |
| Grandmother/ aunt | 1.2 | 1.86 | 1.5 | 2.12 | 1.8 | 2.24 | 1.6 | 2.53 | 1.4 | 2.17 | 0.7 | 1.95 |
| Grandfather/ uncle | 0.9 | 1.62 | 0.7 | 1.32 | 1.2 | 1.88 | 1.2 | 1.74 | 0.7 | .00 | 0.2 | 1.00 |
| Female helper | 1.1 | 1.40 | 1.1 | 1.84 | 1.7 | 1.91 | 1.0 | 2.24 | - | - | 3.0 | 5.20 |
| Male helper | 0.6 | 1.58 | 0.5 | 1.25 | 1.4 | 3.10 | 1.6 | 2.59 | - | - | 3.0 | - |

The mean time spent by mothers per child per day is 3.8 hours

- Confidence interval:
- Lower limit: 3.8-1.96×.05 = 3.6
- Upper limit: 3.8+1.96×.05 = 3.9
- Here std. deviation = .97

Observations on the standard deviations calculated on the mean time spent comparatively for male and female child show that:

- The estimated standard deviation for female children in rural areas compared to that of male children is almost double and there is greater variability between caregivers in respect of female children. This implies that care given to male children by rural caregivers is relatively less variable (more stable).
- The estimated standard deviation on mean time spent by urban and CHT caregivers is comparable both for male and female children and there is less variability. This implies that in both urban areas and CHT childcare practices are relatively consistent between boys and girls.

Table 23 lists the major childcare practices performed by caregivers in the course of a day.

**Table 23: Distribution of caregivers by major daily childcare practices and by area (in per cent)***

| Major daily childcare practices | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Breastfeeding/feeding solid food | 38 | 73 | 76 | 21 | 28 | 48 |
| Cleaning: bathing/washing hands and face/brushing teeth/washing clothes | 100 | 100 | 100 | 32 | 27 | 68 |
| Giving medication during illness | 1 | 2 | 1 | 1 | 1 | 0.4 |
| Tutoring | 3 | 4 | 5 | 4 | 5 | 5 |
| Playing, walking, running and going outside with child | 14 | 13 | 11 | 19 | 30 | 18 |
| Taking child on lap | 13 | 13 | 3 | 28 | 32 | 11 |
| Others | 0.1 | 0.2 | 0 | 0.3 | 1 | 1 |
| No care provided | 5 | 6 | 5 | 37 | 27 | 23 |

*** Multiple response**

Female caregivers play a dominant role in practices relating to the physical care of children, such as feeding, cleaning and giving medicine during illness. By contrast, only about one-fifth of male caregivers claim to be involved in the physical aspect of child care. The situation is different in CHT, with approximately one-half and two-thirds of men respectively asserting an involvement in the feeding and cleaning of children. In respect of care promoting children's emotional development (such as tutoring, playing and holding a child), male caregivers have a more significant role compared to female caregivers. A substantial proportion (23 to 37 per cent) of male caregivers provide no care whatsoever. Sometimes physical and emotional childcare practices are combined, for instance, when a mother feeds a child in a warm and loving way. A few such situations were identified during the household-level observation of caregiving practices.

**Perceived Limits of Childhood**

Caregivers were asked to give their opinions regarding the upper age limit of childhood. Opinions varied widely between caregivers and by area, as shown in Table 24.

**Table 24: Distribution of caregivers by perceived upper age limit of childhood and by area (in per cent)**

| Upper age limit | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Up to 1 year : | | | | | | |
| ➢ Male child | 17 | 9 | 13 | 8 | 12 | 6 |
| ➢ Female child | 17 | 11 | 16 | 10 | 10 | 5 |
| Up to 2 years: | | | | | | |
| ➢ Male child | 43 | 38 | 40 | 39 | 30 | 33 |
| ➢ Female child | 43 | 38 | 42 | 31 | 39 | 41 |
| Up to 3 years: | | | | | | |
| ➢ Male child | 23 | 33 | 21 | 25 | 29 | 28 |
| ➢ Female child | 21 | 31 | 20 | 30 | 21 | 19 |
| Up to 5 years: | | | | | | |
| ➢ Male child | 3 | 4 | 3 | 8 | 5 | 6 |
| ➢ Female child | 4 | 4 | 3 | 5 | 4 | 3 |
| Up to 8 years: | | | | | | |
| ➢ Male child | 10 | 12 | 17 | 16 | 16 | 16 |
| ➢ Female child | 10 | 12 | 14 | 18 | 20 | 23 |
| Up to 12 years: | | | | | | |
| ➢ Male child | 2 | 2 | 3 | 4 | 3 | 6 |
| ➢ Female child | 3 | 3 | 2 | 3 | 4 | 5 |
| Up to 15 years: | | | | | | |
| ➢ Male child | .3 | 1 | 1 | 0 | .3 | 1 |
| ➢ Female child | 1 | .1 | 1 | 1 | 1 | 1 |
| Don't know/no response: | | | | | | |
| ➢ Male child | 1.7 | 1 | 2 | 0 | 0 | 4 |
| ➢ Female child | 1 | .9 | 2 | 2 | 1 | 3 |

According to the research findings, more than 60 per cent of caregivers believe that childhood extends to the age of 2 or 3 years, most probably since this is the age up to which a child requires intensive physical care. One-tenth to about one-sixth of caregivers perceive 8 as the cut-off age perhaps based on the pattern of physical growth of a child, especially a female child. Some caregivers (1 to 3 per cent) set the upper limit of childhood at 12 or 15 years. Similar findings emerged from intensive interviews, although urban mothers identified 8 years as the upper limit.

The findings from FGDs with opinion leaders in rural and urban areas identified a range from 1 to 18 years as the cut-off age for a child. However, the majority of participants settled on 12 years, with only a few favouring an upper limit of 13 to 18. In CHT the cut-off age was identified as 10.

FGDs with adolescents yielded comparable findings.

**Table 25: Distribution of adolescents by perceived upper limit of childhood mentioned during FGD and by area**

| Adolescents | Upper age limit of childhood (in years) | | |
|---|---|---|---|
| | **Rural** | **Urban** | **CHT** |
| Girls | 18 | 18 | 7 |
| Boys | 12 | 12 | 12 |

Boys are uniform in accepting 12 years as the upper limit of childhood. Girls from both rural and urban areas view 18 years as the cut-off point while those from CHT identified a much lower age (7 years) as the cut-off age.

**Measures to Ensure Physical Growth and Mental Development**

The specific measures for healthy physical growth and mental development of a child suggested by the survey respondents are shown in Table 26.

**Table 26: Distribution of caregivers by suggested measures for healthy physical growth and mental development and by area (in per cent)***

| Measures for healthy physical growth | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Feeding colostrum | 25 | 22 | 28 | 25 | 21 | 16 |
| Regular breastfeeding | 33 | 28 | 37 | 35 | 37 | 32 |
| Feeding nutritious food | 59 | 63 | 66 | 71 | 44 | 57 |
| Immunization | 13 | 13 | 14 | 14 | 28 | 26 |
| Keeping child clean | 68 | 53 | 73 | 64 | 38 | 63 |
| Taking sick child to doctor | 29 | 33 | 43 | 43 | 33 | 39 |
| Ensuring safety of child | 30 | 15 | 23 | 18 | 27 | 24 |
| Don't know | 1 | 2 | 1 | 1 | 1 | 1 |
| **Measures for healthy mental development** | | | | | | |
| Affectionate and warm behaviour | 77 | 45 | 100 | 95 | 86 | 91 |
| Spending time with child | 19 | 21 | 35 | 31 | 14 | 23 |
| Being sensitive and responding to child's questions | 3 | 6 | 7 | 5 | 1 | 3 |
| Playing with child/arranging play activities | 22 | 17 | 36 | 42 | 58 | 67 |
| Protecting child from danger | 17 | 6 | 12 | 7 | 19 | 15 |
| Don't know | 1 | 2 | 1 | 2 | 1 | 1 |

*** Multiple response**

Although responses differed between areas and male/female caregivers, there was a broad consensus about the most important measures required to ensure a child's healthy physical growth: feed nutritious food, keep the child clean and take a sick child to the doctor. Relatively less importance was given to keeping the child safe, feeding colostrum and immunization, (although caregivers in CHT accorded more importance to immunization).

There was an overwhelming acceptance amongst caregivers of the need for affectionate and warm behaviour to promote children's healthy mental development, with a striking 100 per cent of female and 95 per cent of male caregivers in urban areas holding this view. The other two measures considered important for children's mental development were playing or setting up play activities and simply spending time with children: more than one-third of urban caregivers and well over half of those in CHT identified the need for play. Protecting a child from danger was given a lower priority (7 to 19 per cent) especially among male caregivers, while least importance was given to being sensitive and responding to a child's questions (1 to 7 per cent).

**Table 27: Measures for healthy child development by area (findings from intensive interviews)**

| Rural | Urban | CHT |
|---|---|---|
| Regular breastfeeding | Regular breastfeeding | Regular breastfeeding |
| Feeding colostrum | Feeding colostrum | Feeding colostrum |
| Feeding child with nutritious/extra food | Feeding child with nutritious/extra food | Feeding child with nutritious/extra food |
| Keeping child clean | Keeping child clean | Keeping child clean |
| Timely immunization | Timely immunization | Timely immunization |
| Taking child to doctor for treatment | Taking child to doctor for treatment | Taking child to doctor for treatment |
| Putting child to sleep | Putting child to sleep | Putting child to sleep |
| Bathing child | Bathing child | Bathing child |
| Educating child | Educating child | Educating child |
| Providing toys | Providing toys | Providing toys |
| Providing clothes | Providing clothes | Providing clothes |
| Playing with child | Playing with child | Playing with child |
| Keeping child happy | Keeping child happy | Keeping child happy |
| Behaving in caring and loving way with child | Behaving in caring and loving way with child | Behaving in caring and loving way with child |
| | Taking child out visiting | Taking child out visiting |
| | Teaching child good behaviour | Teaching child good behaviour |
| | Paying attention to child's clothes and appearance | Paying attention to child's clothes and appearance |
| | Giving good advice to child | Giving good advice to child |
| | Inspiring child to do good things | Inspiring child to do good things |
| | | Keeping child away from harmful activities |
| | | Conversing with child |

**Responses from intensive interviews (see Table 27) indicated the perceived need for feeding practices, immunization and cleanliness for healthy physical growth. The emphasis on emotional caring practices is evidence that cultural behaviours stimulate emotional development, but these behaviours are restricted mainly to urban areas and CHT.**

**Care for Physical Growth and Mental Development of Children**

Information on care provided by caregivers to children at different ages to support their physical growth and mental development is contained in Table 28.

**Table 28: Distribution of caregivers by type of care given for physical growth and mental development of child by age group and by area (in per cent)***

| Type of care by age group | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **1 day – 1 year** | | | | | | |
| Breastfeeding | 56 | - | 53 | - | 54 | - |
| Feeding supplementary solid food | 25 | 19 | 28 | 11 | 10 | 12 |
| Cleaning: brushing teeth/washing face and hands/ bathing/ changing clothes | 72 | 27 | 75 | 30 | 82 | 43 |
| Massaging with oil | 20 | 2 | 14 | 4 | 7 | 0 |
| Putting to sleep | 8 | 2 | 12 | 2 | 14 | 2 |
| Immunization | 10 | 5 | 14 | 2 | 2 | 5 |
| Taking child to doctor | 4 | 8 | 6 | 8 | 2 | 0 |
| Playing with child | 31 | 48 | 26 | 52 | 23 | 53 |
| Helping child to learn | 0 | 0 | 1 | 1 | 0 | 0 |
| Giving loving care: taking child on lap | 19 | 44 | 22 | 59 | 12 | 18 |
| Doing nothing | 1 | 11 | 1 | 5 | 0 | 5 |
| Don't know | 1 | 2 | 1 | 1 | 2 | 4 |
| **>1–3 years** | | | | | | |
| Providing care and behaving well | 100 | 100 | 100 | 100 | 100 | 100 |
| Playing with child | 4 | 14 | 10 | 14 | 2 | 4 |
| Being friendly | 7 | 5 | 7 | 6 | 9 | 9 |
| Encouraging child to do good/new things | 10 | 8 | 15 | 4 | 4 | 5 |
| Doing nothing | 0 | 0 | 0 | 0 | 0 | 0 |
| **>3–5 years** | | | | | | |
| Providing care and behaving well | 100 | 100 | 100 | 100 | 100 | 100 |
| Teaching how to read | 8 | 10 | 7 | 8 | 4 | 6 |
| Playing and walking with the child | 6 | 21 | 8 | 29 | 2 | 5 |
| Explaining difference between right and wrong | 5 | 3 | 5 | 2 | 7 | 10 |
| Giving good food | 14 | 17 | 19 | 15 | 1 | 1 |
| Doing nothing | 2 | 1 | 2 | 2 | 1 | - |

***Multiple response**

This question was put to respondents separately according to the status of availability of a targeted child within the relevant age groups. More than two-thirds of caregivers did not respond to the question, as they did not have a child within the age group in question.

Care provided during the first year is mostly that required to meet children's physical needs, such as breastfeeding, supplementary feeding, brushing teeth, washing face, changing dirty clothes, putting child to sleep, immunization, massaging with oil and taking child to doctor. Care meeting children's cognitive, emotional and social needs is mostly mentioned for children over

1. The principal measure taken to promote children's mental development is providing care and behaving well. Though not practised by a large proportion of caregivers, other types of care include encouraging children to do good/new things, playing with them, being friendly, teaching them how to read and the difference between right and wrong. For children aged 3 to 5 years, giving good food is also included; no physical care is mentioned for 1 to 3-year-olds.

This indicates that caregivers are primarily concerned about a child's physical growth needs in the first year, while in subsequent years they become more sensitive to the child's need for cognitive and emotional support. The difference between the care provided by male and female caregivers is that female caregivers attend to both physical and emotional needs, whereas male caregivers – apart from some cleaning and feeding during the first year – are mostly involved in meeting children's emotional needs.

Child care practices identified through household-level observation that impact on children's physical and mental development are presented below.

*Feeding practices (1 day to 3 years)*
- Taking child on lap
- Patting on back
- Rocking
- Giving loving care
- Being sensitive to child's demand for food
- Talking with child
- Telling stories
- Feeding with bottle
- Feeding with spoon
- Cleaning bottle with hot water and soap.

The feeding practices listed above reflect both the behaviours of feeding and the emotional care which is integrated with feeding them.

*Changing clothes (1 day to 3 years)*
- Changing clothes after soiling and urination
- Washing clothes with soap
- Singing, talking to and rocking child while changing clothes
- Keeping urine-soaked clothes in haystack without washing.

Both positive and negative behaviours concerning clothes washing were observed.

*Toilet and cleaning practices (3 to 5 years)*
- Urinating while standing
- Cleaning child after defecation with cloth/soap/water
- Mother helping child to defecate in yard of house
- Mother/father/grandfather helping child to defecate on pot
- Using wet cloth to clean child after defecation
- Leaving child left unattended and unclean after defecation.

A child is usually helped by different caregivers with cleaning after defecation. Indigenous materials are used.

*Play/entertainment (3 to 5 years)*
- Playing with sisters and brothers inside house
- Playing with father and elder sister outside house (yard)
- Playing pretend cooking with utensils

- Playing with rattle
- Playing with red material with sister
- Playing with ball with sister
- Playing with bottle
- Playing with cloth dolls
- Playing alone.

Playing with a child is a universal activity and a traditional behaviour. The play materials are locally procured.

*Caring practices (1 day to 1 year)*

- Patting on back and caring for child
- Kissing forehead/cheek of child
- Affectionately embracing child
- Walking with child when crying
- Keeping child on lap when feeding

The above list highlights some of the traditional practices followed in Bangladeshi culture through which affection is shown to the child.

*Negative caring practices (3 to 5 years)*

- Shouting at / scolding child
- Spanking child (usually brothers and sisters)
- Leaving child alone when crying
- Beating child with hand or stick
- Responding harshly or being indifferent to child's questions
- Mother not attending to hungry child (busy cooking)
- No one attending while child plays alone with dirt and dirties clothes
- Child moving around outside house alone.

Punishment is used against a child when he or she does something wrong in Bangladeshi society. Different forms of punishment exist ranging from negligence to beating.

**Care Needed to Promote Physical Growth and Skills**

Ensuring that a child is properly fed, happy and plays with caregivers have been identified as important measures for promoting physical growth and skills. Table 29 specifies a range of measures to promote the physical growth and skills of children at different ages.

**Table 29: Distribution of caregivers by measures to promote a child's physical growth and skills, by age group and by area (in per cent)***

| Measures to promote physical growth and skills | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **1 day to 1 year** | | | | | | |
| Breastfeeding and other supplementary feeding** | 67 | 51 | 74 | 61 | 64 | 60 |
| Keeping child happy | 26 | 38 | 20 | 33 | 23 | 19 |
| Bathing child | 14 | 3 | 12 | 5 | 2 | 2 |
| Providing food in time | 6 | 11 | 8 | 9 | 20 | 21 |
| Massaging child's body with oil | 4 | 8 | 3 | 6 | 5 | 7 |
| Playing with child | 1 | 2 | 2 | 2 | 0 | 4 |
| **1 to 3 years** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Giving nutritious food: egg, milk, fish, meat | 66 | 54 | 67 | 48 | 59 | 62 |
| Playing with child | 16 | 27 | 20 | 26 | 30 | 40 |
| Breastfeeding | 4 | 1 | 5 | 4 | 2 | 2 |
| Doing nothing | 26 | 33 | 24 | 37 | 21 | 14 |

*__Multiple response__ ** none specified exclusive breastfeeding

Breastfeeding combined with supplementary feeding has been identified as the most important measure to promote physical growth and skills during the first year of life, followed by actions designed to keep the child happy. Similarly, in the 1 to 3 year age group, providing nutritious food, and playing with the child have been identified as the key actions. About one-sixth to one-third of males and one-fifth to one-quarter of females think that there is nothing to be done by caregivers for a child aged 1 to 3 years to promote his or her physical growth and skills.

**Cognitive Development**

Children develop cognitive capacities in different phases: up to 1 year; > 1 to 3 years; and > 3 to 5 years. The table below describes the measures taken by caregivers in different areas to support a child's cognitive development (including intellect) during each phase.

A large proportion of caregivers said they do nothing to develop the intellect of a child aged 1 day to 1 year (37 to 50 per cent), but this proportion declines as the child's age increases: >1 year to 3 years: 17 to 38 per cent; and >3 years to 5 years: 15 to 34 per cent.

**Table 30: Distribution of caregivers by measures taken to support child's cognitive development by age group and by area (in per cent)***

| Measures to support child's cognitive development | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **1 day to 1 year** | | | | | | |
| Breastfeeding | 5 | - | 5 | - | 5 | - |
| Giving nutritious food: fruit juice, egg, milk, fish, meat | 16 | 10 | 15 | 7 | 10 | 14 |
| Feeding supplementary/solid food | 1 | 0.4 | 1 | 0 | 1 | 0 |
| Playing with child | 6 | 6 | 10 | 13 | 8 | 17 |
| Teaching to talk | 9 | 10 | 12 | 9 | 17 | 13 |
| Doing nothing | 47 | 50 | 40 | 47 | 37 | 37 |
| **1 to 3 years** | | | | | | |
| Breastfeeding | 3 | - | 2 | - | 1 | - |
| Giving nutritious food: fruit juice, egg, milk, fish, meat | 26 | 24 | 24 | 14 | 23 | 17 |
| Playing with child | 6 | 10 | 9 | 16 | 11 | 17 |
| Teaching to talk | 21 | 23 | 24 | 24 | 37 | 32 |
| Doing nothing | 31 | 36 | 32 | 38 | 17 | 21 |
| **3 to 5 years** | | | | | | |
| Providing toys/taking for a walk/ singing songs | 8 | 10 | 8 | 14 | 9 | 11 |
| Teaching to talk/learn | 37 | 35 | 39 | 43 | 60 | 59 |
| Allowing to mix with others | 2 | 2 | 2 | 1 | 1 | 2 |
| Giving nutritious food | 19 | 15 | 17 | 8 | 11 | 12 |
| Doing nothing | 26 | 33 | 24 | 34 | 15 | 15 |

*** Multiple response**

The specific measures cited to develop a child's intellect include providing nutritious food, playing with the child and teaching him or her how to talk. A very low proportion of caregivers identified breastfeeding as a measure to develop the intellect of a child.

Respondents were asked about obstacles to the healthy physical growth and mental development of a child. A number of caregivers said they were aware of few such obstacles (Table 31). The majority of caregivers in rural and urban areas stated that they were not aware of any specific obstacle to mental development. Among those who were able to identify obstacles, sickness and malnutrition were named as the primary impediments to physical growth, while sickness and lack of proper care were mentioned as important factors impeding emotional development.

**Table 31: Distribution of caregivers by identified obstacles to healthy physical growth and mental development of child by gender and by area (in per cent)***

| Obstacles | Rural | | | | Urban | | | | CHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Female | | Male | | Female | | Male | |
| **Physical growth** | **Boy Child** | **Girl Child** | **Boy Child** | **Girl Child** | **Boy Child** | **Girl Child** | **Boy Child** | **Girl Child** | **Boy Child** | **Girl Child** | **Boy Child** | **Girl Child** |
| No obstacle | .3 | .2 | 4 | 3 | .2 | 1 | 4 | 3 | .1 | .3 | 0 | .2 |
| Don't know | 16 | 17 | 16 | 17 | 14 | 16 | 10 | 10 | 21 | 22 | 20 | 21 |
| Malnutrition/ Insufficient food | 22 | 21 | 24 | 24 | 32 | 31 | 28 | 28 | 42 | 42 | 48 | 47 |
| Sickness | 62 | 62 | 62 | 61 | 52 | 53 | 59 | 60 | 36 | 36 | 34 | 34 |
| Poverty/ unhealthy environment | .4 | .4 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Violence/ abuse/neglect/ ignorance of parents | 4 | 4 | 3 | 3 | 6 | 6 | 6 | 6 | 8 | 8 | 9 | 9 |
| Absence of appropriate breastfeeding/ immunization practices | 5 | 4 | 4 | 4 | 8 | 6 | 6 | 6 | 6 | 6 | 4 | 3 |
| **Mental development** | | | | | | | | | | | | |
| No obstacle | .4 | .3 | 3 | 3 | 1 | 1 | 3 | 4 | .1 | .1 | .4 | 1 |
| Don't know | 74 | 74 | 79 | 78 | 56 | 56 | 58 | 58 | 44 | 43 | 35 | 35 |
| Sickness | 6 | 6 | 8 | 8 | 12 | 12 | 25 | 26 | 25 | 25 | 25 | 25 |
| Lack of proper care | 12 | 12 | 4 | 4 | 19 | 19 | 5 | 5 | 19 | 19 | 23 | 22 |
| Violence/ Abuse/neglect/ ignorance of parents | 4 | 4 | 5 | 5 | 6 | 6 | 6 | 6 | 9 | 8 | 9 | 10 |
| Insufficient play | 2 | 2 | 1 | 1 | 4 | 4 | 3 | 3 | 2 | 2 | 1 | 2 |
| Boredom/ Anxiety/unhap piness | 3 | 3 | 2 | 2 | 5 | 4 | 4 | 4 | 7 | 8 | 12 | 11 |

*** Multiple response**

**Indicators of Physical Growth and Mental Development**

Survey respondents (see Table 32) and participants in FGDs (see Tables 33 and 34) were asked what benchmarks – i.e. indicators – they used to assess the level of physical or mental development of a given child. Caregivers had a number of ways of assessing physical development but were less well equipped when it came to assessing mental development.

**Table 32: Distribution of caregivers by awareness of indicators of child**

**development by gender and by area (in per cent)***

| Indicators of physical development | Rural | | | | Urban | | | | CHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Female | | Male | | Female | | Male | |
| | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child |
| Don't know | 15 | 16 | 11 | 11 | 12 | 13 | 10 | 10 | 30 | 30 | 26 | 25 |
| Movement and growth | 52 | 50 | 60 | 60 | 55 | 53 | 66 | 65 | 53 | 52 | 58 | 58 |
| Food intake/ eating habits | 12 | 12 | 13 | 13 | 15 | 15 | 14 | 14 | 4 | 4 | 4 | 4 |
| Freedom from disease and sickness | 18 | 20 | 18 | 18 | 18 | 20 | 12 | 12 | 14 | 14 | 15 | 15 |
| Sitting/ crawling/ walking | 10 | 10 | 9 | 9 | 6 | 7 | 6 | 6 | 1 | 1 | 11 | 1 |
| Participation in play and games | 2 | 2 | 1 | 1 | 2 | 2 | 1 | 2 | 1 | 1 | 1 | 1 |
| **Indicators of mental development** | | | | | | | | | | | | |
| Don't know | 68 | 68 | 69 | 69 | 48 | 48 | 60 | 58 | 43 | 43 | 36 | 35 |
| Capacity to recognize others | 2 | 2 | 4 | 4 | 3 | 3 | 3 | 4 | 3 | 3 | 2 | 2 |
| Capacity to communicate | 4 | 4 | 6 | 6 | 8 | 9 | 9 | 9 | 7 | 8 | 8 | 8 |
| Happy state | 26 | 26 | 22 | 22 | 41 | 41 | 30 | 30 | 47 | 47 | 55 | 56 |

*** Multiple response**

The physical movement and growth of a child were identified as primary indicators of physical development, while happiness was mentioned as an important indicator of mental development.

**Findings from Intensive Interviews**

In the intensive interviews caregivers identified the following indicators of child development which encompass both physical and mental development.

- Health of child: build and growth
- Absence of sickness or fever
- Eating habits and appetite
- Movement, e.g. walking
- Play activity (including frequency)
- Behaviour and manners
- Self-expression (talking)

**Table 33: Indicators of physical growth by area (findings from FGDs)**

| FGD participants | Rural | Urban | CHT |
|---|---|---|---|
| Opinion leaders (various ages) | • Growth (i.e. increase in height) according to age<br>• Level of consumption of food and feeding habits<br>• Nutritional status<br>• Health/body development<br>• Capacity to move: walk and move organs | • Crawling and lying on front<br>• Increase in weight<br>• Increase in height | • Health/body development<br>• Growth according to age |
| Adolescent boys (12 to 18 years) | • Health/body development<br>• Level of consumption of food and feeding habits<br>• Increase in weight<br>• Participation in games and play<br>• Freedom from disease | • Health/body development<br>• Level of consumption of food and feeding habits<br>• Increase in weight<br>• Participation in games and play<br>• Freedom from disease | • Health/body development |
| Adolescent girls (12 to 18 years) | • Growth according to age<br>• Increase in weight<br>• Health/body development | • Growth according to age<br>• Increase in weight<br>• Health/body development | • Health/body development |

**Table 34: Indicators of mental development by area (findings from FGDs)**

| FGD participants | Rural | Urban | CHT |
|---|---|---|---|
| Opinion leaders (various ages) | • Capacity to talk<br>• Movement<br>• Capacity to think and learn<br>• Participation in play<br>• Level of intelligence<br>• Extent of knowledge/information<br>• Capacity to socialize<br>• Extent of movement/normal behaviour<br>• Level of curiosity/asking questions<br>• Participation in work<br>• Imitating behaviour<br>• Ability to judge right and wrong<br>• Keeping happy<br>• Capacity to remember/memorize<br>• Disciplined behaviour | • Extent of movement/normal behaviour<br>• Capacity to talk<br>• Imitating behaviour<br>• Capacity to socialize<br>• Participation in play<br>• Disciplined behaviour<br>• Mental capacity demonstrated through intelligent behaviour<br>• Skill of recognition | • Extent of knowledge/information<br>• Capacity to talk<br>• Extent of movement/ normal behaviour<br>• Disciplined behaviour |
| Adolescent boys (12-18 years) | • Extent of knowledge/information<br>• Capacity to think and learn<br>• Disciplined behaviour<br>• Keeping happy<br>• Capacity to talk | • Extent of knowledge/information<br>• Capacity to think and learn<br>• Disciplined behaviour<br>• Keeping happy<br>• Capacity to talk | • Participation in play<br>• Capacity to talk<br>• Capacity to think and learn<br>• Extent of crying (as a way of demanding something) |
| Adolescent girls (12 – 18 years) | • Skill of recognition<br>• Extent of movement/normal behaviour<br>• Extent of knowledge/information<br>• Ability to judge right and wrong<br>• Keeping happy<br>• Participation in play | • Skill of recognition<br>• Extent of movement/normal behaviour<br>• Extent of knowledge/ information<br>• Ability to judge right and wrong<br>• Keeping happy<br>• Participation in play | • Capacity to talk<br>• Participation in play<br>• Sensitivity or reaction to physical signals/ non-verbal gestures |

Opinion leaders from rural areas suggested as many as 15 indicators of mental development, compared to 8 and 4 indicators by their urban and CHT counterparts respectively. Judging by the suggestions given by the rural and urban opinion leaders, it seems that opinion leaders in these areas have a reasonable understanding of the indicators of children's physical and mental development. It should be remembered, however, that the suggested indicators reflect the group's level of understanding and not that of any individual opinion leader. While the adolescents had many suggestions, they demonstrated a more limited understanding of the indicators of children's physical and mental development.

## Findings from Intensive Interviews

### *Ways of stimulating child's curiosity*

Caregivers mentioned the following traditional practices used to stimulate a child's curiosity.

- Engaging child with toys/in play
- Talking with child
- Giving loving (affectionate) care to child
- Behaving cheerfully
- Sensitizing child physically through gentle pinching
- Taking child visiting outside
- Arranging education of child
- Teaching child good behaviour

The following were identified as indicators of inquisitiveness and curiosity in a child.

- Child can judge between right and wrong
- Child's sensitivity is enhanced
- Child has experience and knowledge
- Child's brain develops
- Child is happy
- Child is able to learn fast
- Child mixes with others (including children)
- Child leads his/her life smoothly

Caregivers value the development of curiosity as one aspect of a child's emotional and social development.

### *Activities children do on their own*

In response to a question about things children do on their own, caregivers gave the following responses.

*Under 1 year*

- Pick things up
- Destroy or breaks things
- Play (mentioned by mother in CHT)

*1 to 3 years*

- Put on television
- Play
- Help with light household chores
- Feed themselves
- Bathe
- Copy elders

*3 to 5 years*

- Play
- Help with household chores
- Dress on their own

- Have a bath
- Eat
- Study
- Go to school
- Copy elders
- Move around outside
- Wash in the morning
- Go to toilet
- Destroy household objects

***How child can help parents***

Caregivers listed different ways in which children (aged 3 to 5 years) can help parents inside and outside the house.

*Inside house*

- Cooking (girl)
- Household chores(girl)
- Fetching clothes (girl)
- Serving drinking water (girl)
- Cleaning/sweeping house
- Washing dishes
- Serving food
- Getting reading materials (books)

*Outside house*

- Buying things from shop
- Going with father to market (boy)
- Looking after cattle and poultry
- Putting out clothes to dry in sun
- Fetching things from neighbours' house

There is little discernable difference in the extent to which the above practices are followed between different geographical areas since they are mostly traditional practices passed down from generation to generation.

## Section 5: Care of Children with Disabilities

Responses by caregivers regarding their behaviour towards children with disabilities are given in Table 35. The majority of caregivers (77 to 85 per cent) said that they were not aware of discriminatory behaviour, either mental or physical, towards children with disabilities.

**Table 35: Distribution of caregivers by awareness of discriminatory behaviour towards child with disabilities (in per cent)**

| Status | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Yes | 22 | 15 | 20 | 20 | 23 | 21 |
| No | 78 | 85 | 80 | 80 | 77 | 79 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Table 35a: Distribution of caregivers by behaviour towards children with disabilities and by area (in per cent)***

| Behaviour towards children with disabilities | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Hates/neglects/avoids/ teases | 87 | 79 | 79 | 66 | 87 | 85 |
| Gives less care/love/ affection | 18 | 23 | 27 | 34 | 10 | 11 |
| Feels pity/shows sympathy | 1 | 3 | 2 | 7 | 6 | 8 |
| Prevented from playing | 1 | 1 | .3 | 3 | - | - |
| Prevented from attending social function | .3 | 1 | 1 | 3 | 1 | 2 |
| Others | .5 | .4 | 2 | - | 1 | - |

*** Multiple response**

Among those caregivers who specified the types of discriminatory behaviour against children with disabilities, the overwhelming majority (66 to 87 per cent) stated that they were hated, neglected, avoided or teased, while a smaller proportion (10 to 34 per cent) said they were given less care or love (Table 35a).

Findings from the intensive interviews confirm the picture that emerged from the survey. Severe forms of discrimination against children with disabilities identified by interview participants included:

- Giving inadequate food
- Scolding and neglecting
- Not sending to school
- Not allowing to play
- Beating
- Mocking
- Considering as a liability of the family.

During FGDs, participants were asked about appropriate behaviours towards children with disability. Their responses are contained in Table 36.

**Table 36: Behaviours recommended by opinion leaders and adolescents towards children with disabilities by area (findings from FGDs)**

| Category of participants | Rural | Urban | CHT |
|---|---|---|---|
| Opinion leaders | • Ensure additional financial support<br>• Strengthen earning skills and job opportunities<br>• Keep child cheerful<br>• Arrange treatment<br>• Arrange for child's education/training through special schools<br>• Organize participation in games<br>• Encourage child to be active<br>• Behave in friendly manner towards child – do not neglect | • Ensure additional financial support<br>• Strengthen earning skills and job opportunities<br>• Keep child cheerful<br>• Arrange treatment<br>• Arrange for child's education/training through special schools<br>• Behave in friendly manner towards child – do not neglect<br>• Behave normally<br>• Show sympathy<br>• Cannot say | • Ensure additional financial support<br>• Arrange for child's education/training through special schools<br>• Build *ashram*: special homes for care and training of children with disabilities<br>• Help child to become self-reliant<br>• Mobilize society (through organization) to assist children with disabilities<br>• Organize special clinics for treatment<br>• Take steps to ensure that child's potential is fulfilled and allow him/her to mix normally in society |
| Adolescent girls | • Ensure additional financial support<br>• Arrange treatment<br>• Arrange for child's education/training through special schools<br>• Organize participation in games<br>• Behave in friendly manner towards child – do not neglect<br>• Help child to move - walking<br>• Take child for outings<br>• Take special care<br>• Provide nutritious food<br>• Provide food fortified with iodine | • Same as rural | No suggestions given |
| Adolescent | • Keep child cheerful | • Same as rural | No particular suggestions |

| | | | |
|---|---|---|---|
| Boys | • Arrange for child's education/training through special schools<br>• Behave in friendly manner towards child – do not neglect<br>• Mobilize society (through organization) to assist children with disabilities<br>• Provide nutritious food<br>• Protect child from further infections/dangers - keep him/her safe | | |

Opinion leaders from urban/rural areas and CHT gave positive suggestions regarding the care of children with disabilities. However, the opinion leaders from CHT have additionally underscored the need for nurturing a sense of social responsibility for the disabled child. Caregivers from CHT have mentioned mobilizing the entire society to establish institutional (training) facilities on health and educational care for the child with disability. The adolescents, both boys and girls from the urban and rural areas have expressed concerns about disabled child providing positive suggestions, while those from CHT have not given any particular suggestion in this regard. It may be interpreted that in CHT, concerns on disability are dealt by the adult opinion leaders not particularly by the adolescents.

## Section 6: Development of Learning Skills: Process of Socialization

The survey-based findings on cultural and religious practices which help to strengthen a child's process of socialization and development are discussed in Table 37.

**Table 37: Distribution of caregivers by cultural/religious practices/beliefs influencing child development by sex and area (in per cent)***

| Cultural practices (timing) | Possible implications for growth and development of child | Sex of child | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|---|---|
| | | | Female | Male | Female | Male | Female | Male |
| Putting sweets/honey in mouth after birth (immediately after birth) | Development of liking for sweet foods | Male<br>Female | 1<br>1 | 1<br>1 | 1<br>1 | 2<br>2 | 6<br>6 | 7<br>6 |
| Putting (i) black spot on side of forehead/ and (ii) shaving head for first time (within one month of birth) | (i) Protection from evil influences and (ii) growth of hair | Male<br>Female | 14<br>15 | 12<br>15 | 9<br>11 | 9<br>9 | 4<br>4 | 4<br>4 |
| *Annyo prashon*, i.e. food ceremony followed by Hindus (from 5 to 9 months) | Physical growth of child and habituation to local foods | Male<br>Female | 4<br>4 | 4<br>4 | 4<br>4 | 4<br>5 | 2<br>3 | 4<br>3 |
| Ceremony of giving rice to child (from 5 to 9 months) | Physical growth of child and habituation to local foods | Male<br>Female | 8<br>8 | 4<br>6 | 4<br>4 | 5<br>5 | 4<br>5 | 4<br>5 |
| Ceremony of giving name to child (from 6 months to 1 year) | Giving own and family identity to child | Male<br>Female | 1<br>1 | .4<br>0 | 1<br>1 | 1<br>1 | 2<br>2 | 2<br>2 |
| Observing birthday | Recognizing child's growth | Male<br>Female | 12<br>13 | 6<br>7 | 16<br>16 | 13<br>13 | 3<br>4 | 2<br>3 |
| Holding singing functions (1 to 1½ years) | Helping child to talk | Male<br>Female | 1<br>.2 | 1<br>.3 | .4<br>.1 | 0<br>0 | 0<br>.1 | 0<br>0 |
| Don't know | Not applicable | Male<br>Female | 46<br>46 | 62<br>57 | 43<br>42 | 52<br>53 | 35<br>34 | 35<br>34 |

| Religious beliefs/practices (religion) | Possible implications for growth and development of child | Sex of child | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|---|---|
| | | | Female | Male | Female | Male | Female | Male |
| Giving *azan* (call to prayer) just after birth (Muslims) | Social recognition of birth of child through religious announcement | ➢ Male<br>➢ Female | 9<br>10 | 9<br>9 | 7<br>9 | 8<br>6 | 10<br>14 | 6<br>12 |
| Religious blessing within 5-7 days of birth (Muslims, Hindus, Christians, Buddhists) | Blessings from religious leaders | ➢ Male<br>➢ Female | 18<br>19 | 14<br>18 | 27<br>28 | 19<br>19 | 45<br>46 | 46<br>47 |
| Circumcision (Muslims) | Religious blessing | ➢ Male | 6 | 4 | 4 | 5 | 5 | 5 |
| *Akika*, i.e. naming ceremony (Muslims) | Giving name through religious rites | ➢ Male<br>➢ Female | 29<br>32 | 32<br>34 | 26<br>28 | 39<br>41 | 12<br>13 | 10<br>10 |
| Religious amulet (all religions) | Protecting child from evil influences | ➢ Male<br>➢ Female | 1<br>2 | 1<br>2 | 1<br>1 | 1<br>1 | .4<br>.4 | 2<br>.4 |
| Teaching name of Allah and his Prophet (Muslims) | Religious teaching: creating positive image | ➢ Male<br>➢ Female | 2<br>4 | 1<br>1 | 2<br>3 | 1<br>1 | .4<br>1 | 0<br>2 |
| Teaching about religious prohibitions (all religions) | Religious teaching: child learns about right and wrong | ➢ Male<br>➢ Female | 1<br>4 | 1<br>4 | 1<br>4 | .4<br>5 | .3<br>3 | 0<br>3 |
| Don't know | Not applicable | ➢ Male<br>➢ Female | 47<br>48 | 49<br>50 | 56<br>55 | 43<br>46 | 72<br>71 | 72<br>72 |

*** Multiple response**

Skills are often acquired over generations through a process of acculturation and diffusion, in which cultural and religious practices/teachings play a vital part. Traditional practices affecting the physical growth and mental development of a child are sub-divided into two categories: cultural and religious. The primary purposes of the practices identified under these two heads are:

- ensuring growth of the child
- giving own/family identity to the child
- protecting the child from evil influences

In addition, religious teaching helps a child to understand the difference between right and wrong. These practices assist the child to adapt to his/her physical and social environment. Seven different practices/beliefs under each category (cultural and religious) were specified. Practices influencing physical growth, such as feeding the child, and those influencing mental

development, such as protection from evil influences, identification with one's own religious faith as a symbol of bonding (security) with the greater community, were mentioned most frequently.

**Caregivers' Influence on Child's Learning Process for Development**

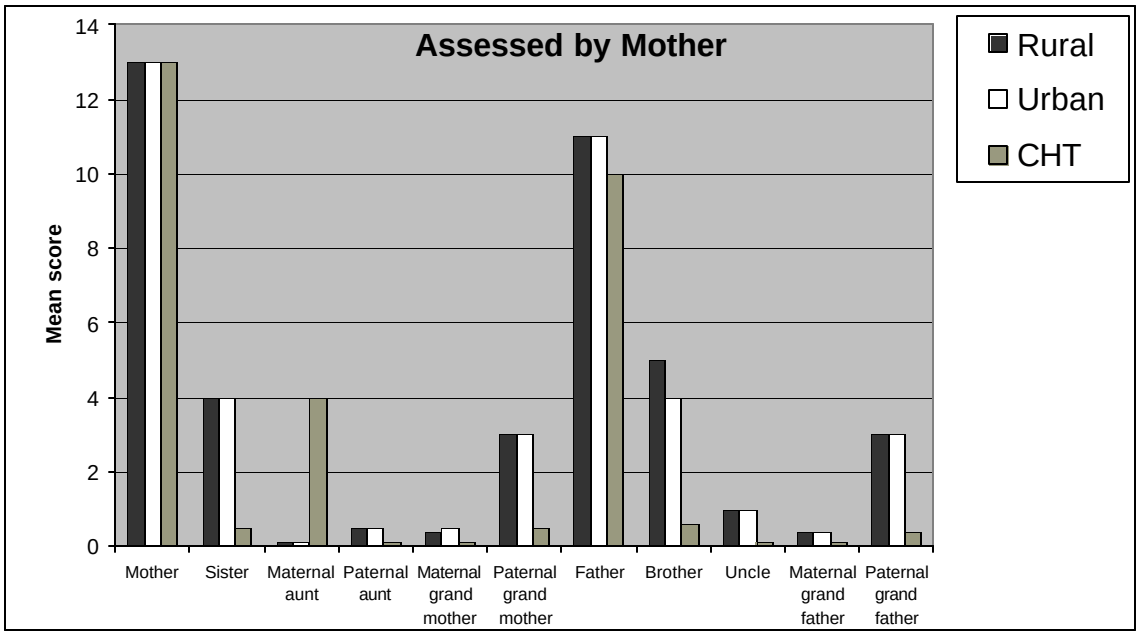
**Table 38: Distribution of parents by their role and influence on child's learning process by area (assessed in terms of mean scores: 0-13)**

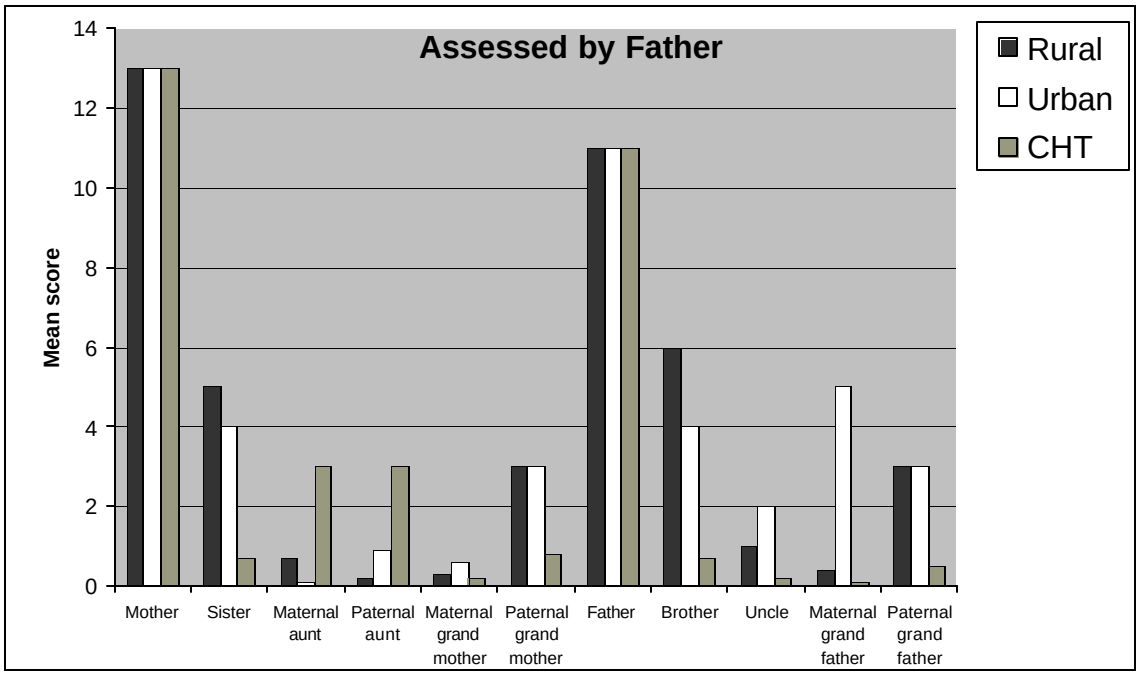
| Types of caregiver | Mean score assigned | | | | | |
|---|---|---|---|---|---|---|
| | By mother | | | By father | | |
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Mother | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 | 13.0 |
| Sister | 4.0 | 4.0 | 0.5 | 5.0 | 4.0 | 0.7 |
| Maternal aunt | 0.1 | 0.1 | 4.0 | 0.7 | 0.1 | 3.0 |
| Paternal aunt | 0.5 | 0.5 | 0.1 | 0.2 | 0.9 | 3.0 |
| Maternal grandmother | 0.4 | 0.5 | 0.1 | 0.3 | 0.6 | 0.2 |
| Paternal grandmother | 3.0 | 3.0 | 0.5 | 3.0 | 3.0 | 0.8 |
| Father | 11.0 | 11.0 | 10.0 | 11.0 | 11.0 | 11.0 |
| Brother | 5.0 | 4.0 | 0.6 | 6.0 | 4.0 | 0.7 |
| Uncle | 1.0 | 1.0 | 0.1 | 1.0 | 2.0 | 0.2 |
| Maternal grandfather | 0.4 | 0.4 | 0.1 | 0.4 | 0.5 | 0.1 |
| Paternal grandfather | 3.0 | 3.0 | 0.4 | 3.0 | 3.0 | 0.5 |

Mean scores reflecting the ranked order of caregivers' role and influence within the family on a child's learning process reveal the following:

- Mothers' influence on the child's learning process and development is the highest (13), irrespective of area, followed by the influence of fathers (10-11);
- In both rural and urban areas, sisters (4-5) and brothers (4-6) exert next greatest influence on the learning process of a child, while in CHT maternal (3-4) and paternal aunts (0.1-3) play a significant role;
- The influence of the paternal grandparents (3) is quite high in both rural and in urban areas; but not in CHT; and
- The influence of the remaining caregivers is less than 1.

**Chart 4: Mean scores reflecting the role and influence of caregivers on child's learning process as assessed by mother and father**




The degree of influence of caregivers on a child's learning process assessed separately by mother and father tally almost completely (see bar chart above).

Children learn practical skills through traditional and customary practices which are part of routine household-level experiences. Major caregiving practices of this kind have been identified through direct household-level observation. These are shown in Table 39 and are specified in order of frequency of occurrence and observation.

**Table 39: Ranked order of major learning practices by source of learning**

**(caregivers) (findings from household-level observation)**

| Type of learning practice by child's age (in ranked order) | Primary source of learning | Secondary source of learning |
|---|---|---|
| Teaching alphabet (3 to 5 years) | Mother | Father, brother, sister |
| Teaching name of objects in immediate environment (2 years +) | Mother | Father, brother, sister |
| Teaching behaviour and ways to interact with others (3 years plus) | Mother | Father, brother, sister, grandparents, aunt |
| Emulating religious practices (3 years +) | Mother | Father, brother, sister, grandparents, aunt |
| Learning to pick up heavy things (4 to 5 years) | Mother | Father, brother, sister |
| Playing with clay and learning to make food (3 to 5 years) | Mother | Father, brother, sister |
| Feeding hay to cows (3 years +) | Father | Brother, sister, grandparents, aunt |
| Learn to make houses with bamboo sticks (3 years +) | Father | Brother, sister, grandparents, aunt |
| Learning complex skills to make items for everyday use, e.g. clay pots, mats, wooden tools and fishing nets (4 to 5 years) | Mother, father | Brother, sister, grandparents, aunt |
| Learning to draw pictures from picture books (3 years +) | Sister, brother | Mother, father, uncle, aunt |
| Playing with indigenous materials (mats) and practising musical lessons (4 to 5 years) | Sister, brother | Mother, father, uncle, aunt |

An analysis of the findings in the table above demonstrates the dominant role of the mother in the family as the informal teacher of a child. If she is educated, the mother starts teaching her child the alphabet. She also passes on knowledge about essential objects in the immediate environment. The child also picks up everyday practical skills by imitating his/her father and siblings and gradually adjusts to the social and physical environment. Grandparents and uncles/aunts also play an important role in this regard. Learning practices for children under 2 years were not observed.

A hierarchy of acquired behavioural skills classified in terms of mean age (in months) at the time of initiation of a particular behaviour are specified in Table 40. These are derived from the findings of surveys with caregivers and FGDs with opinion leaders.

**Table 40: Distribution of basic behavioural skills by mean age (in months) at time of initiation by child**

| Age of initiating behaviour(in months) | Behaviours initiated |
|---|---|
| Less than 1 month | ➢ Seeing |
| 1 to 6 months | AS above plus:<br>➢ Feeling hungry<br>➢ Recognizing<br>➢ Hearing |
| 6 to 12 months | As above plus:<br>➢ Crawling |

| | |
|---|---|
| 12 to 24 months | As above plus:<br>➢ Walking<br>➢ Speaking<br>➢ Learning<br>➢ Feeling<br>➢ Understanding<br>➢ Mixing with others |
| 24 to 32 months | As above plus:<br>➢ Smelling<br>➢ Thinking<br>➢ Acquiring knowledge<br>➢ Being curious |

The first behaviour initiated by a child, in the view of caregivers/opinion leaders, is seeing, which occurs from immediately after birth up to less than a month of age. The next series of behaviours initiated between one and six months are feeling hungry, recognizing and hearing. By 12 months crawling is added. Behaviours initiated in the next phase, from 12 to 24 months, are walking, speaking, learning, feeling, understanding and mixing (interacting) with others. According to caregivers and opinion leaders, the most complex behaviours requiring intense mental efforts are initiated after 24 months, namely, smelling, thinking, acquiring knowledge and being curious. Hardly any difference in response was observed in this regard between urban and rural caregivers. Estimates by caregivers from CHT fell within the age range given in the table above for a given behaviour, but were slightly higher than in rural and urban areas.

Caregivers are divided in their perceptions of the role and influence of older relatives on a child's learning process. The survey findings on this point are set out in Table 41.

**Table 41: Distribution of caregivers (older relatives) by their role and influence in enhancing a child's learning capabilities and by area (in per cent)***

| Type of role and influence | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Educate child about manners/behaviour/way of talking | 69 | 69 | 73 | 73 | 79 | 87 |
| Child learns through imitating older relatives | 13 | 17 | 14 | 21 | 16 | 14 |
| Child is given formal education | 19 | 14 | 18 | 13 | 11 | 11 |
| Child learns Cleanliness | 1 | 1 | 2 | 2 | 2 | 1 |
| Don't know | 23 | 18 | 16 | 12 | 15 | 9 |

***Multiple response**

Most caregivers, more than two-thirds (69 per cent) from rural areas, around three-quarters (73 per cent) from urban areas and more than three-quarters from CHT reported that they teach children manners, such as how to talk and behave with others. A little over one-tenth to one-fifth stated that children learn also through imitating their elders. Nearly one-fifth of rural and urban female caregivers said they give coaching in formal education to the children, compared to more than one-tenth of males in rural/urban areas and males/females from CHT. Only a negligible proportion of caregivers (1 to 2 per cent) claimed to have been instructing children on cleanliness. Roughly one-tenth to one-fifth of caregivers said that they were unaware of influences on children's learning processes.

The findings from the FGDs with opinion leaders and survey of caregivers (Table 41) on the influences on children's learning processes are consistent. The opinion leaders basically confirmed three distinct processes, namely:

- Older relatives informally (by telling stories) teach children manners, how to behave, survival skills;
- Children observe and imitate their older relatives; and
- Older relatives, if educated themselves, impart formal education.

Caregivers emphasize the role of mothers in teaching skills both formally and through informal interactions. Mothers help the child to:

- enhance vocabulary
- eat, dress and bathe
- wash, brush teeth, and stay clean
- use toilet
- write
- learn alphabet
- learn religious teachings/practices
- recognize objects through picture books
- remember name and identity of objects in the immediate environment.

All the behaviours cited above were also identified during household-level observation.

Table 41a illustrates caregiving practices of fathers in the child's learning process and development.

**Table 41a: Distribution of caregivers on role of fathers in learning processes of child and by area (in per cent)***

| Fathers' role in learning process | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Do nothing | 59 | 71 | 54 | 56 | 40 | 28 |
| Feeding | 2 | 2 | 3 | 3 | 3 | 5 |
| Washing face and hands, brushing teeth | 1 | 1 | 1 | 2 | 2 | 2 |
| Massaging oil | .1 | .1 | 0 | .1 | .3 | 1 |
| Buying clothes/foods/toys | 6 | 2 | 5 | 4 | 17 | 20 |
| Arranging medical treatment: bringing medicine/doctor | 1 | 1 | 1 | .4 | 2 | 1 |
| Playing with child/taking for a walk/teaching to talk | 4 | 8 | 9 | 14 | 7 | 9 |
| Keeping company/giving loving care/taking on lap | 41 | 27 | 43 | 36 | 45 | 52 |

*** Multiple response**

The majority of caregivers in rural and urban areas expressed the view that fathers play no role in the learning process of the child. In CHT, however, around half of caregivers recognized the role of fathers in providing emotional support for a child's learning, for instance, by taking the child on his lap or taking an older child visiting outside. Being a predominantly matrimonial **[??matriarchial??]** community, CHT caregivers stress the role of fathers in providing loving care to a child.

The following specific practices have been highlighted by caregivers regarding the role of fathers in improving the learning skills of a child:

- Giving loving care and taking the child on their lap: rest of Bangladesh - 27 to 43 per cent; CHT - 45 to 52 per cent
- Buying clothes, foods, sweets, toys: rest of Bangladesh - 2 to 6 per cent; CHT - 17 to 20 per cent
- Playing with child, taking for a walk, teaching to talk: rest of Bangladesh - 4 to 14 per cent; CHT - 7 to 9 per cent.

Findings from the qualitative research shed further light on the role played by fathers in a child's learning process.

Caregivers rarely mention (<1%) fathers' involvement in behaviours such as helping a child to wash, use oil, brush his/her teeth, dress and arranging medical treatment. Intensive interviews and observation did, however, identify other behaviours practised by fathers which nurture a child's development and learning processes. Specific behaviours by fathers (n= 56) observed in the households included:

- Massaging child with oil before bathing: above 3 years (very seldom observed)
- Taking child to pond for bathing: above 3 years in rural areas
- Helping child to dress after bathing: above 3 years (very seldom observed)
- Buying toys/dolls/sweets from shops: all ages
- Taking child on lap when crying: 1 to 2 years (very seldom observed)

- Taking child on back/shoulder when visiting outside: above 2 years
- Riding on buffalo with child (for fun): above 3 years in rural areas (very seldom observed)
- Using hand fan (local) to keep child cool while sleeping: above 2 years: (very seldom observed)
- Helping child to use toilet: above 3 years in CHT and urban areas (very seldom observed)
- Helping child to talk by imitating speech of father: above 2 years
- Showing picture books: above 3 years in urban areas
- Responding to child's questions: above 3 years in urban areas.

Fathers were also observed to impede a child's learning processes through the following negative behaviours:

- Hitting child when she/he is being naughty, for instance, putting hands through wheels of a moving rickshaw
- Being over-protective and restricting child's free movement, especially when child is the only son
- Scolding child when she/he goes to dangerous places, e.g. ponds, ditches
- Shouting at child when she/he spoils beds by defecating on them
- Hitting child when he/she is involved in fighting/quarreling with children in the neighbourhood
- Scolding child when she/he fails to do school work
- Hitting child when he/she is disobedient.

**Acceptable and Unacceptable Behaviours by Child**

Generally, cultural factors interact to determine the acceptability or unacceptability of a child's behaviour. This varies with the age and sex of a child. Tables 42a and 42b describe acceptable and unacceptable behaviour by a boy child and a girl child respectively according to the perceptions of caregivers by age of child and by area.

**Table 42a. Distribution of caregivers by responses on acceptable/unacceptable behaviour by boy child by area (in per cent)***

| Behaviour | 1 day to 3 years | | | | | | >3 to 5 years | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acceptable | Rural | | Urban | | CHT | | Rural | | Urban | | CHT | |
| | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| Saying rhymes/ teaching to read | 26 | 24 | 26 | 19 | 34 | 37 | 59 | 54 | 56 | 55 | 43 | 49 |
| Playing | 33 | 51 | 37 | 51 | 25 | 26 | 15 | 33 | 17 | 31 | 23 | 23 |
| Teaching good manners | 18 | 15 | 17 | 13 | 23 | 20 | 5 | 5 | 6 | 6 | 4 | 5 |
| Not crying or being naughty | 11 | 14 | 13 | 14 | 20 | 20 | 6 | 7 | 7 | 4 | 14 | 14 |
| Brushing teeth | 6 | 8 | 6 | 8 | 4 | 1 | 3 | 4 | 3 | 4 | 4 | 3 |
| Going to school | | | | | | | 13 | 17 | 13 | 15 | 23 | 18 |
| Helping mother/ helping with domestic work | | | | | | | 2 | 1 | 1 | 1 | 1 | 1 |
| Don't know | 15 | 10 | 11 | 13 | 12 | 12 | 11 | 8 | 10 | 10 | 7 | 7 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Unacceptable** | | | | | | | | | | | | |
| Fighting/quarreling/scolding | 30 | 32 | 23 | 24 | 32 | 32 | 38 | 40 | 31 | 26 | 36 | 35 |
| Disobeying elders (by not attending to studies and not eating in time) | 22 | 22 | 26 | 19 | 30 | 27 | 43 | 48 | 54 | 55 | 50 | 48 |
| Being naughty, e.g. by breaking things | 30 | 34 | 41 | 40 | 30 | 30 | 5 | 12 | 7 | 16 | 9 | 6 |
| Playing with mud/dirt | 8 | 10 | 5 | 7 | 12 | 11 | 6 | 6 | 4 | 4 | 14 | 12 |
| Don't know | 17 | 15 | 13 | 22 | 11 | 14 | 16 | 10 | 13 | 12 | 8 | 13 |

*** Multiple response**

Caregivers' views about the behaviours that are acceptable in children depend mostly on the child's age. Children are expected, broadly, to play when they are younger and to devote their time to more academic pursuits as they get older. Particular weight attached to obedience to elders amongst older children.

For a boy child aged 1 day to 3 years, acceptable behaviours in order of frequency of mention are 'playing' (25 to 51 per cent); 'saying rhymes/ teaching to read' (19 to 37 per cent); 'teaching good manners' (13 to 23 per cent); and 'not crying or being naughty' (11 to 20 per cent). For a boy child aged 3 to 5 years, acceptable behaviours are 'saying rhymes/teaching to read' (43 to 59 per cent); 'playing' (15 to 33 per cent); and 'going to school' (13 to 23 per cent).

For a boy child aged 1 day to 3 years, unacceptable behaviours are 'being naughty, e.g. by breaking things' (30 to 41 per cent); 'fighting/quarreling/scolding' (23 to 32 per cent); and 'disobeying elders' (19 to 30 per cent). For a boy child aged 3 to 5 years, unacceptable behaviours are 'disobeying elders' (43 to 55 per cent); 'fighting/quarreling/scolding' (26 to 40 per cent); and 'being naughty' (5 to 16 per cent).

**Table 42 b. Distribution of Caregivers by their responses on the deeds acceptable or unacceptable by a girl child by area (in per cent)***

| **Behaviour** | **1 day to 3 years** | | | | | | **>3 to 5 years** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Rural** | | **Urban** | | **CHT** | | **Rural** | | **Urban** | | **CHT** | |
| | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** | **Female** | **Male** |
| Saying rhymes/ teaching to read | 21 | 20 | 20 | 14 | 26 | 29 | 60 | 56 | 57 | 59 | 45 | 50 |
| Playing | 34 | 51 | 37 | 51 | 25 | 26 | 15 | 34 | 17 | 30 | 23 | 23 |
| Teaching good manners | 16 | 14 | 15 | 11 | 23 | 18 | 5 | 5 | 6 | 6 | 5 | 5 |
| Not crying or being naughty | 19 | 21 | 20 | 21 | 29 | 29 | 5 | 6 | 6 | 4 | 13 | 12 |
| Brushing teeth | 5 | 7 | 5 | 7 | 4 | 1 | 3 | 3 | 3 | 3 | 3 | 2 |
| Going to school | | | | | | | 12 | 17 | 13 | 13 | 22 | 18 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Helping mother/ helping with domestic work | | | | | | | 2 | 1 | 1 | 1 | 1 | 1 |
| Don't know | 15 | 10 | 12 | 13 | 10 | 11 | 11 | 8 | 9 | 9 | 8 | 7 |
| **Unacceptable** Fighting/quarrelin g/scolding | 30 | 33 | 23 | 22 | 33 | 32 | 37 | 39 | 30 | 25 | 35 | 35 |
| Disobeying elders (by not attending to studies and not eating in time) | 23 | 25 | 26 | 25 | 32 | 27 | 44 | 50 | 54 | 58 | 51 | 51 |
| Being naughty, e.g. by breaking things | 29 | 32 | 38 | 35 | 31 | 31 | 7 | 9 | 8 | 9 | 9 | 6 |
| Playing with mud/ dirt | 8 | 9 | 6 | 7 | 11 | 10 | 5 | 6 | 5 | 4 | 13 | 12 |
| Don't know | 18 | 16 | 14 | 22 | 11 | 14 | 15 | 13 | 12 | 18 | 9 | 12 |

*** Multiple response**

For a girl child aged 1 day to 3 years, acceptable behaviours in order of frequency of mention are 'playing' (26 to 51 per cent); 'not crying or being naughty' (19 to 29 per cent); 'saying rhymes/ teaching to read' (14 to 29 per cent); and 'teaching good manners' (11 to 23 per cent), while for a girl child aged 3 to 5 years, acceptable behaviours are 'saying rhymes/teaching to read (45 to 60 per cent); 'playing' (15 to 34 per cent); and 'going to school' (12 to 22 per cent).

For a girl child aged 1 day to 3 years, unacceptable behaviours are 'being naughty' (29 to 38 per cent); 'fighting/quarreling/scolding' (22 to 33 per cent); and 'disobeying elders' (23 to 32 per cent). For a girl child aged 3 to 5 years, unacceptable behaviours are 'disobeying elders' (44 to 58 per cent); 'fighting/quarreling/scolding' (25 to 39 per cent); and 'being naughty' (6 to 9 per cent).

As will be seen from the list below, there is a considerable overlap between the survey findings described above and behaviours identified by caregivers in the intensive interviews as unacceptable for children:

- being disobedient
- creating problems
- using slang
- fighting/quarreling with others
- being dirty
- refusing to study
- misbehaving with elders
- damaging household objects
- crying excessively
- stealing

## Section 7: Behaviours Resulting in Exclusion: Discriminating between Girl and Boy Child

About two-thirds of caregivers from rural and urban areas and 90 per cent from CHT reported that they are unaware of behaviour discriminating between the boy and girl child. Such a statement is often misleading, however, as behaviours that have become internalized and turned into customs are often practised unknowingly. Such behaviours, which lead to a preference for sons, are accepted as part of the culture and are not viewed as discriminatory.

**Table 43: Distribution of caregivers by their behaviours discriminating between girl and boy child and by area (in per cent)***

| Type of behaviour | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Daughters receive less love and affection | 43 | 36 | 39 | 39 | 27 | 35 |
| Daughters given less food/less costly clothes | 18 | 14 | 16 | 17 | 8 | 8 |
| Daughters face neglect/less care | 6 | 4 | 4 | 11 | 1 | 12 |
| Daughters not allowed to pursue education | 22 | 16 | 21 | 15 | 8 | 8 |
| No discrimination against daughters | 4 | 3 | 6 | 4 | 1 | 4 |
| Others | 1 | 1 | 1 | 1 | 4 | - |
| Don't know | 18 | 38 | 23 | 27 | 53 | 42 |

*** Multiple response**

Those who mentioned discrimination did so in connection with daughters, who most often receive less love and affection. Findings from the intensive interviews indicate that a large number of caregivers are unaware (don't know) about discrimination between boy and girl children. A very low proportion of caregivers (1 to 6 per cent) stated that they do not discriminate against a girl child at all.

The types of discriminatory behaviour that emerged from the survey findings include:

- Girls are given less love and affection: 36 to 43 per cent in rural and urban areas; 27 to 35 per cent in CHT
- Girls are given less food and clothes: 14 to 18 per cent in rural and urban areas; 8 per cent in CHT
- Girls are neglected: 4 to 11 per cent in rural and urban areas; 1 to 12 per cent in CHT
- Girls are restricted from obtaining an education: 15 to 22 per cent in rural and urban areas; 8 per cent in CHT.

The reasons cited by caregivers for discriminating against the girl child are:

- girls require marriage dowries
- boys live with parents; girls leave parental home
- boys are earning members of the family.

## Section 8: Emotional Development, Curiosity, Confidence-building

The emotional development of a child has been traced through the following:

- Stimulating/identifying child's feelings
- Expression of curiosity
- Identifying child's deficiencies
- Preparing child for first visit to school
- Building self confidence

### Stimulating Child's Feelings

The majority of caregivers are not aware that one can stimulate a child's feelings. The distribution of caregivers' responses on whether or not they can stimulate a child's feelings is shown in Table 44.

**Table 44: Distribution of caregivers by their awareness on being able to stimulate child's feelings and by area (in per cent)**

| Area | Male | | Female | |
|---|---|---|---|---|
| | Aware | Unaware | Aware | Unaware |
| Rural | 12 | 88 | 15 | 85 |
| Urban | 16 | 84 | 20 | 80 |
| CHT | 36 | 64 | 27 | 73 |

The overwhelming majority of caregivers (64 to 88 per cent), as shown in Table 45, are unaware of any steps to stimulate a child's feelings. Levels of awareness are lowest in rural and urban areas (lower in urban areas) but notably higher in CHT. Possibly urban caregivers are more aware because of their higher exposure to media and other modernizing influences. The more positive situation in CHT is because of the homogeneous nature of communities in CHT and strong bonds that exist among the population due to their religious and cultural beliefs. These may have influenced their psyche regarding the emotional development of a child.

**Table 45: Distribution of caregivers by their awareness about steps to stimulate child's feelings and by area (in per cent)***

| Steps to stimulate child's feelings (age of child) | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Not aware | 85 | 88 | 80 | 84 | 73 | 64 |
| Encourage child to do good/positive deeds (4 to 5 years) | 3 | 2 | 5 | 3 | 7 | 7 |
| Meet demand of child (any age) | 1 | 2 | 2 | 2 | 2 | 3 |
| Teach child to read/go to school (4-5 years) | 1 | 1 | 2 | 3 | 3 | 4 |
| Teach good manners/behaviour (3-5 years) | 2 | 3 | 3 | 3 | 6 | 10 |
| Tickle child (1 year and above) | 5 | 4 | 6 | 5 | 4 | 6 |
| Encourage talking and playing (2 years and above) | 3 | 2 | 3 | 3 | 8 | 12 |
| Others | .3 | 1 | 1 | 1 | .1 | 1 |

*** Multiple response**

Encouraging the child to do good deeds, teaching them good manners, encouraging talk and play and tickling them +are some of the steps mentioned by caregivers as being effective to stimulate a child's feelings.

**Identifying Child's Feelings**

The emotional development of a child has been investigated by different age groups: 1 day to 3 years, 1 to 3 years and 3 to 5 years. Separate investigations have been made for a girl child and boy child. Table 46a shows the distribution of caregivers according to their responses on the ways to determine a child's feelings (emotions) by age, sex and area.

**Table 46a: Distribution of caregivers by ways to determine child's feelings (emotions) by age, sex and area (in per cent)**

| Ways to determine child's feelings | Rural | | | | Urban | | | | CHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Girl child | | Boy child | | Girl child | | Boy child | | Girl child | | Boy child | |
| | 1 day –3 years | >3-5 years | 1 day -3 years | >3-5 years | 1 day –3 years | >3-5 years | 1 day –3 years | >3-5 years | 1 day -3 years | >3-5 years | 1 day –3 years | >3-5 years |
| **Girl child** | | | | | | | | | | | | |
| Being pensive/ hurt/ crying | 16 | 16 | 15 | 16 | 15 | 16 | 14 | 16 | 27 | 29 | 27 | 29 |
| Being delighted/happy/ laughing | 10 | 6 | 10 | 6 | 8 | 6 | 9 | 6 | 19 | 17 | 19 | 17 |
| Calling 'Mama' to get mother's attention | 2 | 4 | 2 | 3 | 2 | 3 | 2 | 3 | 3 | 3 | 4 | 3 |
| Others | .2 | 1 | .3 | 1 | .3 | 1 | .3 | 1 | .1 | .3 | .1 | .3 |
| Don't know | 75 | 76 | 76 | 76 | 77 | 78 | 78 | 78 | 61 | 61 | 61 | 61 |
| **Boy child** | | | | | | | | | | | | |
| Being pensive/ hurt/ crying | 25 | 22 | 25 | 22 | 19 | 18 | 18 | 20 | 35 | 37 | 35 | 37 |
| Being delighted/happy/ laughing | 8 | 6 | 8 | 6 | 8 | 5 | 7 | 5 | 18 | 14 | 19 | 15 |
| Calling 'Mama' to get mother's attention | 2 | 4 | 2 | 5 | 3 | 3 | 3 | 3 | 5 | 6 | 5 | 6 |
| Others | .3 | 1 | .4 | 1 | .4 | 1 | .3 | 1 | 2 | 2 | 1 | 1 |
| Don't know | 69 | 70 | 70 | 70 | 75 | 75 | 76 | 75 | 52 | 52 | 52 | 52 |

More than two-thirds (69 to 78 per cent) of both female and male caregivers from rural and urban areas did not know how to determine the feelings (emotions) of a child. In CHT, however, the equivalent figures were lower: over half for male caregivers (52 per cent) and around 60 per cent for female caregivers. 'Being pensive/hurt/crying' was the most widely recognized way of identifying a child's feelings by all caregivers. The next best indicator of a child's feelings was

being delighted/happy/laughing. Comparatively, caregivers in CHT demonstrated greater knowledge on the ways to identify the emotions of a child.

Tables 46b and 46c show that caregivers perceive boys and girls to be frightened by the same things, with marginal differences in the relative proportions in the three age groups.

**Table 46b. Distribution of caregivers' reasons for a boy child being frightened and by area (in per cent)***

| Reasons for being frightened | 1 day to 1 year | | | | | | >1 to 3 years | | | | | | >3 to 5 years | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rural | | Urban | | CHT | | Rural | | Urban | | CHT | | Rural | | Urban | | CHT | |
| | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| Seeing cat/dog/ cow/ insects** | 29 | 28 | 18 | 16 | 40 | 39 | 57 | 57 | 50 | 52 | 52 | 49 | 47 | 46 | 39 | 47 | 45 | 40 |
| Hearing loud sounds/ shouts | 48 | 43 | 55 | 54 | 33 | 33 | 6 | 6 | 7 | 8 | 6 | 6 | 4 | 5 | 4 | 5 | 6 | 7 |
| Being scolded/ hit | | | | | | | 21 | 22 | 29 | 22 | 18 | 20 | 29 | 34 | 38 | 30 | 28 | 34 |
| Seeing strange persons | 6 | 8 | 5 | 7 | 14 | 19 | 6 | 9 | 6 | 6 | 13 | 11 | | | | | | |
| Being alone/seeing darkness/ shadow/having nightmares | 6 | 11 | 9 | 11 | 10 | 7 | 5 | 6 | 7 | 7 | 16 | 17 | 5 | 6 | 6 | 5 | 12 | 10 |
| Falling out of bed | 3 | 3 | 3 | 2 | 2 | 1 | | | | | | | | | | | | |
| Seeing mad person | | | | | | | 2 | 3 | 3 | 2 | 2 | 4 | 9 | 11 | 9 | 10 | 11 | 11 |
| Hearing ghost stories | | | | | | | | | | | | | 3 | 5 | 4 | 5 | 4 | 3 |
| Not frightened of anything | 2 | 4 | 5 | 7 | 2 | 1 | 1 | 1 | 0.4 | 1 | 1 | 0 | 1 | 0.4 | 1 | 2 | 1 | 1 |
| Don't know | 9 | 10 | 10 | 9 | 9 | 11 | 8 | 6 | 8 | 7 | 5 | 5 | 1 | 6 | 8 | 8 | 5 | 6 |

*** Multiple response**

** Insects: snake, lizard, cockroach

Boys up to 1 year are most often frightened by loud sounds or shouts (33 to 55 per cent), followed by the sight of an animal or insect (16 to 40 per cent). Older boys are most frequently frightened by the sight of an animal or insect (39 to 57 per cent), and by being scolded or hit (18 to 38 per cent).

**Table 46c. Distribution of caregivers' reasons for a girl child being frightened and by area (in per cent)***

| Reasons for being frightened | 1 day to 1 year | | | | | | > 1 to 3 years | | | | | | >3 to 5 years | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rural | | Urban | | CHT | | Rural | | Urban | | CHT | | Rural | | Urban | | CHT | |
| | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| Seeing cat/dog/ cow/ insects** | 28 | 27 | 17 | 16 | 40 | 38 | 58 | 57 | 50 | 57 | 52 | 50 | 47 | 45 | 40 | 47 | 45 | 42 |
| Hearing loud sounds/ shouts | 49 | 44 | 55 | 55 | 34 | 34 | 7 | 7 | 9 | 10 | 6 | 5 | 4 | 4 | 5 | 5 | 7 | 6 |
| Being scolded/ hit | | | | | | | 21 | 22 | 27 | 23 | 19 | 20 | 30 | 36 | 38 | 31 | 28 | 33 |
| Being alone/seeing darkness/ shadow/having nightmares | 7 | 12 | 9 | 11 | 11 | 7 | 4 | 7 | 7 | 6 | 15 | 17 | 5 | 6 | 6 | 5 | 11 | 10 |
| Seeing strange persons | 6 | 8 | 4 | 6 | 14 | 19 | 6 | 8 | 5 | 8 | 13 | 11 | | | | | | |
| Falling out of bed | 3 | 3 | 3 | 2 | 2 | 1 | | | | | | | | | | | | |
| Seeing mad person | | | | | | | 2 | 3 | 3 | 2 | 2 | 5 | 9 | 11 | 9 | 11 | 11 | 12 |
| Hearing ghost stories | | | | | | | | | | | | | 3 | 5 | 4 | 6 | 4 | 3 |
| Not frightened of anything | 2 | 4 | 5 | 7 | 2 | 1 | 6 | 4 | 6 | 5 | 4 | 2 | 1 | 1 | 1 | 2 | 1 | 1 |
| Don't know | 8 | 10 | 10 | 8 | 9 | 11 | 2 | 2 | 2 | 2 | 1 | 2 | 7 | 6 | 7 | 7 | 4 | 4 |

*** Multiple response**
**** Insects: snake, lizard, cockroach**

Very young girls (up to 1 year) are most often frightened when they are exposed to loud sounds or shouts (34 to 55 per cent), followed by the sight of an animal or insect (16 to 40 per cent). Older girls (> 1-3 years or >3-5 years) are most frequently frightened by the sight of an animal or insect (40 to 58 per cent), or by being scolded or hit (19 to 38 per cent).

**Expression of Curiosity by Child**

Being curious is one of the ways that a child expresses feelings and emotions. The majority of rural caregivers (females and males) and the majority of urban female caregivers stated their ignorance about curiosity being an indicator of the emotional development of a child, while all caregivers irrespective of gender from CHT stated that they were aware of this.

**Table 47: Distribution of caregivers by steps taken to arouse curiosity of child and by area (in per cent)**

| Steps taken | Rural | | | | | | Urban | | | | | | CHT | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | | Male | | | Female | | | Male | | | Female | | | Male | | |
| | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs | 1 day – 1 yr | >1 yr-3 yrs | > 3 yrs-5 yrs |
| Respond to questions/ identify objects | 50 | 82 | 78 | 56 | 89 | 86 | 55 | 85 | 84 | 53 | 94 | 92 | 71 | 88 | 82 | 70 | 86 | 83 |
| Buy rattle musical toy)/books of rhymes/ pictures | 6 | 5 | 5 | 2 | 2 | 2 | 5 | 4 | 4 | 3 | 3 | 3 | 5 | 5 | 5 | 9 | 7 | 9 |
| Teach child to play/allow more time to play with others | 3 | 1 | 1 | 1 | 2 | 1 | 2 | 3 | 2 | 4 | 3 | 2 | 2 | 1 | 2 | 2 | 1 | 0.4 |
| Send child to school | 0 | 0.3 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 0.3 | 0 | 1 | 1 |
| Others | 3 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 4 | 1 | 1 | 1 | 1 | 1 | 0.4 | 1 | 0.4 |
| Do nothing | 43 | 20 | 25 | 42 | 17 | 20 | 43 | 19 | 23 | 40 | 13 | 16 | 26 | 14 | 20 | 24 | 13 | 16 |

*** Multiple response**

Hardly any difference was observed between different age groups on caregivers' awareness about steps to arouse the curiosity of a child. Frequent interactions with a child and responding to a child's questions were identified as measures to stimulate curiosity among children. Other measures mentioned by a few caregivers were buying musical toys or books with rhymes/pictures for the child, allowing the child to play with others and sending the child to school.

**Identifying Child's Physical and Mental Deficiencies**

More than 90 per cent of caregivers (92 to 97 per cent) stated that they have no knowledge regarding the physical or mental deficiencies of a child.

**Table 48: Distribution of caregivers by status of knowledge on physical and mental deficiencies of a child and by area (in per cent)***

| Response | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Yes | 5 | 3 | 3 | 4 | 5 | 8 |
| No | 95 | 97 | 97 | 96 | 95 | 92 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

Of those who said that they had some knowledge on the physical and mental deficiencies of a child (Table 48a), the majority of caregivers from rural areas (52 to 61 per cent) and exactly half from CHT specified illness as a physical deficiency. Less than half (42 to 44 per cent) of caregivers from urban areas shared this view. Organic defects, the inability to walk and speak at the appropriate time were identified by other caregivers as physical deficiencies.

Very few caregivers knew about children's mental deficiencies. Those who did, mentioned 'lack of concentration/attentiveness' (3 to 27 per cent) and 'abnormal/crazy behaviour' (7 to 10 per cent) as the most important examples.

**Table 48a: Distribution of caregivers by knowledge on types of physical and mental deficiencies of a child and by area (in per cent)***

| Types of physical deficiency | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Illness | 61 | 52 | 42 | 44 | 50 | 50 |
| Other organic defects | 17 | 25 | 10 | 20 | 20 | 14 |
| Inability to walk at appropriate time | 9 | 13 | 33 | 24 | 15 | 14 |
| Inability to speak at appropriate time | 4 | - | 8 | 8 | 13 | 5 |
| Not crying immediately after birth | 1 | 2 | - | - | - | - |
| Cannot sit upright | - | - | 2 | - | - | - |
| Blindness/deafness | 0.4 | 2 | 2 | 4 | - | 5 |
| No weakness | 5 | 2 | 2 | - | 3 | - |
| **Types of mental deficiency** | | | | | | |
| Lack of concentration/ attentiveness | 3 | 4 | 27 | 12 | 18 | 9 |
| Abnormal/crazy behaviour | 7 | 7 | 6 | 12 | 10 | 9 |
| Feeling scared of anything unknown | 2 | 5 | 2 | - | 3 | 5 |
| Stammering | 4 | 2 | - | 12 | 15 | - |
| Intelligence does not develop according to age | 2 | - | 6 | 4 | - | - |

*** Multiple response**

**Preparing Child for First Visit to School**

A child's first day at school is considered to be a very important event. Parents and the child are exposed to different degrees of trauma/reward through this experience, depending on how well the parents prepare themselves and the child for the event. An overwhelming majority of caregivers from both rural and urban areas and the majority of female caregivers from CHT said they were not aware of any need to prepare a child for his or her first day at school. By contrast, the majority of male caregivers from CHT identified the need for such preparation.

**Table 49: Distribution of caregivers by their perceptions of need to prepare child for first day at school and by area (in per cent)***

| Caregivers' perceptions | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Not aware | 69 | 73 | 64 | 67 | 57 | 44 |
| Buy new book, pen, exercise books | 8 | 7 | 9 | 8 | 17 | 20 |
| Parents accompany child | 5 | 4 | 6 | 5 | 7 | 7 |
| Prepared child physically and mentally | 6 | 4 | 7 | 6 | 7 | 11 |
| Arouse interest in learning | 5 | 5 | 8 | 7 | 8 | 11 |
| Convince child about importance of going to school | 11 | 10 | 12 | 12 | 12 | 17 |

*** Multiple response**

Those who mentioned the need to prepare a child for his or her first day at school specified measures such as buying new books, pens and exercise books. They also mentioned the need to motivate the child adequately about the importance of going to school, to stimulate the child's interest in learning and to accompany the child to the school.

**Building Self-confidence**

Building a child's self-confidence is universally acknowledged to be an important factor in the child's emotional development. Table 49a describes the status of caregivers' understanding of the concept of 'self- confidence' relating to a child.

**Table 49a: Distribution of caregivers by understanding of 'self- confidence' in a child and by area (in per cent)**

| Status of understanding | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Understand | 20 | 25 | 23 | 31 | 39 | 60 |
| Do not understand | 80 | 75 | 77 | 69 | 61 | 40 |

The majority of caregivers (69 to 80 per cent) in rural and urban areas do not understand the meaning of self-confidence in relation to a child. However, the level of understanding among caregivers in CHT is comparatively higher, with 60 per cent of male caregivers in CHT saying they understand the concept.

**Table 49b: Distribution of caregivers by understanding of possible benefits of a child being self-confident and by area (in per cent)**

| Understanding of benefits | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Acting independently | 64 | 66 | 70 | 70 | 59 | 57 |
| Developing confidence to achieve success | 20 | 18 | 15 | 15 | 26 | 25 |
| Avoiding fear and understanding others | 13 | 11 | 12 | 8 | 12 | 14 |
| Participating in multiple activities | 3 | 3 | 3 | 5 | 4 | 3 |
| Others | 1 | 1 | 0.3 | 1 | - | 1 |

The majority of caregivers who understand the meaning of self-confidence in relation to a child, mentioned that a self-confident child can act independently (59 to 70 per cent). In addition, a few caregivers said that a child can develop self-confidence as a way of achieving success in life (15 to 26 per cent) and can avoid fear (inhibitions) and understand others (8 to 14 per cent).

**Table 49c: Distribution of caregivers by steps to build self-confidence in a child and by area (in per cent)***

| Steps to build self-confidence | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Converse with child only on positive things | 36 | 26 | 41 | 34 | 37 | 43 |
| Help educate child | 25 | 35 | 23 | 35 | 35 | 40 |
| Encourage child to succeed/achieve | 20 | 22 | 18 | 16 | 18 | 16 |
| Avoid scolding/ shouting/saying negative things/ discourage from talking about anything negative | 17 | 16 | 19 | 14 | 13 | 8 |
| Stimulate child by giving small tasks | 6 | 8 | 6 | 7 | 3 | 5 |
| Introduce new ideas to child | 3 | 2 | 3 | 1 | 3 | - |
| Others | 3 | 2 | 3 | 3 | 1 | 1 |

*** Multiple response**

Both female and male caregivers (26 to 43 per cent) identified conversing with the child is an important measure to promote a child's self-confidence. Other important measures include helping educate the child (23 to 40 per cent), encouraging the child to succeed/achieve (16 to 22 per cent), and avoiding scolding/shouting/saying negative things/discouraging from talking about anything negative' (8 to 19 per cent).

In the qualitative part of the research, caregivers were asked to identify measures to strengthen the mental development of a child. In a separate question, caregivers were requested to describe the harmful effects of a lack of healthy mental development. The findings are summarized in Tables 50a and 50b.

**Table 50a: Responses on measures to strengthen child's mental development (qualitative investigations)**

| Method of investigation/ respondents | 1 day to 1 year | >1 to 3 years | >3 to 5 years |
|---|---|---|---|
| **Intensive interviews** | • Ensure loving care<br>• Buy clothes for child | • Buy clothes for child<br>• Buy toys for child<br>• Converse frequently and closely with child<br>• Adjust to or meet child's demands | • Buy clothes for child<br>• Converse frequently and closely with child<br>• Adjust to or meet child's demands<br>• Take child visiting outside |
| **FGDs:**<br>• **Opinion leaders** | • Ensure loving care<br>• Behave in a positive manner<br>• Do not hit child<br>• Explain to/do not scold child<br>• Ensure safe and healthy environment for child | • Buy toys for child<br>• Behave in a positive manner<br>• Do not hit child<br>• Explain to/do not scold child<br>• Ensure safe and healthy environment for child<br>• Converse frequently and closely with child<br>• Play with child/enable child to play with other children | • Behave in a positive manner<br>• Do not hit child<br>• Take child visiting outside<br>• Explain to/do not scold child<br>• Ensure safe and healthy environment for child<br>• Converse frequently and closely with child<br>• Play with child/enable child to play with other children<br>• Help child pursue education<br>• Arrange for recreation for child<br>• Allow freedom of movement |
| • **Adolescent boys** | • Ensure safe and healthy environment for child<br>• Ensure loving care<br>• Behave in a positive manner<br>• Explain to/do not scold the child | • Ensure safe and healthy environment for child<br>• Behave in a positive manner<br>• Explain to/do not scold child<br>• Buy toys for child<br>• Adjust to or meet child's demands<br>• Converse frequently and closely with child<br>• Play with child/enable child to play with other children | • Ensure safe and healthy environment for child<br>• Behave in a positive manner<br>• Explain to/do not scold child<br>• Adjust to or meet child's demands<br>• Converse frequently and closely converse with child<br>• Help child pursue education<br>• Play with child/enable child to play with other children<br>• Avoid bad company/dangerous environment |

| Method of investigation /respondents | 1 day to 1 year | >1 to 3 years | >3 to 5 years |
|---|---|---|---|
| • **Adolescent girls** | • Ensure safe and healthy | • Ensure safe and healthy environment | • Ensure safe and healthy environment for child |

| | | | |
|---|---|---|---|
| | environment for child<br>• Behave in a positive manner<br>• Ensure loving care<br>• Keep child cheerful | for child<br>• Behave in a positive manner<br>• Buy toys for child<br>• Adjust to or meet child's demands<br>• Converse frequently and closely with child<br>• Explain to/do not rebuke child<br>• Play with child/enable child to play with other children<br>• Keep child cheerful | • Behave in a positive manner<br>• Adjust to or meet child's demands<br>• Converse frequently and closely with child<br>• Explain to/do not scold child<br>• Help child pursue education<br>• Play with child/enable child to play with other children<br>• Keep child cheerful |
| **Household-level observation:**<br>• **Evidence of child's self-confidence building traits** | | | • Child washing own clothes<br>• Child massaging oil into body himself/herself<br>• Child brushing own teeth |
| • **Evidence of care for mental development** | • Child receiving loving care from paternal grandmother<br>• Mother helping child to talk<br>• Child enjoying embracing older brother | • Child receiving loving care from paternal grandmother<br>• Child enjoying looking at own image in looking glass<br>• Child trying to put on clothes: imitating putting on sari<br>• Grandparents encouraging child to play<br>• Crying when play obstructed or being naughty practices (negative behaviour)<br>• Father imitating sound of cock to encourage child to talk | • Father and child conversing<br>• Child receiving loving care from paternal grandmother<br>• Child watching cartoon film on television and laughing<br>• Child enjoying looking at own image in looking glass<br>• Grandparents encouraging child to play<br>• Child trying to put on clothes: imitating putting on sari<br>• Crying when play obstructed or being naughty (negative behaviour)<br>• Father imitating sound of cock to encourage child to talk<br>• Child imitating carpenter<br>• Child asking questions when encounters new object<br>• Child feeding domestic animals: ducks and hens<br>• Driving dog as a game<br>• Mother telling horror stories (negative behaviour) |

**Table 50b: Responses to question on harmful effects of lack of healthy mental development of a child using qualitative methods of investigation**

| Responses to question | Intensive interviews | FGD findings | | Household-level observation |
|---|---|---|---|---|
| | | Opinion leaders | Adolescents | |
| **Harmful effects of lack of healthy mental development** | • Child can't move normally<br>• Can't play<br>• Can't mix with others<br>• Can't pursue formal education<br>• Will be mentally handicapped<br>• May become mad<br>• Can't say | • Child will be mentally handicapped<br>• May become mad<br>• May become a fool<br>• Will become inactive<br>• Will become deaf and dumb<br>• Will become a liability to the family and the community<br>• Will develop physical disability<br>• May become a wayward/spoilt child<br>• May become indisciplined/ terrorist<br>• Can't say | **Adolescent girls:**<br>• May become mad<br>• Can't pursue formal education<br>• May become indisciplined/a terrorist<br>• Will develop physical disability<br>• Can't move normally<br>• Will be mentally handicapped<br>• Will become deaf and dumb<br>• Will lose interest in learning<br>• Can't achieve respectable position in society<br>• Will not be able to differentiate between right and wrong<br>**Adolescent boys:**<br>• May become a fool<br>• Will not become a good citizen<br>• Will not be able to understand responsibilities<br>• Will be neglected in society<br>• Will fail to take right decisions<br>• Will be disobedient<br>• Will go astray | Not Applicable |

Responses in Table 50b are comparable with those obtained through the survey, except for the statements of the adolescent boys. The adolescent boys expressed the view that a child who does not have a healthy mental development will become an irresponsible citizen, will not understand his/her responsibilities, and will fail to take the right decisions. In the current social context, these responses should be viewed seriously, since a large number of youths are today facing adverse psychological conditions leading to negative social consequences.

A number of practices were observed at household level which play a part in strengthening the mental development process in a child, namely:

- child functions independently reflecting process of becoming self-reliant
- child watches cartoons and observes objects in immediate environment as source of both entertainment and cognitive stimulation, and
- older relatives provide loving and supportive care, e.g. grandparents take child on lap and converse with him/her.

## Section 9: Impact of Violence: Physical and Mental

Violence in the form of physical beating or mental neglect directly affects the emotional and physical health of a child. In Bangladesh, however, the practice of hitting a child is almost universal. How far society is changing and what practices exist at family level are matters of interest for the design of future interventions to change the attitudes of caregivers in this regard.

**Table 51: Distribution of caregivers by their level of understanding of the impact on a child directly exposed to violence (either experiencing or seeing) (in per cent)**

| Impact of violence on child | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Suffers from mental depression | 9 | 12 | 9 | 8 | 11 | 11 |
| Becomes scared | 43 | 37 | 35 | 44 | 51 | 48 |
| Becomes aggressive | 43 | 45 | 52 | 38 | 38 | 39 |
| No impact | 2 | 3 | 3 | 2 | 1 | 2 |
| Don't know | 9 | 8 | 5 | 11 | 6 | 6 |

*** Multiple response**

Caregivers often physically punish a child who has done something damaging or wrong. Table 51 reveals caregivers' perceptions of the impact of violence on children. Caregivers are aware of some harmful impact of exposing a child to violence: approximately one-third to one-half mentioned that a child becomes either scared or aggressive if exposed to violence.

**Table 52: Distribution of caregivers (parents only) by type of physical violence used against child and by area (in per cent)**

| Type of violence | Rural | | | | Urban | | | | CHT | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Female | | Male | | Female | | Male | |
| | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child | Boy Child | Girl Child |
| **a. Violence by father** | | | | | | | | | | | | |
| Mild slap/blow/hit | 15 | 15 | 19 | 20 | 14 | 13 | 19 | 20 | 24 | 18 | 19 | 16 |
| Scolding/rebuking | 2 | 3 | 2 | 4 | 1 | 2 | 2 | 1 | 2 | 1 | 0 | 0 |
| Pulling by hair/ear | 1 | 1 | 1 | 0.4 | 1 | 1 | 1 | 0 | 0 | 2 | 1 | 0 |
| Severely beating with stick | 9 | 7 | 7 | 7 | 5 | 5 | 7 | 8 | 9 | 5 | 14 | 7 |
| No use of violence | 74 | 76 | 74 | 73 | 79 | 80 | 75 | 74 | 68 | 76 | 71 | 77 |
| **b. Violence by mother** | | | | | | | | | | | | |
| Mild slap/blow/hit | 35 | 24 | 26 | 17 | 36 | 28 | 29 | 19 | 39 | 34 | 27 | 25 |
| Scolding/rebuking | 2 | 2 | 3 | 2 | 1 | 0.4 | 3 | 0.4 | 2 | 2 | 1 | 0 |
| Pulling by hair/ear | 0.4 | 1 | 0 | 0.1 | 0 | 0.2 | 0 | 1 | 1 | 1 | 0 | 0 |
| Severely beating with stick | 12 | 8 | 8 | 5 | 10 | 6 | 4 | 5 | 12 | 7 | 14 | 15 |
| No use of violence | 54 | 68 | 65 | 78 | 56 | 68 | 66 | 77 | 50 | 59 | 61 | 62 |

*** Multiple response**

Regarding use of physical violence, three degrees of violence used by mothers and fathers were described:

| | Mother | Father |
|---|---|---|
| • Mild act of violence: | 19-42% | 16-26% |
| ✓ Slap/blow/ hit | | |
| ✓ Pulling by hair/ear | | |
| ✓ Scolding/rebuking | | |
| • Severely beating with stick | 4-15% | 5-14% |
| • No use of violence | 54-77% | 71-80% |

In summary, approximately 30 per cent of parents revealed that they used some kind (mild or severe) of violence against the child, while the remainder stated that they did not use any violence at all.

Table 53 shows the distribution of the impact of violent behaviour on the child as perceived by caregivers.

**Table 53: Distribution of caregivers by their perception of good or bad impact of violent behaviour on child and by area (in per cent)***

| Type of caregiver | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | Good | Bad | DK | Good | Bad | DK | Good | Bad | DK |
| Mother | 11 | 83 | 6 | 9 | 86 | 6 | 10 | 88 | 2 |
| Sister | 13 | 80 | 6 | 7 | 84 | 8 | 7 | 87 | 6 |
| Others | 11 | 80 | 9 | 7 | 87 | 6 | 7 | 91 | 2 |
| Female subtotal | 12 | 82 | 6 | 9 | 86 | 6 | 10 | 88 | 2 |
| Father | 10 | 85 | 5 | 8 | 88 | 4 | 14 | 83 | 6 |
| Brother | 9 | 86 | 5 | 9 | 85 | 6 | 0 | 90 | 10 |
| Others | 10 | 83 | 8 | 7 | 91 | 3 | 16 | 80 | 4 |
| Male subtotal | 10 | 85 | 5 | 8 | 88 | 4 | 13 | 84 | 4 |
| Grand total | 11 | 83 | 6 | 8 | 86 | 5 | 11 | 87 | 3 |

*** Multiple response**

An overwhelming majority of caregivers (80 to 91 per cent) perceived the impact of violent behaviour inflicted by parents on the child as negative. There were marginal differences between the perceptions of caregivers in different areas.

**Table 54: Distribution of caregivers' perceptions of the impact of violence on child development and by area (in per cent)***

| Type of influence on child development | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **Mental impact:** Becomes submissive/dull | 9 | 15 | 11 | 17 | 16 | 21 |
| Becomes vindictive | 6 | 8 | 6 | 8 | 5 | 3 |
| Becomes fearful/timid | 2 | 5 | 4 | 5 | 3 | 2 |
| **Subtotal** | 17 | 28 | 21 | 30 | 24 | 26 |
| **Physical impact:** Develops organic defects | 71 | 64 | 65 | 67 | 79 | 79 |
| Don't know | 21 | 19 | 24 | 15 | 8 | 9 |

*** Multiple response**

Around two-thirds to three-quarters of respondents identified a physical impact (i.e. develops organic defects) of violent behaviour on child development. A smaller proportion (17 to 30 per cent) identified a range of psychological impacts, such as becoming submissive/dull, fearful/timid, and vindictive. About one-tenth of the respondents in CHT and about one-fifth of the respondents in rural and in urban areas said that they were not aware of any impact.

The incidents of violence observed at household level by observers and field investigators are listed in Table 55.

**Table 55: Type of violence observed at household level**

| Girl child's experience of violence | Boy child's experience of violence |
|---|---|
| When child trying to go outside, mother rebuked and prevented child from going | When child tried to read elder sisters' books, mother snatched them away and rebuked child |
| Child trying to climb window, mother prevented her | When child spilled *chun* for betel leaf from the pot, mother drove child out of house |
| Mother slapped child when she tried to grab food from aunt's kitchen | Elder sister slapped child who did not participate in games |
| Child tried to grab food from others, mother slapped her | Father rebuked child who did not do school work |
| Mother rebuked child when she did not obey her and perform given tasks | Child tried to dress himself, mother obstructed act, child was crying |
| Child is indisciplined and disobedient for which she is rebuked by all caregivers | Child wanted to accompany father to the market, father rebuked child |
| Child was quarreling and fighting with other child, mother rebuked her | Child refused to listen to the father, father rebuked child |
| Child visiting outside for which father rebuked him | Child wanted a bag from others, mother slapped the child |
| Child spilled cooking oil on the floor, mother caned the child | When child cried out mother looked responded to child |
| Child demanded the stick from brother, whom beat him with it | Child tried to wash own clothes, elder sister obstructed the act and rebuked child |
| Mother tried to put child to sleep, when child did not sleep, mother slapped him/her | Father rebuked child fighting with other children |
| Child was playing with dirt/dust after bathing, grandmother rebuked | Elder sister shouted at child to stop him crying |
| Child was playing with sharp instrument (*boti*), father rebuked | Mother rebuked child who threw telephone set on the floor |
| Child soaked dress with water, mother rebuked her | Child spent whole day outside house, on his return mother hit child with narrow stick (*kunchi*) |
| Child wanted to put on mothers' sari, mother rebuked | Child argued with father, who had beaten the child with big stick |

The frequency, reason and intensity of the incidents of violence described in the above table hardly varies with the gender and age of the child. Parents, older sisters/brothers and other older relatives abuse small children (by rebuking or hitting them), most often on grounds which do not even justify such behaviour.

Intensive interviews with caregivers, male and female, revealed their beliefs regarding the extent of damage that a child suffers as a result of abuse (see Table 56).

**Table 56: Impact of child abuse (from intensive interviews)**

| Damage suffered by child as a result of violence | | |
|---|---|---|
| **Rural** | **Urban** | **CHT** |
| • Child suffers brain damage<br>• If abused severely both hand and leg may bleed<br>• Child learns about fighting and will ultimately follow such violent practices<br>• If mistreated (quarreling), child will also mistreat others<br>• Child becomes bold<br>• Child may be become blind<br>• Beating spoils child's nature<br>• Fatal accidents can occur due to beating<br>• Child becomes extremely disturbed psychologically, becomes depressed and loses concentration/ ability to learn | • If abused severely both hand and leg may bleed<br>• If mistreated (quarreling) , child will also mistreat others<br>• Child becomes bold<br>• Child becomes extremely disturbed psychologically, becomes depressed and loses concentration/ability to learn | • Child becomes extremely disturbed psychologically, becomes depressed and loses concentration/ability to learn<br>• Child may become crazy and psychotic |

Findings from the FGDs on the condition of a child following abuse are consistent with those obtained through intensive interviews.

## Section 10: Socialization Skills

Family is the basic social institution, providing opportunities for learning through interactions between and among caregivers and children. Interaction between family members helps pass on social and cultural practices and norms, which the child absorbs by emulating the behaviour of elders. The skills of socialization develop at a very early age. A child has opportunities to interact within and also beyond the immediate family - in the extended kinship groups - especially in rural areas and CHT.

Table 57 below presents the responses of caregivers regarding the type of care a child requires to develop socialization skills.

**Table 57: Distribution of caregivers by type of care needed for developing skill of interaction with others (socializing) by children up to 1 year and by area (in per cent)**

| Types of care | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Give child to others to hold | 49 | 55 | 41 | 41 | 56 | 33 |
| Allow child to play with other children | 50 | 36 | 50 | 41 | 38 | 67 |
| Allow child to get to know other children of same age | 8 | 9 | 15 | 15 | 13 | 17 |
| Do nothing | 0.3 | 3 | 0 | 0 | 0 | 0 |
| Don't know | 1 | 1 | 0 | 7 | 0 | 0 |

*** Multiple response**

Giving a child to others to hold (33 to 56 per cent) was identified as an important socialization practice for very young children. For older children, other practices, such as allowing the child to play with (36 to 67 per cent) or get to know (8 to 17 per cent) other children are considered by caregivers to help the development of socialization skills.

**Table 58: Distribution of caregivers by kind of play engaged in with children aged 1-3 years and by area (in per cent)**

| Kind of play | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| Playing with toys (car/ball/doll/rattle) | 58 | 89 | 64 | 93 | 84 | 79 |
| Pretending to ride horse | 1 | 1 | 0.2 | 1 | 0 | 0 |
| Singing songs/saying rhymes/playing flute | 0.3 | 0.2 | 1 | 0 | 0.4 | 0 |
| Playing hide-and-seek | 1 | 0.4 | 1 | 1 | 0 | 0 |
| Helping child to run and jump | 4 | 7 | 4 | 13 | 3 | 3 |
| No play | 53 | 34 | 49 | 27 | 39 | 43 |

*** Multiple response**

The vast majority of respondents said that they play with children using different toys, for example, doll, car, ball or rattle. Very few mentioned any other kinds of play, such as saying rhymes, playing hide-and-seek, running or jumping. A significant proportion of respondents (27 to 53 per cent) reported that they do not play with children at all. It emerged from the survey that, in rural and urban areas, male caregivers play more with children than females, whereas this pattern is reversed in CHT (although the difference is not significant).

Children's play activities, according to caregivers, include:

- Parent pretending to be a horse (child riding on back)
- Singing songs and saying rhymes
- Playing hide-and-seek (*kanamachi*)
- Running and jumping
- Playing with rattle/doll/ball
- Imitating grown-ups
- Flying kites
- Playing with marbles, *dangguli* (indigenous game), swinging top, clay and cotton dolls
- Dressing up/make-believe.

The overwhelming majority (74 to 85 per cent) of caregivers stated that children's participation in games and play is important for developing their socialization skills.

**Table 59: Distribution of caregivers on the importance of playing for child aged 1-3 and 3-5 years and by area (in per cent)***

| Importance of playing | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male |
| **Child aged 1 – 3 Years** | | | | | | |
| Makes child cheerful | 62 | 58 | 69 | 58 | 74 | 75 |
| Helps child grow physically | 42 | 54 | 38 | 52 | 26 | 21 |
| Child learns to interact with others | 11 | 9 | 14 | 12 | 6 | 15 |
| Don't know | 0.4 | 1 | 0.4 | 1 | 0 | 0 |
| **Child aged 3 – 5 Years** | | | | | | |
| Makes child cheerful | 67 | 57 | 67 | 71 | 83 | 79 |
| Child learns to interact with others | 12 | 7 | 7 | 9 | 5 | 10 |
| Helps child develop emotionally | 4 | 3 | 3 | 2 | 5 | 3 |
| Helps child grow physically | 36 | 55 | 39 | 48 | 21 | 25 |
| Don't know | 1 | 1 | 0.2 | 1 | 1 | 0 |

*** Multiple response**

Caregivers identified playing and participating in games with others as providing good opportunities for socialization. Caregivers recognized the impact of participation in games and play on a child's physical and emotional development. There was also a strong shared view that participation in games makes a child cheerful and encourages him or her to interact with others. No major differences were observed in caregivers' views relating to children aged 1-3 years and those aged 3-5 years, except for an identified emotional impact amongst 3 to 5 year-olds.

Findings from intensive interviews and FGDs highlighted the importance of developing children's socialization skills at a very early age. The instances identified in this regard during household observation include a multitude of cultural practices (see Table 60).

**Table 60: Socialization skills by age group and by area (findings from intensive interviews and FGDs)**

| Age Group | Rural | Urban | CHT |
|---|---|---|---|
| 1 to 3 ears | • Child separating big/little fish, mother slicing fish<br>• Mother teaching child to talk/ manners<br>• Child playing games with brothers and sisters<br>• Child sitting eating breakfast with rest of family<br>• Child giving alms (rice) to beggars<br>• Younger sister keeping child company | • Child sharing sweets and *chanachur* with others<br>• Mother teaching child to talk/manners<br>• Child playing games with brothers and sisters<br>• Child sitting eating breakfast with rest of family<br>• Child giving alms (rice) to beggars<br>• Younger sister keeping child company | • Child separating big/little fish, mother slicing fish<br>• Mother teaching child to talk/manners<br>• Child playing games with brothers and sisters<br>• Child sitting eating breakfast with rest of family<br>• Child giving alms (rice) to beggars<br>• Younger sister keeping child company |

| | | | |
|---|---|---|---|
| › 3 to 5 ›ears | • Child separating big/little fish, mother slicing fish<br>• Mother teaching child to talk/manners<br>• Child helping mother clean yard<br>• Child helping mother pick stones, etc. out of harvested rice and store **[CHECK]**<br>• Child playing with friends outside<br>• Child watching school classes<br>• Child watching fisherman catch fish, holding one fish tightly and dancing into house<br>• Child playing games with brothers and sisters<br>• Child listening to songs on radio in neighbour's house<br>• Child sitting eating breakfast with rest of family<br>• Child going to bridge with father<br>• Child fetching mat for guests to sit on<br>• Child going to madrassah to study Arabic with other children<br>• Child giving alms (rice) to beggars<br>• Child separating fish from fishing net<br>• Child asking questions and insisting on answers | • Child sharing sweets and *chanachur* with others<br>• Mother teaching child to talk/manners<br>• Child playing with friends outside<br>• Child watching school classes<br>• Child playing games with brothers and sisters<br>• Child listening to songs on radio in neighbour's house<br>• Child sitting eating breakfast with rest of family<br>• Child fetching mat for guests to sit on<br>• Child going to madrassah to learn Arabic with other children<br>• Child giving alms (rice) to beggars<br>• Child asking questions and insisting on answers | • Child separating big/little fish, mother slicing fish<br>• Mother teaching child to talk/manners<br>• Child helping mother to clean yard<br>• Child helping mother pick stones, etc. out of harvested rice and store **[CHECK]**<br>• Child playing with friends outside<br>• Child watching school classes<br>• Child playing games with brothers and sisters<br>• Child listening to songs on radio in neighbour's house<br>• Child sitting eating breakfast with rest of family<br>• Child fetching mat for guests to sit on<br>• Child giving alms (rice) to beggars<br>• Child asking questions and insisting on answers |

## Section 11: Media Influences: Use and Exposure

### Exposure to Media for Information on Child Care

Caregivers were asked about their exposure to mass media and messages on child care (see Table 61).

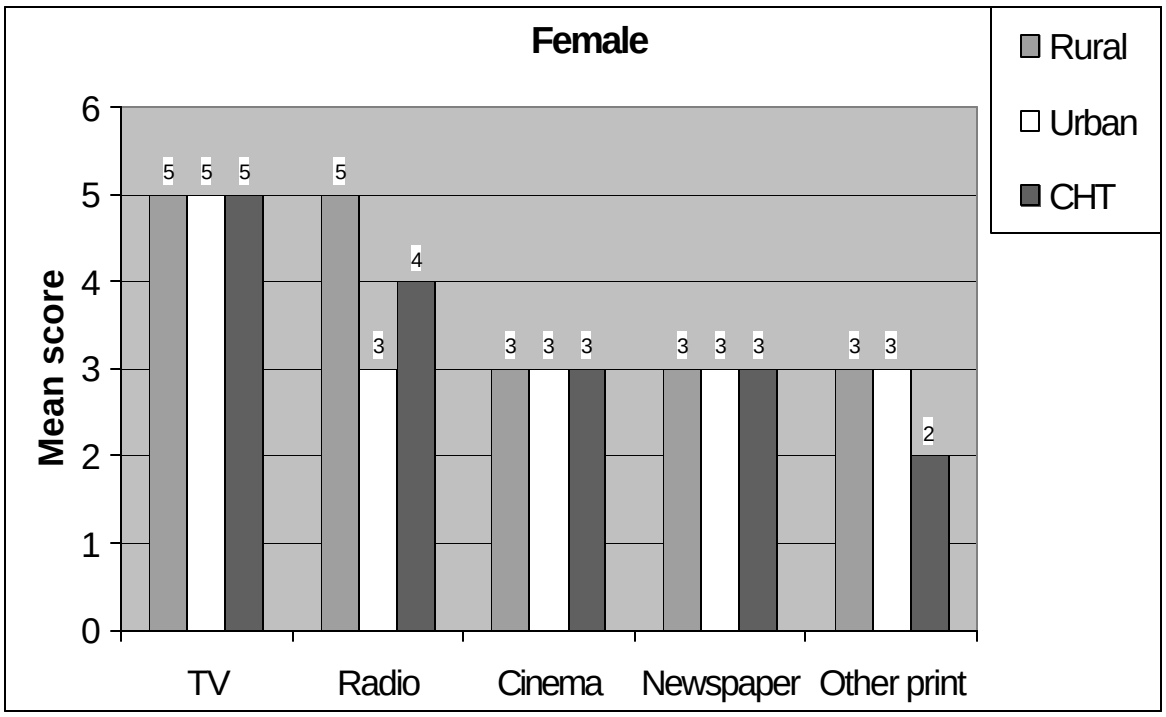
**Table 61: Distribution of caregivers by exposure to media disseminating information on child care and by area (mean scores: 0-)**

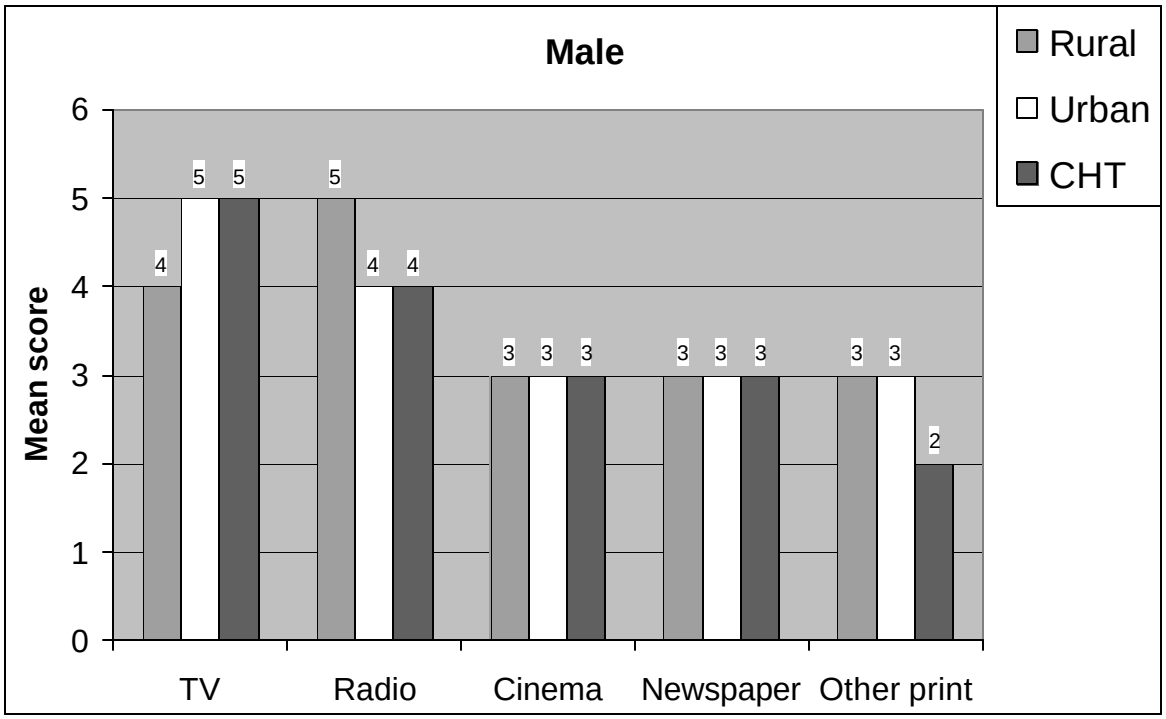
| Type of media | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Television | 5 | 5 | 5 | 4 | 5 | 5 |
| Radio | 5 | 3 | 4 | 5 | 4 | 4 |
| Cinema | 3 | 3 | 3 | 3 | 3 | 3 |
| Newspaper | 3 | 3 | 3 | 3 | 3 | 3 |
| Other print | 3 | 3 | 2 | 3 | 3 | 2 |

**[CHECK. The use of mean scores here rather than percentages should perhaps be explained to readers. Is the range 0-5 or 0-6?]**

Television is the medium to which caregivers are exposed most frequently, with a mean score of 5 for caregivers in all areas (except males in rural areas, mean score 4). Television is followed by radio, with a mean score of 4-5, except for female caregivers from urban areas (mean score 3). Cinema and newspapers are ranked the same with a score of 3, followed by other print media (posters, booklets, leaflets). These findings show that all the media have some influence on caregivers through the provision of information on child care.

**Chart 5: Bar chart showing mean scores on relative exposure to media disseminating information on child care by female and male caregivers**




**[CHECK – Labels on horizontal axis in second chart need to be slanted]**

There is hardly any difference between the level of exposure of male and female caregivers to mass media, except that males are slightly less exposed to television in rural areas, while females in urban areas are marginally less exposed to radio.

.

Table 62 describes the specific messages that caregivers are exposed to through different media.

**Table 62: Distribution of caregivers by subject of media messages received and by area (in per cent)***

| Area/Subject of media messages | Radio | | Television | | Cinema | | Newspaper | | Print | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male |
| **ural** | | | | | | | | | | |
| Health-related essages on child are (ORS, munization) | 19 | 44 | 15 | 44 | 0 | 0 | 7 | 7 | 32 | 29 |
| Breastfeeding | 30 | 39 | 20 | 25 | 0 | 0 | 7 | 7 | 19 | 27 |
| Cleanliness | 8 | 8 | 5 | 4 | 0 | 0 | 1 | 1 | 3 | 1 |
| Maternal care | 7 | 5 | 4 | 4 | 0 | 0 | 2 | 7 | 4 | 1 |
| Visiting a doctor | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Good behaviour with ildren | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Education of children | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Others | 4 | 2 | 3 | 3 | 0 | 0 | 2 | 5 | 4 | 2 |
| **rban** | | | | | | | | | | |
| Health-related essages on child are (ORS, munization) | 27 | 44 | 31 | 55 | 23 | 68 | 25 | 77 | 36 | 46 |
| Breastfeeding | 25 | 34 | 38 | 37 | 5 | 12 | 11 | 25 | 20 | 38 |
| Cleanliness | 8 | 5 | 10 | 5 | 2 | 0 | 3 | 5 | 6 | 2 |
| Maternal care | 7 | 10 | 9 | 10 | 35 | 74 | 6 | 27 | 2 | 5 |
| Visiting a doctor | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 |
| Good behaviour with ildren | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 1 |
| Education of children | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 2 | 0 | 0 |
| Others | 6 | 2 | 4 | 2 | 22 | 11 | 4 | 6 | 4 | 6 |
| **HT*** | | | | | | | | | | |
| Health-related essages on child are (ORS, munization) | 28 | 33 | 29 | 34 | 3 | 4 | 8 | 8 | 8 | 7 |
| Breastfeeding | 23 | 28 | 19 | 21 | 8 | 2 | 12 | 9 | 14 | 5 |
| Cleanliness | 14 | 14 | 11 | 10 | 1 | 0 | 6 | 3 | 4 | 4 |
| Maternal care | 2 | 5 | 2 | 4 | 1 | 0 | 4 | 5 | 1 | 2 |
| Visiting a doctor | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| Good behaviour with ildren | 1 | 1 | 1 | 1 | 0 | 2 | 0 | 0 | 2 | 0 |
| Education of children | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Others | 11 | 6 | 7 | 3 | 23 | 0 | 23 | 1 | 23 | 1 |

*** Multiple response**

An analysis of the status and degree of caregivers' exposure to messages (by subject) on child care reveals the following:

- The subjects covered in messages transmitted through the mass media (in order of frequency) are 'Child care information on preventive measures, e.g. EPI and ORS', followed by 'Child feeding focusing on breastfeeding and supplementary feeding', 'Cleanliness' and 'Maternal care'. Messages dealing with 'Good behaviour with children' were very rarely mentioned. An analysis of the messages disseminated by the mass media shows that messages relating to preventive health measures, such as EPI and ORS, were given priority, while there was hardly any focus on the children's mental development or acquisition of social skills. No programme dealt with the concept of ECD in a holistic way, emphasizing both physical and mental development. It was noted that caregivers did not refer to family planning as a child care measure.

- Seventy-seven per cent of urban male caregivers reported that they had been exposed to a message on 'Modern child care' in the newspapers, compared to 55 per cent and 44 per cent of male caregivers on the television and radio **[CHECK – in urban areas?]** respectively. By contrast, approximately one-quarter to one-third of female caregivers in urban areas reported being exposed to such a message through various media, compared to 7 to 19 per cent in rural areas.

- Exposure to messages on 'Maternal care' was very low in CHT, while exposure to messages on the emotional development of a child was non-existent.

There is a positive co-relation between the subject of messages that caregivers have been exposed to and the type of childcare messages so far emphasized in the media under different development programmes, such as FP-MCH and primary health care. To date, such programmes have prioritized messages on EPI, ORS and breastfeeding. The findings of the survey confirm this situation.

**Credible Person as Source of Information on Child Development**

Table 63 specifies the most credible source of information on child development from among two groups: 'Health personnel' and 'other community/family-level persons'.

**Table 63: Distribution of mean scores reflecting recommendation of a credible source (person) for obtaining information on child development by caregiver and by area**

**63a. Assigned scores for health personnel**

| Type of caregiver | Doctor | | | Nurse/midwife | | | H &FP worker (GO & NGO) | | | Village doctor | | | TBA | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT |
| Female | 7 | 8 | 9 | 1 | 1 | .4 | 6 | 6 | 3 | 2 | .4 | 1 | 1 | 1 | .3 |
| Male | 7 | 9 | 9 | 1 | 1 | .4 | 5 | 5 | 3 | 4 | 1 | 1 | 1 | 1 | .3 |

Doctors were identified as the most credible source of information on child development from

among the 'Health personnel': the mean scores for doctors given by female caregivers were 7, 8 and 9, and by male caregivers 7, 9 and 9 in rural, urban and CHT areas respectively (against a maximum score of 11). The next most credible source was 'Health and FP workers', who had scores ranging between 3 to 6, as shown in Table 63a.

**63b. Assigned scores for community/family-level persons**

| Type of caregiver | Teacher | | | Religious leader | | | Neighbour | | | Grandfather | | | Grandmother | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT | Rural | Urban | CHT |
| Female | 1 | 1 | .01 | 1 | .1 | .01 | 3 | 2 | 1 | 1 | .3 | .2 | 1 | 1 | .2 |
| Male | 1 | 1 | .01 | 1 | .2 | .01 | 2 | 3 | 1 | 1 | 1 | 0 | 1 | 1 | .01 |

None of the community or family members was perceived to be a significantly credible source of information, although neighbours were given a slightly higher score by male and female caregivers in rural and urban areas. Caregivers in CHT did not give a high value to any member of this group.

**Preferred Media for Information on Child Growth and Development**

Tables 64 and 65 describe caregivers' preferred media as sources of information on the physical growth and mental development of a child.

**Table 64: Distribution of caregivers by level of awareness of media as source of information on physical growth of child and by area (in per cent)***

| Type of media | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Radio | 35 | 21 | 36 | 47 | 35 | 39 |
| Television | 23 | 48 | 36 | 27 | 52 | 43 |
| Newspaper | 0.3 | 1 | 0 | 2 | 4 | 1 |
| Print Media | 2 | 2 | 2 | 2 | 2 | 4 |
| Other Sources | 8 | 4 | 7 | 6 | 4 | 5 |
| No exposure to any media | 41 | 35 | 36 | 38 | 29 | 29 |

*** Multiple response**

Information on the physical growth of a child encompasses the following:

- feeding colostrum
- breastfeeding child regularly
- giving child nutritious food
- taking child for regular vaccinations
- keeping child clean
- looking after child and following child care practices in regular manner
- seeking doctor's advice when child becomes sick, and
- protecting child from dangers/accidents.

Caregivers were most aware of radio and television as sources of information on the physical

growth of a child. In rural areas, radio was generally preferred by both female and male caregivers (35 and 47 per cent respectively), whereas television was more popular in urban areas (48 and 52 per cent). In CHT, female caregivers were equally exposed to television and radio (36 per cent), while male caregivers showed a slight preference for television (43 per cent) over radio (39 per cent). Relatively little importance was given to other media, and a large proportion of respondents (29 to 41 per cent) stated that they had no exposure to any of the media mentioned.

**Table 65: Distribution of caregivers by level of awareness of media as a source of information on mental development of child and by area ( in per cent)***

| Type of media | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Rural | Urban | CHT | Rural | Urban | CHT |
| Radio | 18 | 12 | 28 | 15 | 15 | 27 |
| Television | 12 | 30 | 26 | 9 | 25 | 33 |
| Newspaper | 0.2 | 1 | 1 | 1 | 4 | 1 |
| Print Media | 1 | 2 | 1 | 1 | 2 | 2 |
| Other sources | 5 | 4 | 7 | 3 | 2 | 5 |
| No exposure to any media | 68 | 58 | 51 | 77 | 65 | 46 |

*** Multiple response**

Information on the emotional development of a child includes:

- taking child on lap and giving loving care
- being friendly with child
- conversing with child and telling stories
- responding to child's questions
- being active with child **[CHECK]**
- taking child visiting outside, and
- playing with child.

Between one-half and three-quarters of caregivers were not aware of information being available through any media on the mental development of a child. Among those with a different perception, the pattern closely followed that described above in relation to information on physical growth, but the levels of awareness were significantly lower.

Tables comparing the type of media to which caregivers are most exposed with income status, educational status, and awareness of measles vaccines have been prepared and are presented below (Tables 66, 67 and 68 respectively). For this purpose, respondents have been divided into two groups on the basis of their mean monthly family income, as follows:

- 'Poor' - those with a mean monthly family income of Tk.4999 (US$93) and below, and
- 'Non-poor' - those with mean monthly family income in excess of Tk.4999.

Similarly, three groups have been created to reflect the respondents' level of completed education, namely:

- illiterate
- primary completed, and
- above primary.

**Table 66: Distribution of caregivers by media most exposed to regarding child development by income status (poor and non-poor) and by area (in per cent)***

| Type of media | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Radio | 34 | 44 | 24 | 26 | 32 | 42 |
| Television | 17 | 31 | 40 | 54 | 29 | 49 |
| Newspaper | 0.2 | 1 | 0.4 | 2 | 0.3 | 0.4 |
| Print media | 1 | 2 | 1 | 2 | 2 | 4 |
| Other sources | 8 | 6 | 5 | 4 | 8 | 5 |
| No exposure to any media | 48 | 33 | 38 | 30 | 41 | 27 |

*** Multiple response**

As regards listening to child development messages on the radio in rural areas and CHT, the non-poor (42 to 44 per cent) have greater exposure than the poor (32 to 34 per cent). In urban areas, however, the difference between poor (24 per cent) and non-poor (26 per cent) is marginal. When it comes to watching television programmes on child development, the exposure of the non-poor is much greater across all areas, a difference of 14 per cent in rural and urban areas, and 20 per cent in CHT.

**Table 67: Distribution of caregivers by media most exposed to regarding child development, by educational level and by area (in per cent)***

| Type of media | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Radio | 32 | 39 | 48 | 21 | 25 | 29 | 28 | 43 | 43 |
| Television | 15 | 23 | 38 | 36 | 43 | 62 | 25 | 39 | 50 |
| Newspaper | 0.2 | 0.2 | 2 | 0.3 | 0.2 | 4 | 0 | 1 | 1 |
| Print media | 1 | 1 | 3 | 0.4 | 1 | 3 | 2 | 1 | 4 |
| Other sources | 9 | 7 | 5 | 6 | 4 | 3 | 8 | 7 | 5 |
| No exposure to any media | 50 | 40 | 26 | 44 | 39 | 22 | 45 | 29 | 26 |

*** Multiple response**

The frequency of caregivers' exposure to messages on child development on the radio and television increases with the level of literacy irrespective of area. The higher the educational status, the greater the exposure to media (electronic) messages on child development.

**Table 68: Distribution of caregivers by media most exposed to regarding child development by level of awareness of measles vaccines and by area (in per cent)***

| Type of media | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines |
| Radio | 67 | 61 | 39 | 35 | 61 | 53 |
| Television | 42 | 38 | 76 | 68 | 64 | 54 |
| Newspaper | 2 | 1 | 3 | 2 | 1 | 1 |
| Print media | 3 | 2 | 3 | 2 | 6 | 3 |
| Others | 9 | 15 | 5 | 10 | 4 | 13 |

*** Multiple response**

The level of exposure to radio and television child development messages in rural/urban areas and CHT is higher among caregivers who are aware of measles vaccines than among those who are not.

## Section 12: Comparative Analysis of Caregivers' Practices by Income, Education and Awareness of Measles Vaccines

In this section, the findings regarding caregivers' levels of awareness on a few selected childcare variables have been compared with the level of income, education and awareness of measles vaccines. The variables are:

- measures influencing emotional development of child
- six childhood diseases (compared with income and education only)
- the need and importance of a child becoming curious
- the need and importance of a child having a special skill/quality
- the role of parents in the emotional development of the child

**[CHECK – 'mental' and 'psychological' are used interchangeably in this section regarding a child's development. Is this OK or do we want to stick to one throughout?]**

### Measures Influencing Emotional Development of Child

Table 69 compares caregivers' awareness about the measures influencing a child's emotional development with their income status.

**Table 69: Distribution of caregivers by level of awareness about measures influencing mental development of child, income status (poor and non-poor) and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Yes | 42 | 57 | 56 | 70 | 70 | 87 |
| No | 58 | 43 | 44 | 30 | 30 | 13 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Poor caregivers (42 to 70 per cent) in rural/urban areas and CHT were proportionately less aware than non-poor caregivers (57 to 87 per cent) about the measures influencing the emotional development of a child. The differences between poor and non-poor caregivers are statistically significant.

Table 70 compares caregivers' awareness about measures influencing the emotional development of a child with their educational level.

**Table 70: Distribution of caregivers by level of awareness about measures influencing mental development of child, level of education and area (in per cent)**

| Status of awareness | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above Primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Yes | 40 | 50 | 62 | 57 | 60 | 74 | 68 | 81 | 85 |
| No | 60 | 50 | 38 | 43 | 40 | 26 | 32 | 19 | 15 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

The majority of caregivers with no education are not aware about measures influencing the emotional development of a child, while the majority of those who have completed their education up to primary level and beyond are aware. The differences between caregivers regarding awareness are statistically significant.

**Table 71: Distribution of caregivers by level of awareness about measures influencing mental development of child, awareness of measles vaccines and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines |
| Yes | 54 | 45 | 69 | 58 | 87 | 72 |
| No | 46 | 55 | 31 | 42 | 13 | 28 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Caregivers' awareness on measures influencing the mental development of a child is higher among those who are aware (54, 69 and 87 per cent) of measles vaccines than among those who are not (45, 58 and 72 per cent) irrespective of geographical area.

**Six Childhood Diseases**

Table 72 compares caregivers' awareness about the six childhood diseases with their income status.

**Table 72: Distribution of caregivers by level of awareness about six childhood diseases, income status and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Yes | 86 | 91 | 87 | 92 | 84 | 87 |
| No | 14 | 9 | 13 | 8 | 16 | 13 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .199**

According to income status, there is hardly any difference between the levels of awareness of caregivers about the six childhood diseases in rural/urban areas and CHT: the overwhelming majority (84 to 92 per cent) in all areas said that they were aware of the six childhood diseases. The equal high levels of awareness among poor and non-poor caregivers are due to intensive and extensive information, education and communication initiative under EPI over the past decade or so.

Table 73 compares caregivers' awareness about the six childhood diseases with their educational level.

**Table 73: Distribution of caregivers by level of awareness about six childhood diseases, level of education and area (in per cent)**

| Status of awareness | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Yes | 83 | 90 | 96 | 82 | 90 | 97 | 78 | 89 | 92 |
| No | 17 | 10 | 4 | 18 | 10 | 3 | 22 | 11 | 8 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Caregivers with lower levels of education in all areas were proportionately less aware about the six childhood diseases than more educated caregivers. The differences observed are statistically significant.

**Need and Importance of Child Becoming Curious**

Table 74 compares caregivers' levels of awareness about the need and importance of a child becoming curious with their income status.

**Table 74: Distribution of caregivers by level of awareness about need and importance of child becoming curious, income status and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Yes | 53 | 67 | 58 | 70 | 80 | 86 |
| No | 47 | 33 | 42 | 30 | 20 | 14 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .009**

Caregivers of low income status in all areas (53 to 80 per cent) are proportionately less aware than non-poor caregivers (67 to 86 per cent) about the need and importance of a child becoming curious. The differences between poor and non-poor caregivers in this regard are statistically significant.

Table 75 compares caregivers' levels of awareness about the need and importance of a child becoming curious with their educational levels.

**Table 75: Distribution of caregivers by level of awareness about need and importance of child becoming curious, level of education and area (in per cent)**

| Status of awareness | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Yes | 51 | 62 | 71 | 60 | 58 | 75 | 78 | 80 | 89 |
| No | 49 | 38 | 29 | 40 | 42 | 25 | 22 | 20 | 11 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Less educated caregivers in all areas are proportionately less aware about the need and importance of a child becoming curious than caregivers with more education, with the exception of urban caregivers who have completed their primary schooling. **[CHECK – what is the explanation for this?]** The differences between caregivers seen in this table are statistically significant.

**Table 76: Distribution of caregivers by awareness about need and importance of child becoming curious, level of awareness of measles vaccines and area (in percent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines |
| Yes | 64 | 56 | 69 | 61 | 89 | 80 |
| No | 36 | 44 | 31 | 39 | 11 | 20 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Awareness about the importance of a child becoming curious is higher among caregivers who are aware of measles vaccines (64 per cent, 69 per cent and 89 per cent) than among those who are not (56 per cent, 61 per cent and 80 per cent), irrespective of area.

**Need and Importance of Child Having Special Skill/Quality**

Table 77 compares caregivers' levels of awareness on the need and importance of a child having a special skill/quality with their income status.

**Table 77: Distribution of caregivers by level of awareness on need and importance of**

**child having a special skill/quality, income status and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Yes | 31 | 40 | 32 | 47 | 19 | 27 |
| No | 69 | 60 | 68 | 53 | 81 | 73 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .002**

Poor caregivers in rural/urban areas and CHT (19 to 32 per cent) were less aware about the need and importance of a child having a special skill/quality than non-poor caregivers (27 to 47 per cent). These differences are statistically significant.

Table 78 compares caregivers' level of awareness about the need and importance of a child having a special skill/quality with their educational level.

**Table 78: Distribution of caregivers by level of awareness about need and importance of child having a special skill/quality, level of education and area (in per cent)**

| Status of awareness | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Yes | 29 | 38 | 43 | 33 | 33 | 52 | 17 | 27 | 26 |
| No | 71 | 62 | 57 | 67 | 67 | 48 | 83 | 73 | 74 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .001**

Broadly, levels of awareness on the need and importance of a child having a special skill/quality increase with the level of education. However, it was found that awareness levels were the same for urban caregivers with no/primary education, and a slight drop in awareness was noted among caregivers educated above primary level compared to those with primary schooling. **[CHECK – What is the reason for this?]** The differences between caregivers based on their level of education are statistically significant.

**Table 79: Distribution of caregivers by level of awareness on importance of child having a special skill/quality, level of awareness of measles vaccines and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines |
| Yes | 40 | 31 | 48 | 32 | 33 | 17 |
| No | 60 | 69 | 52 | 68 | 67 | 83 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Caregivers' awareness regarding the importance of a child having a special skill/quality is higher

in all areas among those who are aware of measles vaccines (40 per cent, 48 per cent and 33 per cent) than among those who are not (31 per cent, 32 per cent and 17 per cent).

**Role of Parents in Emotional Development of Child**

Table 80 examines caregivers' levels of awareness about the role of parents in the mental development of a child in comparison with their income status.

**Table 80: Distribution of caregivers by level of awareness of role of parents in mental development of child, income status and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Poor | Non-poor | Poor | Non-poor | Poor | Non-poor |
| Yes | 58 | 67 | 55 | 67 | 71 | 83 |
| No | 42 | 33 | 45 | 33 | 29 | 17 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Caregivers of low income status in all areas (55 to 71 per cent) were less aware about the role of parents in the mental development of a child than non-poor caregivers (67 to 83 per cent). These differences are statistically significant.

Table 81 describes caregivers' awareness of the role of parents in the mental development of a child compared with their education.

**Table 81: Distribution of caregivers by level of awareness about role of parents in mental development of child, level of education and area (in per cent)**

| Status of awareness | Rural | | | Urban | | | CHT | | |
|---|---|---|---|---|---|---|---|---|---|
| | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary | No education | Grade I-V primary completed | Above primary |
| Yes | 56 | 65 | 69 | 55 | 56 | 72 | 71 | 80 | 79 |
| No | 44 | 35 | 31 | 45 | 44 | 28 | 29 | 20 | 21 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .008**

Less educated caregivers in all areas were less aware about the role of parents in the emotional development of a child than caregivers with more education, except in CHT where those with education above primary level were actually marginally less aware than those with primary education. **[CHECK – explanation?]** These differences between caregivers are statistically significant.

**Table 82: Distribution of caregivers by awareness about role of parents in mental development of child, awareness about measles vaccines and area (in per cent)**

| Status of awareness | Rural | | Urban | | CHT | |
|---|---|---|---|---|---|---|
| | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines | Aware of measles vaccines | Not aware of measles vaccines |
| Yes | 65 | 60 | 65 | 61 | 85 | 71 |
| No | 35 | 40 | 35 | 39 | 15 | 29 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 |

**Chi square result: <p= .000**

Higher levels of awareness about the role of parents in the mental development of a child were found among those who are aware of measles vaccines (65 per cent, 65 per cent and 85 per cent) than those who are not (60 per cent, 61 per cent and 71 per cent), irrespective of area.

**Logistic Regression Analysis for ECD Urban and Rural Analysis**

A logistic regression analysis was carried out to identify the factors that are important correlates of time spent by mothers. In the logistic regression the dependent variable was mothers and breastfeeding mothers who spent mean time caring for their children: less than three hours in a day is considered zero and otherwise it is a unity.

The independent variables included in the analysis are given and discussed below.
*Division*: In order to see the effects of each division separately considered a dummy variable was introduced to assess the independent effects of the division. For instance, to see the effects of Dhaka division, we considered Dhaka = 1 and others zero.
*Type of residence*: Similarly, two models were carried out, one for urban areas and one for rural areas. In this case also a dummy variable was introduced. If Urban = 1, otherwise it is zero
*Sex of child*: Male = 1, otherwise it is zero
*Age of mothers*: Age of the mothers less than equal to 25 years = 0, otherwise it is 1
*Education of mothers*: No education is considered as 0, otherwise it is 1
*Occupation*: Housewife = 1 and others = 0 Service = 1 and others = 0
*Income*: Those mothers who have income = 0, otherwise 1
*Chittagong Hill Tracts*: If mean time is less than 3 then it is 1, otherwise it is 0.

| Variable | Rural coefficients | Significance p –values | Urban coefficients | Significance |
|---|---|---|---|---|
| Dhaka | 1.4770 | .000 | -0.0288 | 0.809 |
| Chittagong | 4.8306 | .000 | 3.3548 | 0.000 |
| Rajshahi | 4.0132 | .000 | 2.5374 | 0.000 |
| Khulna | 2.7360 | .000 | 1.2602 | 0.000 |
| Barisal | 4.2446 | .000 | 2.7688 | 0.000 |
| Sylhet | 4.5394 | .000 | 3.0636 | 0.000 |
| Rural | -1.4758 | .000 | 1.4758 | 0.000 |
| Age of mothers | -0.0779 | .394 | -0.0779 | 0.396 |
| Educational level of mothers | -0.2027 | 0.036 | -0.2027 | 0.036 |
| Economic condition | -0.2304 | 0.016 | -.2304 | 0.016 |
| Housewife | -.01524 | 0.539 | -0.1524 | 0.539 |

| | | | | |
|---|---|---|---|---|
| Service | 0.0306 | 0.925 | 0.0306 | 0.923 |
| Chittagong Hill Tracts | 2.4037 | 0.000 | - | - |
| Monthly income | 0.4401 | 0.036 | 0.4401 | 0.036 |
| Constant | -0.0442 | 0.859 | -0.0442 | 0.858 |

**-2 Log Likelihood Chi-square is 3152.282 which is significant p<0.000 Model is 1033.961 with 13 degrees of freedom is significant p<0.000**

Among the independent variables, geographical division, region of residence, economic condition of mothers, education of mothers, monthly income of mothers, and mothers from Chittagong Hill Tracts are important factors influencing the mean time spent caring for the child. Among the divisional coefficients, mothers from Chittagong and Rajshahi divisions are more likely to spend time, while mothers from Dhaka division are less likely to spend time on child care than those from other divisions. Mothers from Chittagong Hill Tracts are positively associated with the mean time they devote to child care. The coefficient of the rural mothers indicates that rural mothers are less likely than urban mothers to spend time on child care. The age of the mother is also an important correlate of child caring. The coefficient is negative demonstrating that the lower the age of the mother, the higher the likelihood of her spending time on child care. Similarly, the higher the level of education of the mother, the lower the probability of her spending more time caring for her children. The poor economic condition of the mother is also negatively associated with child caring. The findings of the regression analysis may be considered as conditional, since co-factors such as parity and members present in a family were not entered in the regression model. Hence, the influence of these and other similar variables on the conclusions has not been established.

# VI. Conclusion: Positive/Negative Practices and Implications

## A. Summary of Positive and Negative Practices

The table below sets out the salient findings reflecting the positive and negative childcare practices obtained through quantitative and qualitative methods of data collection.

| Positive Practices | Negative Practices |
|---|---|
| **Household status**<br>• Caregivers falling within 'non-poor' category own three minor electronic items in rural areas and CHT and four in urban areas. one of the electronic items is a radio.<br>• More than half of households in rural areas (59 per cent) and CHT (64 per cent) are assessed to be clean.<br>• About one-third of households in all areas are judged to be safe, i.e. houses are not situated in a hazardous location, they are fenced and children are not at risk of accidents.<br>**Care during pregnancy**<br>• The level of awareness among caregivers on care during pregnancy is generally high in all areas.<br>• The majority of caregivers in rural and in urban areas identified radio and television as sources of information on care during pregnancy. | **Household status**<br>• More than half of the household surroundings in rural (55 per cent) and urban areas (68 per cent) are assessed as unhealthy, mostly meaning that it is congested or dark.<br>• More than 40 per cent of households in all areas are situated in hazardous locations which pose the risks of accidents to children.<br>**Care during pregnancy**<br>• Awareness level on ANC/PNC services is low.<br>• Level of awareness regarding measures to ensure safe delivery is low in CHT.<br>• Almost no one identified the need to provide mental support during pregnancy.<br>**Preventive childcare measures**<br>• Findings from in-depth interviews suggest that, with exception of CHT, caregivers in general are not sufficiently aware of impact of caring practices on physical and mental development of child.<br>• Awareness about common childhood diseases is high for some and low for others, but generally lower among caregivers in CHT.<br>• Despite extensive educational efforts on breastfeeding in recent years, level of awareness on exclusive breastfeeding and (among some groups) the importance of feeding colostrum is low. |

| Positive Practices | Negative Practices |
|---|---|
| **Preventive childcare measures** | |

- Very high proportion of caregivers reported that they had immunized their children.
- Use of ORS is high.

**Child care for development**

- Specific measures have been suggested to develop the intellect of a child, including providing nutritious food, playing with child, teaching how to talk and mixing with others.
- A large proportion of caregivers in CHT (47-56 per cent) identified cheerfulness as an indicator of mental development.
- Intensive interviews and FGDs with opinion leaders identified a number of positive practices promoting emotional development of a child, but these are not necessarily being followed at household level.
- Practices during play/ entertainment (3 to 5 years)
  - playing with sisters and brothers inside house
  - playing with father and elder sister outside house
  - playing pretend cooking with utensils
  - playing with rattle
  - playing with red material with sister
  - playing with ball with sister
  - playing with bottle
  - playing with cloth dolls.

- A number of negative practices persist in relation to feeding of a child, i.e. child eating with dirty hands, mother and father bottlefeeding child and overusing teat.
- Extensive bottlefeeding practices were observed during household-level observation, especially in urban areas.
- Despite very high level of acceptance of vitamin A (BDHS:1999-2000: 73 per cent), caregivers have hardly mentioned vitamin A as one of the measures for preventing childhood diseases.

**Child care for development**

- On average, mother spends four hours per day caring for child, while all other caregivers including father spend less than an hour.
- Frequency of care by male caregivers is less than 25 per cent, except in some cases in CHT. Care by male caregivers usually includes picking up and washing/cleaning child.
- Practice of taking sick child to doctor for treatment rarely mentioned.
- Perception of upper age limit of childhood varies widely. Majority (> 70 per cent) of caregivers identified up to age three as cut-off age of a child.
- Breastfeeding not identified as a practice stimulating development of child's intellect.
- A number of indicators of physical growth have been put forward, e.g. observing movement of child, sickness, but majority of caregivers from rural and urban areas failed to identify indicators of mental development.

| Positive Practices | Negative Practices |
|---|---|
| **Development of learning skills**<br><br>• Mother plays primary role as teacher in processes of learning by child, followed by father. Child also emulates older siblings to learn everyday practical skills; grandparents and uncle/aunt play important roles in this regard.<br><br>**Socialization skills**<br><br>• Giving a child to others to hold has been identified as an important socialization practice for very young children. For older children, allowing child to play or get to know other children help develop socialization skills. | • Negative caring practices observed at household level (with child 3 to 5 years) are:<br>  ➢ shouting at/scolding child<br>  ➢ spanking child (usually brothers and sisters)<br>  ➢ leaving child alone when crying<br>  ➢ beating child<br>  ➢ child moving around outside house alone.<br>• Caregivers specified the following as unacceptable activities for a child:<br>  ➢ using slang<br>  ➢ fighting with others<br>  ➢ being dirty<br>  ➢ refusing to study<br>  ➢ misbehaving with elders<br>  ➢ damaging household articles<br>  ➢ crying excessively.<br><br>**Care of children with disabilities**<br><br>• Findings of intensive interviews identified severe discriminatory practices towards child with disabilities, namely:<br>  ➢ given inadequate food<br>  ➢ scolded and neglected<br>  ➢ not sent to school<br>  ➢ not allowed to play<br>  ➢ beaten<br>  ➢ mocked because of disability<br>  ➢ considered a liability of the family.<br><br>**Discrimination between girl and boy child**<br><br>• Survey findings identified following discriminatory behaviour towards girl child:<br>  ➢ given less love and affection<br>  ➢ given less food/ clothes<br>  ➢ neglected<br>  ➢ restricted from obtaining an education.<br><br>**Development of learning skills**<br><br>• More than two-thirds (71 per cent) of male caregivers and more than half of female caregivers (59 per cent) in rural areas, and more than half of caregivers (56 per cent) in urban areas mentioned that fathers play no role in the learning process of the child.<br>• Father also impedes child's learning process by inflicting punishment. |

| Positive Experiences | Negative Experiences |
|---|---|
| **Media influences**<br><br>• Television and radio have been identified as the media caregivers are most exposed to regarding information on child care.<br><br>• The most widely disseminated messages by the mass media are on EPI and ORS, followed by 'Child feeding focusing on breastfeeding and supplementary feeding', 'Cleanliness' and 'Maternal care' (in that order). Messages concerning 'Good behaviour with children' have rarely been mentioned. | **Socialization skills**<br><br>• More than 60 per cent of caregivers do not understand the meaning of self-confidence in relation to a child, except in CHT, where 60 per cent of male caregivers said they do understand the concept.<br><br>**Impact of violence**<br><br>• Violent behaviour towards a child includes:<br>  ➢ mild acts of violence:<br>  o slap/blow/hit<br>  o pulling by hair/ear<br>  o scolding/rebuking<br>  ➢ Severe beating with stick. |

## B. Implications and Recommendations

A child generally receives loving care from parents and other caregivers in a family. Care of a child is important for their physical growth and mental development including cognitive and emotional development. Although caregivers are aware about providing care to a child, the main focus is on care for physical growth, ignoring the psychosocial aspects of child development. Care for physical growth may ensure certain observable basic behaviour patterns, like walking, talking, seeing and eating, but developing other aspects of a child, such as being communicative (speaking), interactive (socializing), self-confident, independent and inquisitive, is essential to a ensure a good quality of life for a child.

The current study is an attempt to draw a comprehensive scenario of childcare practices in Bangladesh in cross cultural (urban-rural) and socio-economic status (poor and non-poor) situations. The study has been conducted to ascertain the knowledge, attitudes and practice of all caregivers in families from rural, urban and tribal (CHT) areas. Apart from a quantitative survey to establish the rate and frequency of caregiving practices, intensive interviews supported by direct observation of caregivers at household level were conducted to gain an in-depth understanding of child care practices, beliefs and values and their implications for early child development in Bangladesh.

The study primarily identifies current caregiving practices, beliefs and values. It attempts to assess the gap between actual and affordable/feasible improved childcare practices designed to ensure the balanced development of a child from the point of view of physical growth and mental development. This knowledge about existing childcare practices is essential, as it helps to design interventions aiming at future improvement. Knowledge about existing practices sheds light on their strengths and weaknesses and points to the need for and areas of further assessment and interventions for child development. The study also investigated caregivers' cultural beliefs, values and norms, which are integral to child care and development practices.

Analysis of the data obtained through surveys, intensive interviews, FGDs and household-level observation has highlighted the following features of child care which have important implications for future early childhood development endeavours in Bangladesh.

1. The average family size observed in the study is 5.4 in urban areas, and 5.5 in rural areas and CHT. This matches with the latest findings of the Demographic and Health Survey 1999-2000, implying adequate data credibility for the study. Having an average of 5-6 members per family implies that, apart from parents, there are siblings and other older relatives in the family to provide child care to a young child.
2. Unlike many other surveys and despite the lengthy interview time, it was observed that respondents (both male and female caregivers) took sufficient interest in giving answers to often complex questions. This demonstration of caregivers' strong motivation to talk about children may be a reflection of an intense interest in child development.
3. All the responses of caregivers on child development practices reflect actions at family level; hardly a single response focused on any public or community-level institution considered to be a feasible source of child care. This slant is understandable as, to date, childcare practices promoting development have not been the subject of any concerted intervention by a public sector department.
4. Messages in the media, television and radio, for instance, do not promote child care practices focusing on mental development. The media concentrate more on child survival issues, such as ORS and vaccination. Future media programmes could be carefully designed to include messages on ECD focusing on the mental (cognitive and emotional) development of a child.

5. Comparison of exposure to childcare messages on radio/television among 'poor' and 'non-poor' groups showed a substantially higher level of exposure among the non poor in all areas. The frequency of exposure to messages on child development, both from radio and television, increases with caregivers' educational status irrespective of area: the higher the level of education, the greater the exposure to mass media (electronic) messages on child development.
6. Survey data indicate a very low level of awareness regarding care for psychosocial, cognitive and emotional development among caregivers. During intensive interviews and FGDs, however, awareness on these issues, such as the need for and importance of loving care, was evident, although these practices are not really recognized by caregivers as having an influence on child development. This suggests that any future planned effort concerning ECD which focuses on mental/emotional development would be accepted by caregivers.
7. The 12 core principles which form the basis of the study investigations have been adequately covered, with the findings discussed under different sections in Chapter V. Of the 12 principles, caregivers were found to be particularly lacking in knowledge and skills on those relating to child care for emotional, cognitive and social development.
8. Analysis of data on caring practices for young children at household level revealed that caregivers generally consider a person aged up to 2 or 3 years to be a child; very few identified 8, 12, let alone 18 years, as the upper limit of childhood. Caregivers consider physical growth to be the most critical aspect of a child's development. It was observed in many instances that mothers are intensively involved in the care of a child up to the age of about 1 year, while fathers prefer to take care children who are old enough to be able to move independently. Consequently, children aged between 1 and 2 years are somewhat neglected.
9. Child care practices relating to child survival issues, such as acceptance and use of ORS, EPI vaccines and TT, were observed to exist at an increased level, although knowledge of optimal breastfeeding practices was observed to be low, especially in CHT. Moreover, knowledge about caring practices of the child while in the womb is non-existent: caregivers awareness is limited to childcare practices after birth.
10. Caregivers are highly conscious about the safety, security and survival of a child but they are not aware of their household surroundings as a factor influencing these issues. Collected data reveal that a large number of households in rural and urban areas have unhealthy surroundings. However, the situation is considerably better in CHT.
11. Overall, no substantive differences in caregiving practices were observed between urban and rural areas A particularly striking finding in these areas was the generally inadequate knowledge and practices regarding emotional care. The situation in CHT on this issue was, however, much better. CHT has a homogeneous culture where communities looks after all their members and are bonded together by tribal values and norms. The influences of different religious faiths may also be a factor.
12. Caregivers follow mixed care practices, meaning that practices with possible negative implications are often culturally valued as positive. Behaviour demonstrating a child's independence, inquisitiveness and self-reliance is frequently seen as indisciplined, disobedient and argumentative. For example, children are sometimes punished when they try to wash their own clothes or when they argue with their father in order to learn something.
13. Games and play are encouraged by caregivers. Many parents mentioned that they play with children. This is a positive behaviour, which may be further encouraged through community initiatives where parents and children get together to participate in games and sports. Children were observed to use indigenous materials for their games and even to imitate the behaviour of adults for fun.

14. The study identified a number of cultural and religious practices which are observed to be an integral part of the value system recognizing a child and his/her development **[CHECK – have I got the right sense here?]**. These include name-giving and feeding ceremonies. Such practices may be studied further and an assessment made of the scope for incorporating them into efforts to promote quality childcare practices in Bangladeshi society.
15. Both the survey and qualitative data evidence extensive use of violence to discipline children. Harsh punishment, such as beating with a stick, is used without little thought to the consequences. Parents generally perceive beating is a way of correcting a child's behaviour, although a small proportion of caregivers recognize the serious consequences of such behaviour. It was observed that there is little difference between the pattern of use of violence by mothers and fathers as perpetrators against girl and boy children as victims.
16. Caregivers revealed in intensive interviews an understanding of the part that child care can play in improving the functions and capacities of the brain. Although this awareness exists only on a small scale, it suggests that caregivers will be receptive to any future steps to address the brain and emotional development of a child.
17. The mother is the focal point for child care in a family. During the first year of life, a child is mainly looked after by the mother and she is the sole teacher of social and survival skills. Fathers are involved in the care of children mostly aged 3 and above, to whom they provide company and teach socialization skills. They play hardly any part in the feeding, bathing, and cleaning of children up to 1 year, although they sometimes show affection by picking up the child.
18. Children learn about the environment and acquire socialization skills mainly through games with siblings and other children. It was observed that a child quite often tries to help the mother with household chores and in this way acquires survival and socialization skills. Grandparents occasionally provide loving care and company to the child, which is valued as a child care practice in Bangladeshi society.
19. Children often try to do things on their own and also with other caregivers in the family. Such practices are, however, not widely promoted since they are not recognized as an important child care norm.
20. Caregivers in CHT recommended institutional care for children with disabilities but no such suggestion was put forward by caregivers in rural and urban areas. Most caregivers expressed their ignorance about the care of children with disabilities, which is a result of the overall indifference regarding disability in society. The CHT community has a different perspective on the issue and a strong feeling concerning the care of children with disabilities.
21. Caring practices that discriminate between girl and boy children have been recognized to some extent. The main reason for discrimination given by respondents during intensive interviews and FGDs is that there is no point in investing in girls since they ultimately leave the parental home.
22. Comparative analyses were carried out on levels of caregiver awareness regarding certain childcare variables (mainly relating to mental development) by caregivers' status in terms of income, education and awareness about measles vaccines. The results revealed significant differences between poor and non-poor caregivers, those with and without education and those aware and not aware of measles vaccines. These showed that caregivers of low income (poor) or educational (no education) status or who are unaware of measles vaccines are relatively less conscious of the factors influencing a child's mental development. Future programme interventions, while targeting all caregivers, may give relatively greater emphasis to these groups in order to raise their awareness.
23. Analysis of logistic regression revealed that, among the independent variables, geographical division, region of residence, economic condition of mothers, education of mothers, monthly income of mothers, and mothers from Chittagong Hill Tracts are important factors

influencing the mean time spent caring for the child. Among the divisional coefficients, mothers from Chittagong and Rajshahi divisions are more likely to spend time on child care than their counterparts. Mothers from Dhaka division are less likely to spend time on child care than those from other divisions. The coefficient of the rural mothers indicates that rural mothers are less likely than urban mothers to spend time on child care. The coefficient on age of the mother is negative, demonstrating that the lower the age of the mother, the higher the likelihood of her spending time on child care. Similarly, the higher the level of education of the mother, the lower the probability of her spending more time caring for her children. The poor economic condition of the mother is also negatively associated with child caring. The findings of the regression analysis may be considered as conditional, since co-factors such as parity and members present in a family were not entered in the regression model. Hence, the influence of these and other similar variables on the conclusions has not been established.

The above findings have important implications for future programming. When designing future programme interventions to improve existing childcare practices, the following points should be borne in mind:

- intensify programme focus on increasing the level of childcare practices with mothers, fathers and other secondary caregivers all over Bangladesh with more emphasis on Dhaka, Khulna, Barisal and Sylhet divisions;
- target messages to mothers motivating them to devote more time of a higher quality to child care; and
- educate all mothers, especially those of greater age and with higher parity, to devote more time to child care.

The current study has generated a large body of data on the childcare practices of different categories of caregivers. The data on adolescents, male caregivers and caregivers from CHT may be further analyzed as part of separate secondary analysis to determine the strengths and weaknesses of current caring practices related to psychosocial, emotional and cognitive development.

In conclusion, it is clear that child care is highly valued in Bangladeshi society, but the quality of existing practices could be significantly strengthened if initiatives were launched to improve the awareness and practices of caregivers on different aspects of cognitive and emotional development.

# References


1. Bellamy C, The State of The World's Children 2001 , Early Childhood, UNICEF.

2. Miller D.C, A Text and Reference Book for The Social and Behavioral Sciences Handbook of Research Design and Social Measurement, Fourth Edition, Long man, New York and London.

3. Rossi P. H, Evaluation A Systematic Approach, Third Edition, SAGE Publications, Beverly Hills, London, New Delhi, 1985.

4. Dodge A.T, Yandian S.E, Bloomer D, A Trainer's Guide To The Creative Curriculum for Infants and Toddlers, Contributing Authors: Sherrie Rudick, Sarah Minteer Semlak, Peter J. Pizzolongo, Published by Teaching Strategies, Inc, 1998.

5. Landers Cassie, Education Cluster, UNICEF, A Time of Adventure Child Development From One To Three Years, Animated Video II, Readings and Worksheets, New York, New York.

6. Landers Cassie, Education Cluster, UNICEF, Pathways To Learning Child Development From One To Three Years, Animated Video III, Parent Handouts, New York, New York.

7. Early Childhood Matters, Listening to Children, The Bulletin of the Bernard Van Leer Foundation, February/2000, 110.94, C7, BVLF 2000.

8. Gaag J.V.D and Tan J.P, The Benefits of Early Child development Programs An Economic Analysis, Annex- 2: ECD Calculator, Education The World Bank.

9. Children in Crisis, Save The Children.

10. Nathanielsz P.W, Life in the Womb The Origin of Health and Disease, ECCD.

11. Newsweek, Special Edition, Your Child, From Birth to Three.

12. More Than Numbers: Mathematical Thinking in the Early Years, Edited by Dennie Palmer Wolf and Bonnie Neugebauer, Published by Child Care Information Exchange.

13. World Bank Lending on Child Development, A Directory of Projects, Human Development Network Education, September, 1998

14. Evans J. L and Stansbery P.A, Early Development, Parenting in the Early Years: A Review of Programs For Parents of Children From Birth of Three Years Age.

15. Mayo J.Q, Private market Consultant, 1999 Catalog, Early Childhood, From the Publishers of The DLM, Including: Bilingual, ESL, Special Education, Title-

16. Veronicah Larkin Creating Rewarding Early Arts Teaching Experiences, For Children Aged 0-5 Years, Pademelon Press, January 1999.