Equity in health with a special focus on gender inequities in Bangladesh

FINAL REPORT

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List of Acronyms

ANC	Antenatal Care
CC	Community Clinic
CG	Community Group
CHCP	Community Health Care Provider
CI	Concentration index
CS	Civil Surgeon
CSG	Community Support Group
CSO	Civil Society Organization
FGD	Focus Group Discussion
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
HDI	Human Development Index
HRH	Human Resources for Health
IDI	In-Depth Interview
KII	Key Informant Interview
LIC	Low Income Country
MBB	Marginal Budgeting for Bottlenecks
MCWC	Maternal and Child Welfare Centre
PNC	Postnatal Care
TOR	Terms of Reference
SES	Socioeconomic Status
UHC	Upazila Health Complex
UHC	Universal Health Coverage
UHFWC	Upazila Health and Family Welfare Centre
UHFPO	Upazila Health and Family Welfare Officer
UNICEF	United Nations
USC	Union Sub-centre

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Executive Summary

Introduction

Bangladesh, a country with limited resources and an overgrowing population, continually faces an increasing number of challenges in providing quality healthcare services to its citizens. Although the country has gained some remarkable success in health sector in the past two decades, it has still not been able to achieve the desired level of access and equity amongst the most vulnerable and marginalized population.

The use of formal health care is quite low (40 per cent) in rural Bangladesh and only one-fourth of these people utilise public sector facilities. The success of health sector has not spread equally and the existence of regional and gender inequity is evident in majority of areas in the country, and the marginalized population is suffering from a greater extent of healthcare inequity. Therefore, analysing the existing health system barriers from the equity perspective is necessary in order to achieve universal health coverage in Bangladesh.

To reduce the inequity in healthcare, it is imperative to understand the root cause of this and act accordingly. The objective of this study is to understand the extent and causes of inequity with a special focus on gender related inequities, and to identify some possible solutions to overcome the barriers in health service utilization, from both supply and demand side perspectives.

Methodology

The study was designed in three phases consisting of a set of tasks to be conducted simultaneously. During the first phase, to measure the health inequity across different socio economic and demographic groups, we used the modified Tanahashi Model as well as Concentration Index (CI). These measures helped us learn the areas of service provision where the bottlenecks within the health system prevail, but could not explain the gender inequity, which was later explored through the qualitative investigation during field activities. The second phase revealed what the bottlenecks were at the different stages of service provision. At third phase, the study developed a strategy to overcome the implementation constraints of the health system based on the consultation meeting with stakeholders.

The study was a mixed method study containing both qualitative and quantitative components. Both primary and secondary data were collected.

Secondary (Quantitative) Data

For the quantitative part of the study, we analyzed the available national level data to identify the area of the loss of efficiency of the health service provision using BDHS 2014 and Household Income and Expenditure Survey, 2016. This dataset is used mainly to estimate Concentration Index. Concentration Index--based on concentration curve-- is used to estimate and identify whether socioeconomic inequality in some health sector variable exists.

Primary (Qualitative) Data

We conducted multiple Focus Group Discussions (FGDs), In-depth Interviews (IDI), Key Informant Interviews (KII) and consultation workshops to collect primary (qualitative) data to identify the bottlenecks in health care provision and utilization. We conducted these activities in three divisions: Dhaka, Khulna and Sylhet. We had purposively selected one district from each division, then two upazilas from each district and one union per upazila, based on their geographical location and demographic characteristics.

Findings

Findings from Concentration Index (CI) Analysis

Based on the results from Concentration Index, it can be seen that a significant inequality exists in the healthcare utilization. It is also apparent that healthcare utilization is more concentrated to the well-off. In addition, decomposition analysis reveals that wealth related inequality is the largest predictor of inequity in healthcare utilization. However, education and awareness about the facility are also found be relevant.

Findings from Field Activities

A total of 20 FGDs were conducted in Sylhet, Khulna and Dhaka division with different groups of marginalised/disadvantaged population, such as- adolescent girls, poor women, elderly, disabled, fishermen, transgender and homeless people. Along with the FGDs, several primary level government healthcare facilities were visited and KIIs were conducted with multiple healthcare providers and CSO members at community, union and upazila level. Finally, five consultative workshops were being held at three divisions in presence of various stakeholders and their recommendations based on the findings from the field research were obtained through discussion and analysis.

Information was gathered from the respondents from different groups regarding their usual healthcare seeking pattern, the reasons behind their preference, the commonly perceived barriers and facilitating factors in accessing and receiving healthcare, and their suggestions to overcome these barriers in order to provide quality healthcare services. Respective groups also talked about the specific problems they face and what special provisions need to be made to change the current scenario for them.

Usual healthcare seeking pattern

The majority respondents stated that in case of (perceived) minor illnesses, they generally seek healthcare from UHFWCs, traditional healers and local pharmacies. In the episodes of (perceived) major illnesses, they seek care from district-level government and private facilities and sometimes from divisional level government facilities, depending on the severity of the illness and availability of services. In general, they preferred the private facilities to the public ones because of the clean environment, lesser crowd and absence of under the table payment mechanism (for getting an earlier serial or getting any facility at all) of the former.

Perceived barriers in receiving healthcare

The women and adolescent girls complained about absence of female healthcare providers at government facilities as a major barrier in seeking healthcare for them. Also lack of separate waiting room and hygienic toilets were mentioned as a concern. Majority of the upazila level facilities did not have caesarean section delivery services owing to the absence of gynaecologist and anaesthesiologist simultaneously and in some cases, due to absence of proper equipment in the facility. Many facilities did not have any separate breastfeeding corner for the mothers and adolescent corner for the girls, which resulted in lack of privacy and special needs for these two groups.

For the elderlies and disabled, transportation to the facility was a major issue. Furthermore, absence of separate queue in the facilities resulted in long waiting time, which created difficulties in receiving healthcare in government facilities. Although some of the upazila, union and community level facilities had ramp, but almost none of the facilities had wheelchair provision in their premises. Lack of special assistance in the facilities also deemed as a significant barrier for these two groups of people in seeking healthcare, as it restricted their mobility and created difficulties in navigating the services seamlessly. None of the facilities had and disabled friendly toilets or separate waiting room for the elderlies or disabled either.

In the fishermen community, lack of awareness about the healthcare services in government facilities were being observed. They seemed reluctant to seek healthcare from these facilities. Rather, they preferred local pharmacy vendors, traditional healers and private clinics as their source of healthcare service. As the reasons for avoiding

government facilities, the inconvenient and costly transport to the nearby facilities, rigid opening hours, long waiting time, lack of drugs and doctors in the facilities were mentioned by them. Financial barrier also was a major issue for them, thereby they often have to depend on loans at a high interest rate from different sources for their treatment.

For the homeless community, the major barriers were more or less the same as the other groups. Due to their financial crisis, it was hard for them to receive healthcare from private facilities. Thereby, they mostly seek healthcare from government hospitals and free mission hospitals in the area. All of them talked about rigid opening hours and financial struggle as the barriers towards achieving quality health care. It was difficult for most of them to take a leave from their employer during the day, therefore they often were not able to go to the government hospitals for treatment. Furthermore, scarcity of drugs and lack of laboratory services there costed them extra money for purchasing drugs and lab test facilities from outside, which was highly difficult for them.

Among the marginalized groups, the transgender community were seemed to suffer a severe level of discrimination and difficulties in receiving basic healthcare due to the socio-cultural prejudice and lack of awareness in the society about them. They mentioned they suffered discriminative behavior from the health facility staff and doctors irrespective of government and private facilities so often that they avoid seeking healthcare at all, until and unless the illness gets severe. Most of the time, they go to pharmacy vendors and take drugs without prescription. Even majority of the pharmacy vendors do not behave well towards them and unwillingly provides them medicine. They suffer most when it comes to their sexual health issues. Due to the taboos about the issues and lack of proper knowledge among the providers, they often are unable to discuss their health issues openly and get the required treatment. Although they mentioned there are some NGOs working for the transgender community and to an extent, they are helping them with healthcare and family planning services as well.

Absence of consultant doctors, scarcity of drugs and equipment, lack of laboratory and imaging facilities, inadequate ambulance services, unhygienic environment of the facilities, long travel time and long waiting hours, absence of proper surgical facilities and rigid opening hours of the government facilities were quoted as some common barriers by all groups of participants. These marginalized groups also mentioned that their socio-economic status often influenced the behavior of the hospital staff towards them. Several respondents from lower socio-economic status mentioned that they faced misbehavior and poor quality of service from the hospital staff owing to their appearance (clothing) and lack of money to tip the staff in occasions. In general, financial barrier was mentioned as the major barrier in seeking regular and quality healthcare by all the groups as well.

Suggestions to reduce the barriers

General suggestions from the participants regarding the health services included training on improving the doctor-patient relationship, availability of consultant and female doctors, arrangement of proper ambulance services, ensuring adequate supply of drugs and equipment, availability of laboratory services at low cost and clean environment at the government facilities.

A number of suggestions emanated from the women and adolescents, such as- ensuring a clean environment and separate waiting line for them in the facilities, increasing the number of female doctors, making separate sitting arrangements for women and adolescent girls and making provision for a breastfeeding corner for the mothers. The women also requested for the provision of caesarean section delivery at a subsidized cost at their nearby healthcare facilities. The adolescents especially talked about engaging the field-level health/ family planning workers in the adolescence related services can improve the performances of the healthcare provision.

Special provision for the elderlies and disabled were mentioned as an important recommendation by the participants. Especially, provision of a designated transport service and arrangement of special assistance service for them were some of the

notable suggestions from them. They said separate waiting line and sitting arrangement should be made for them and doctors should treat them on a priority basis. Government should make all sorts of treatment cost (fees, medicine and diagnostic tests) free for the elderlies and disabled people as well considering their limited mobility and income issues.

Notable recommendations that came from the fishermen community included establishment of functional community clinic or satellite clinic near the fishermen's village, ensuring availability of free medicines and diagnostic facility at the hospital and providing them with government health benefit for major illnesses.

Transgender community also provided a number of suggestions that can help improve the current obstacles in accessing healthcare for them. The suggestions included education and awareness building program for the healthcare providers about the transgender people, thus alleviating taboos from their mind, which would allow the providers to provide healthcare services to this particular group of people without any biasness or prejudice. Inclusion of gender diversity related educational materials in national curriculum and provision of special health schemes for the transgender community were amongst their other suggestions.

The homeless community suggested to ensure good behavior from the doctors as well as other non-medical staff. Flexible opening hours of the government facilities, a proper information center and an effective mechanism through which all the essential care required for the pregnant women can be received with convenience also need to be ensured in their opinion.

Findings from service providers and facility observation

Health facilities which were visited in Dakhshin Sunamganj, Sylhet included the UHC (under-construction), one UHFWC, one MCWC and two CCs. In Tahirpur, the UHC, Balijuri UHFWC, North Sreepur USC and two CCs were visited and observed during

the study. Health care facilities which were visited in Rampal included the UHC, one UHFWC and two CCs. In Sharankhola, the Upazilla Health Complex, one UHFWC, one USC and two CCs were visited. Sreenagar Upazilla Health Complex in Munshiganj was visited along with one UHFWC, one USC and two CCs. Detailed facility observation and KII with the healthcare providers at these facilities were conducted during the visit. Major issues in healthcare service delivery from supply side perspective coincided with the demand side findings. The healthcare providers talked about the shortage of human resources, drugs and equipment supply as the main barrier in service provision. Especially the constant shortage of support staff (i.e. *aya*, cleaner, pharmacist, MLSS, lab technician etc.) and inadequate capacity of the facilities (e.g. patient to bed ratio, patient to doctor ratio etc.) created major hindrance for the doctors in providing quality health service to the people. Also lack of well-constructed roads and convenient transport was an access barrier for the patients in the remote areas, according to the providers.

During facility observation, lack of cleanliness and hygiene throughout the facilities were observed. Several facilities did not have well-equipped or separate waiting rooms and toilets for male and female patients. Majority of them also lacked any sort of special provision for elderly, disabled or transgender people. Lack of separate breastfeeding corner and adolescent corner were another common findings during observation. Some union level facilities were really old and in need of immediate reconstruction and maintenance work. Transportation to several facilities from comparatively remote villages were inconvenient and ambulance services were inadequate/ non-functional in majority of the areas, which resulted in increased difficulties for the patients in accessing their required healthcare.

Consultative Workshop Findings

Several consultative workshops were conducted in Sylhet, Khulna and Dhaka in the presence of various stakeholders to discuss and validate the findings obtained from our field research activities and obtain the participants' recommendations on how to

solve the existing barriers towards an effective healthcare system in the country. Among several important recommendations provided by the stakeholders, increasing provision of drugs and equipment on a need-based basis, outsourcing of support staff (cleaners and security guard), appointing native doctors to their respective districts in order to prevent transfer and absenteeism issues were being emphasized by the workshop participants. Other substantial recommendations proposed were- ensuring presence of doctors at the facilities during duty hours, discouraging the mechanism of attachment to other facilities, introducing adolescent and disabled corner in each UHC, and weekly visit of MO to union sub-center to overlook the activities and report the status to UHFPO in order to improve the quality of the healthcare services. Also, the role of political and social goodwill in improving the overall health system were agreed upon by them.

Conclusion and Recommendations

Based on both quantitative and qualitative findings, it is clear that inequity in the health service utilization is pervasive. In addition, various marginalized groups are discriminated in getting services. Even though government is attempting to improve the health service delivery in local level, it turns out that severe confidence crisis still persists. Based on the respondents' suggestions and upon consultation with stakeholders, the current study has provided some recommendations with regards to reducing access barrier in public health facilities. Key suggestions included ensuring availability of doctors and flexible opening hours of the facilities, arranging school health camps for the adolescents, over the phone consultation service for elderly and disabled, creation of an emergency fund to support poor and marginalized groups, introducing SSK type model for poor women and homeless and overall health system strengthening for better service provision.

1. Introduction

Bangladesh, despite of being a low-income country, has made remarkable progress in increasing immunization rate, improving child health and increasing access and equity in maternal health in last two decades (Anwar, Y. Nababan, Mostari, Rahman, & Khan, 2015). Considering the socioeconomic status of the country, the progress in major health-related indicators is praiseworthy, but many challenges remain. Inequity in service utilization and access to healthcare, however, continues to be a concern. Inequity in health care utilization affects people in multiple aspects which constricts their sustainable graduation from poverty. A 2019 study in Indonesia shows how the poor suffers from a disproportionate economic burden compared to the rich as they end up spending a higher proportion of their income towards healthcare financing (Wiseman, et al., 2018). Another study finds that access to health care services is

particularly limited for indigenous, low-income, and rural households in Ecuador (Lopez-Cevallos & Chi, 2012).

There is growing body of literature dealing with inequity in health care utilization in global context. According to the study findings from Indonesia, the rural people who constitutes half of the country's population suffers from limited access to skilled health workers and quality medicine. Moreover, the dominance of private sector in healthcare provision results in high out-of-pocket payments for the poor, hindering their access to healthcare and pushing them towards poverty (Wiseman, et al., 2018). A few studies have been conducted in Bangladesh as well which mainly focused on regional variation of inequity in healthcare access and utilization. One such study shows that whereas 38% of urban women opted for institutional deliveries, only 19% rural mothers have done so, indicating a notable level of inequity in utilization of health facilities between urban and rural maternal healthcare seekers (Kamal, Curtis, Hasan, & Jamil, 2016). Another study in rural Bangladesh finds that the use of formal health care is quite low (40 per cent) in rural Bangladesh and only one-fourth of them utilize public sector facilities. In addition, the success of health sector has not shared equally—a stark regional and gender inequity exits though the level of inequity is modest (Hamid, Ahsan, Begum, & Abdullah Al Asif, 2015).

It is evident that with the persistent inequity across genders and marginalized groups, health goal (Goal 3) and other related SDG goals may not be achievable which in turn will hinder the progress towards achieving universal health coverage in Bangladesh. In order to take appropriate measures, a deep understanding of magnitude and root causes of inequity in health care utilization is crucial. Most of the studies conducted in Bangladesh quantified the magnitude of inequity in health care utilization across socio-economic dimensions including age, gender and economic condition. Particularly inequities associated with access and utilization of maternal and child healthcare have been the focus of majority of the studies conducted in Bangladesh. For example, a 2017 survey observed the trends on utilization of four or more (4+) antenatal care (ANC) over a period of 22 years in order to explore the determinants and inequity among pregnant women of Bangladesh (Rahman, et al., 2017).

However, limited attention has been given to the marginalized groups such as transgender, fisherman, urban floating population, adolescents, disabled population

and elderlies. In addition, most studies focus on the quantification of inequity instead of understanding of the root causes. Nevertheless, to reduce the inequity in healthcare and achieve UHC in Bangladesh, it is imperative to understand the root cause behind this persistent inequity in this country's health system. Hence, a qualitative approach to the issue in question is necessary in order to understand both the supply side and demand side barriers associated with health inequity. As evident from the qualitative study findings in Kenya, despite improving the supply side of health services (e.g. availability and accessibility), inequity persisted in healthcare access and utilization owing to their lack of emphasis on the demand side barriers (McCollum, et al., 2019). Therefore, this study concentrates on exploring inequity in health care utilization and developing a clear understanding of the root causes of inequity, especially among marginalised and various gender groups.

1.1 Overall Objectives of the Study

The general objective of the study is to assess equity, especially gender equity in health service utilization in Bangladesh. The specific objectives are:

- To identify the barriers and facilitating factors to health services being experienced and perceived by marginalized/disadvantaged populations
- To explore the perceptions of marginalized/disadvantaged populations and health service providers with regards to options for identifying and addressing those access barriers, and wider social determinants of health in Bangladesh
- To identify the existing mechanisms of participation for vulnerable/marginalized populations.
- To highlight opportunities to improve equity in access to quality health services and wider social determinants of health.
- To estimate inequalities at various aspects using concentration index.

2. Methodology

2.1 Study Design

The study accomplished three sets of activities simultaneously (see Table 1). The first set of activities include use of a Modified Tanahashi Framework as well as Concentration Index (CI) to measure the health inequity across different socio-demographic groups with a special focus on identification of gender issues. These measures helped us discover the areas of service provision where the bottlenecks within the health system prevail.

The second set of activities intended to reveal the bottlenecks at the different stages of service provision. Through a methodology validation workshop with relevant stakeholders, the study regions, subjects and relevant data collection technique were finalized. To pinpoint the bottlenecks of service utilization several data collection procedures have been applied as suggested in (Henriksson, Fredriksson, Waiswa, Selling, & Peterson, 2017), which include numbers of IDIs, FGDs, KIIs. At the final stage, the study provided recommendations to overcome the implementation constraints of the health system based on the consultation meeting with stakeholders.

Table 1: Details of the study design

Phases	Tools to be used	Source of data	Specific Objectives
Stage 1	Modified Tanahashi Framework	Secondary and primary sources (FGDs, KII, Consultation workshop)	• To learn the areas of service provision where the bottlenecks within the health system prevail. • To measure the health inequality across different socio economic and demographic groups
	Concentration Index (CI)	Secondary (BDHS 2014 & HIES 2016)	
Stage 2 & Stage 3	Consultation and other qualitative tools	Primary (FGDs, KII, IDI, Consultation workshop)	• To reveal the bottlenecks at different stages of service provision • Developing strategies to overcome these bottlenecks and overall implementation constraints of the health system.

Table 2 below gives an overview of the research activities which were conducted during stage 2 and 3 of the study.

Table 2: Summary of Research Activities (Phase 2 and 3)

Activities	Sample (n)	Participants	Objectives to be covered	Data Collection Instrument (DCI)	Variables
Key Informant interviews (KII)	25	Health service providers and managers from districts and civil society organization	To explore barriers and facilitating factor to access across the continuum of care and their implications for access to services for the people	Guideline	Supply and demand side bottlenecks; Strategies to improve these bottlenecks
Focus group discussion (FGD)	21 (6 in Sylhet + 7 in Khulna+ + 8 in Dhaka); 6-10 participants each	Health sector managers (CS, UHFPOs, and RMOs)	To explore the supply- side barriers to service provision	Checklist	Supply and demand side bottlenecks; Strategies to improve these bottlenecks
		Female and adolescent girls from the lowest and second lowest socio-economic classes, fisherman, floating population, elderly, and transgender	To understand the perceived barriers related to availability, accessibility, acceptability, quality of care and adherence in relation to gender	Checklist	Supply and demand side bottlenecks; Strategies to improve these bottlenecks
In-depth Interviews (IDI)	25	Disabled people, Health service users	To explore views and experiences of users, including attention to relevant demand-side barriers to services and the wider social determinants of health	Guideline	Supply and demand side bottlenecks; Strategies to improve these bottlenecks

One-day consultation workshop	5 (2 in Sylhet+ 2 in Khulna+ 1 in Munshiganj)	Health managers, CSOs and government officials from relevant department	To review key findings and discuss opportunities to improve equity in the particular district will be held in each selected district	Guideline	Measurements of inequality; factors determining inequality
National workshop	1 (Dhaka)	Experts, policy makers and other stakeholders	To review key findings and discuss opportunities to improve equity		Identifying knowledge gaps; strategies used in other countries to reduce inequality

2.2 Methodological details

The study employed a mixed method containing both qualitative and quantitative components. Both primary and secondary data have been collected.

Secondary (Quantitative) Data

For the quantitative part of the study, we analyzed the available national level data (BDHS, 2014 & HIES, 2016) to measure inequity in health care utilization. This dataset is used mainly to estimate concentration index and understand the variation in utilization across gender. A brief discussion of the tools used in this study is given below.

Tanahashi Framework:

Tanahashi's 1978 work on health service coverage focuses on the effectiveness of coverage approach by conducting analyses of health system bottlenecks. Tanahashi's tool has been substantially used by the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the World Bank, particularly in case of district health system strengthening (DHSS) methods, in order to provide support to health management teams in achieving equitable, effective and universal health coverage (Baker, et al., 2015; O'Connell & Sharkey, 2013). In the original Tanahashi framework, there are five measures of coverage each of which reflects the five distinct stages of the process of service provision. Tanahashi terms these measures or determinants of

coverage as availability, accessibility, acceptability, contact, and effectiveness (Tanahashi, 1978). The difference between each determinant indicates the losses of health system effectiveness, termed as the 'bottleneck' within the health system, points to those areas of service provision that needs prioritization (World Bank, UNICEF, UNFPA, 2009; O'Connell & Sharkey, 2013).

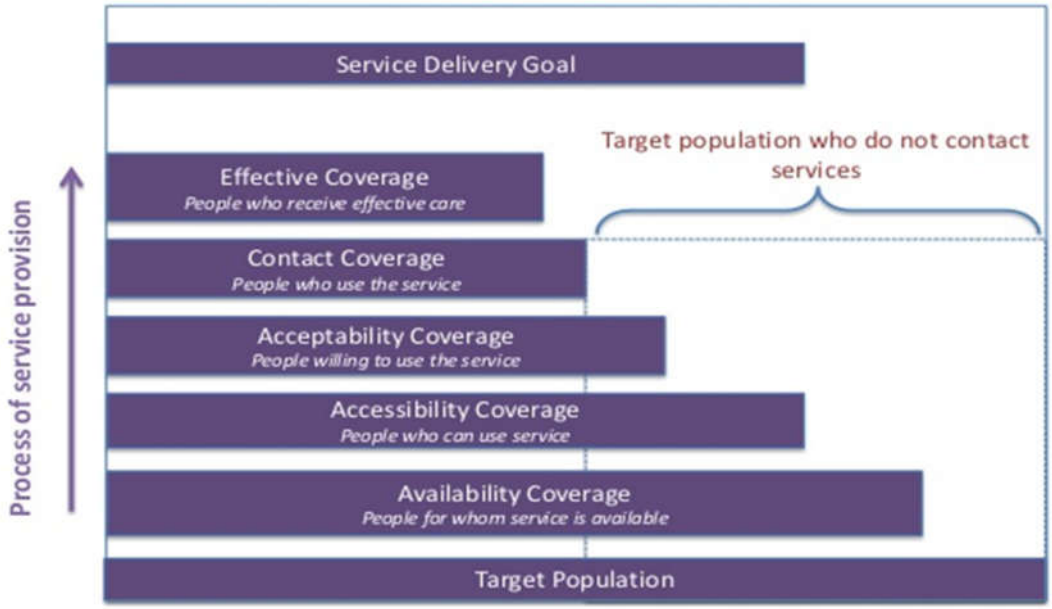


Figure 1: Original Tanahashi Framework

We proposed to use a modified version of the Tanahashi framework in line with methodology of identifying the bottlenecks as suggested in MBB tool[1]. The modified Tanahashi model has six determinants for effective coverage – availability of human resources, availability of essential health commodities, accessibility, initial utilization, continuous utilization, and effective coverage (Henriksson, Fredriksson, Waiswa, Selling, & Peterson, 2017). The six determinants reflect six distinct stages of service provision, as in the original model and this is useful for a stepwise assessment of service coverage. The modified Tanahashi tool was successfully used in bottleneck analysis at national level in Papua New Guinea, Nepal, India, Philippines and

[1] The MBB tool was developed to enable low income countries (LICs) to initiate a national level plan for marginal allocations to health services as well as to estimate cost and budget for these allocations, also to assess their probable effect on health coverage. It is worth mentioning that in this study we did not explicitly use MBB tool rather we used bottleneck identification approaches as suggested in that tool.

Indonesia that aided in planning and budgeting (La Vincente, et al., 2013; Jimenez Soto, et al., Developing and costing local strategies to improve maternal and child health: the investment case framework, 2012; Jimenez Soto, et al., Investment case for improving maternal and child health: results from four countries, 2013). Application of the modified version was also useful in assessing the effective coverage and identifying bottlenecks of maternal and child health interventions at the district level in Bangladesh and Uganda, providing an insight into the crucial constraints to achieve UHC (O'Connell & Sharkey, 2013; Baker, et al., 2015; Henriksson, Fredriksson, Waiswa, Selling, & Peterson, 2017).

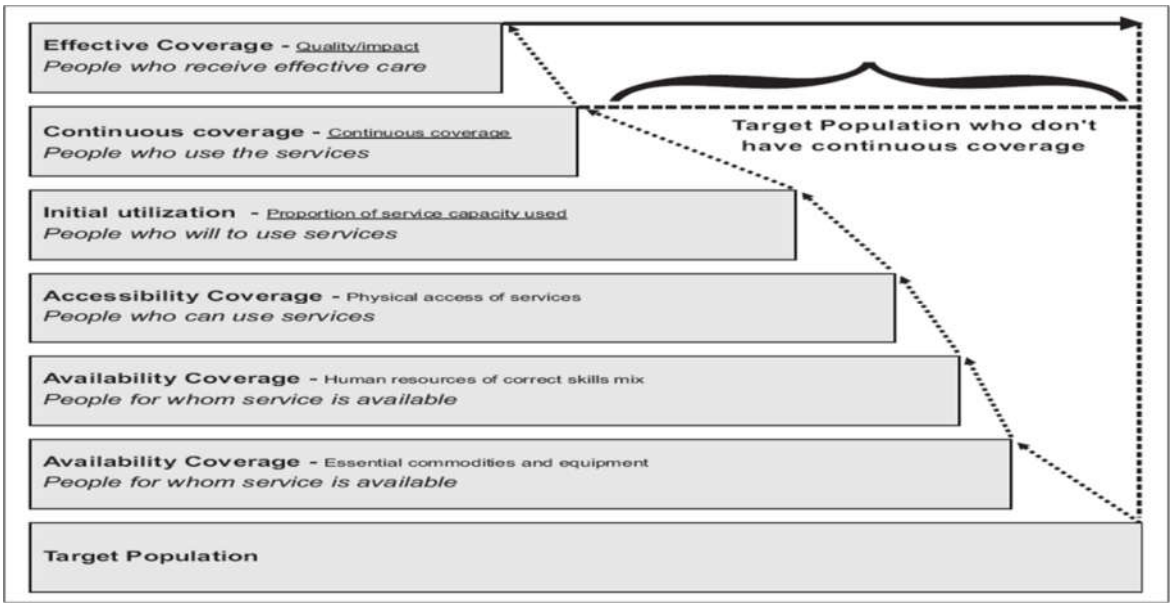


Figure 2: Modified Tanahashi Framework

In this study, we used the revised tool for examining routine immunization or Expanded Programme on Immunization (EPI), an essential child health intervention, that is delivered through outpatient and outreach activities, as a proxy for determining bottlenecks for primary health care services[2] delivered through the same channel (Kerber et al., 2007). The different coverage stages were defined as the following:

[2] Antenatal care, postnatal care, reproductive health including family planning and other child health interventions like IMCI, nutrition education, Vitamin A campaign and micronutrient supplementation (e.g. Zinc). We could not select these tracer interventions for evaluation of effective coverage and system bottlenecks using Tanahashi framework due to lack of availability of data.

- Target population: Population for whom EPI services are intended
- Availability coverage: Proportion of target population for whom EPI services are available: essential commodities and equipment and human resources of correct skill-mix
- Accessibility coverage: Proportion of target population who can access EPI services[3]
- Initial utilization/ coverage: Proportion of target population who received at least one dose of the EPI vaccines
- Continuous coverage: Proportion of target population who continued to receive EPI vaccines
- Effective coverage: Proportion of target population who received all the doses of EPI vaccines (fully vaccinated)

While the modified Tanahashi framework covers significant determinants to measure equity in health sectors, or the bottlenecks of health services delivery, we did not find any evidence in our extensive literature search where this tool was utilized to understand gender inequity. We therefore explored that the gender perspective through the analyses of the qualitative findings and other tools used in this study[4]. For example, the CI model would help to indicate social, economic, political, and cultural issues towards satisfactory health care services and even health seeking behavior that disproportionately affect women's health.

Table 3: Data collection methods using Modified Tanahashi Framework

Dimensions	Data collection method
Availability coverage: Essential commodities and equipment	- KII with hospital/clinic managers (CS, UHFPO, RMO) - Administrative record of the facility/ MIS
Availability coverage: Human resources of correct skill mix	- KII with hospital/clinic managers - Administrative record of the facility/ MIS

[3] Geographically and socio-culturally

[4] In accordance with the Terms of Reference (ToR) of this study, we used a modified version of Tanahashi framework to identify inequities in health service utilization, especially to explore the gender inequity. However, application of Tanahashi framework did not find any gender variation in healthcare utilization in this study.

Accessibility coverage	- KII with hospital/clinic managers - Observation - FGD with health service users
Initial utilization	- KII with hospital/clinic managers - Administrative record of the facility/ MIS - Secondary data
Continuous utilization	- KII with hospital/clinic managers - Administrative record of the facility/ MIS - Secondary data
Effective coverage	- KII with hospital/clinic managers - FGD with users - Consultative workshop - Secondary data

Measuring Inequity with Concentration Index (CI)

In addition to Tanahashi framework, we intend to apply the concept of Concentration Index—based on concentration curve-- as a measure of inequality. Concentration curve is used to identify whether socioeconomic inequality in some health sector variable exists. On the other hand, the CI is the considered as one of the most appropriate measures of health inequality, as it meets the basic requirements of a health inequality index, as it (i) can reveal the socioeconomic dimension to disparities in health; (ii) can reflect the experiences of the total population; and (iii) is sensitive to the fluctuations in the distribution of the population across socioeconomic groups. This measure has recently been used in measuring health inequalities across time and regions. Moreover, with some correction factors, it can estimate inequality for various types of data which makes its use pervasive in the health sector. The challenge of using CI is that it requires at least one continuous ranking variable of socioeconomic status (SES), which limits its practice and applicability sometime (Wagstaff, Paci, & Doorslaer, 1991).

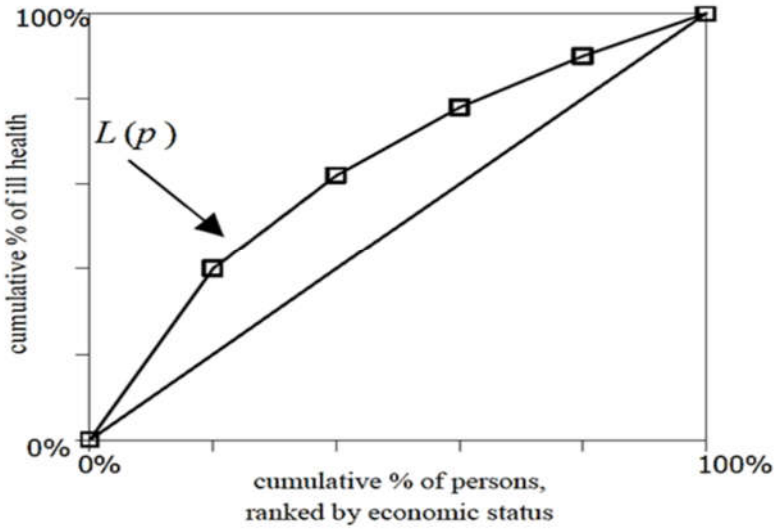


Figure 3: Concentration curve

The current study estimates concentration index using data Bangladesh Demographic and Health Survey, 2014. Utilization of ANC is used to measure CI, and the study also does decomposition to understand the various socio-economic factors that are responsible for health inequality. It is worth mentioning that even though the study focus is inequity across various marginalized groups, we intend to put special focus on the gender dimension. However, a reliable variable is not available in the BDHS dataset that can work a good proxy for all dimensions. Rather, estimates of ANC seems to be more relevant. Even though we will not be able to understand the gender dimension directly, use of decomposition analysis provides us with the opportunity to measure concentration indices for various demographic characteristics which includes some gender characteristics as well such as women empowerment.

The CI is the twofold of the area between the concentration curve and the line of equality (the 45-degree line or the diagonal line) and measures the depth of socio-economic disparity such as health inequality. In case of perfect equality, the concentration curve coincides with the line of equality and the CI is thus 0. It can range from -1 to +1; the larger absolute value of CI indicates greater inequality. The convention is that, when the curve lies above the line of equality, CI is less than 0 which suggests that inequality is more concentrated among low-SES groups. The

opposite is true in case of a concentration curve that lies below the diagonal line (i.e., CI>0 and inequality is more concentrated among high-SES groups) (Zhang & Wang, 2007; Wagstaff, Paci, & Doorslaer, 1991)

The formula for CI calculation is:

$$CI = \frac{2}{\mu} Cov(h, r) \qquad (1)$$

Where, CI is the concentration index μ is the mean of the health outcome, h is health outcome (ANCs) of the individual and r is rank of the individual by wealth distribution. The CI ranges between −1 and +1. The CI takes the value of 0, if the health distribution is completely equal. It is negative when the CC lies above the line of equality, indicating concentration of the health variable more among the poor. Meanwhile, it takes a positive value, if the CC lies below the line of equality, indicating concentration of the health variable more among the rich.

Decomposition of socioeconomic inequality

Decomposition of the CI of a health outcome is used to understand the contribution of different independent variables to inequalities in the health outcome. A regression-based model, as suggested in O'donnell et al (2007) has been used to predict the health outcome variable, as follows:

$$y = \alpha + \sum_k \beta_k x_k + \varepsilon \qquad (2)$$

Where β_k is the coefficient of x_k and ε is the error term. The concentration index of y denoted by (C) can be expressed as:

$$C = \sum_k (\beta_k \overline{x_k} / \mu) C_k + GC_\varepsilon / \mu \qquad (3)$$

Where μ is the mean of y, $\overline{x_k}$ is the mean of x_k (independent variable k), C_k is the CI for x_k, and GC_ε is the generalized concentration for the error term (ε). The first part of the above equation is an explained component, while the second part 'GCε / μ' is an unexplained component or residual. In the first part of equation, i.e. $\beta_k \overline{x_k}$, is the elasticity with respect to k regressor.

In this study health outcome variable is ANCs and right-hand side variable consists of socio-demographic characteristics of respondents.

Primary Data

We conducted multiple FGDs, IDIs, KII and consultation workshops to collect primary data to identify the bottlenecks in health care provision and utilization and strategies to overcome them from the perspective of both the healthcare providers and the users. We conducted these activities in three divisions, which were Dhaka, Khulna and Sylhet. We had purposively selected one district from each division, then two upazilas from each district and one union per upazila, based on their geographical location. The detailed data collection schedule and design have been shown below in Table 4.

Table 4: Design of the FGD, IDI, KII and Consultation Workshop

Week	Division	DCI	Easy to access areas and target groups	Hard to reach areas and target groups
1	**Khulna**		**Bagerhat Upazila**	**Sharankhola Upazila**
		KII (Day 1)	Heath facility managers, Health care providers	Heath facility managers, Health care providers
		IDI (Day 1)	Healthcare users, Disabled	Healthcare users, Disabled
		FGD (Day 2)	Disabled/Elderly, Women/Adolescent girls	Disabled/Elderly, Women/Adolescent girls
		Workshop (Day 3)	KII participants, members of civil society organization, government officials, local government representatives	KII participants, members of civil society organization, government officials, local government representatives
2	**Sylhet**		**Sunamganj Upazila**	**Tahirpur Upazila**
		KII (Day 1)	Heath facility managers, Health care providers	Heath facility managers, Health care providers
		IDI (Day 1)	Healthcare users, Disabled	Healthcare users, Disabled
		FGD (Day 2)	Disabled/Elderly, Women/Adolescent girls	Disabled/Elderly, Women/Adolescent girls
		Workshop (Day 3)	KII participants, members of civil society organization, government officials, local government representatives	KII participants, members of civil society organization, government officials, local government representatives
3	**Dhaka**		**Dhaka Metropolitan**	**Munshiganj Upazila**
		KII (Day 1)		Heath facility managers, health care providers
		IDI (Day 1)		Healthcare users, Disabled
		FGD (Day 2)	Transgender, Homeless, Adolescent girls	Disabled/Elderly/ Women/Adolescent girls
		Workshop (Day 3)	National Workshop with KII participants, members of civil society organization, government officials, local	KII participants, members of civil society organization, government officials, local government representatives

			government representatives, Health systems and Policy Experts and other stakeholders	

Data Collection Instruments (DCI)

Guidelines and checklists were prepared for KIIs, IDIs and FGDs. In addition, standard protocols/guidelines were used for the consultation meetings and workshops.

Key Informant Interviews (KII)

In order to identify the supply side bottlenecks in health service provision, several KIIs were conducted using a semi-structured checklist. Different levels of government healthcare facilities were selected purposively from each division. Healthcare providers and health facility managers were interviewed from the selected facilities. The checklist used for these interviews have been provided in the Annex.

In-Depth Interviews (IDI)

We conducted some IDIs with the disabled people and health service users attending the health facilities in our selected unions. The participants were selected purposively and on an average of 4-5 interviews were conducted in the area. The checklist used for conducting IDI has been given in the Annex section below.

Focus Group Discussions (FGD)

Several FGDs were conducted with our target population, i.e. the marginalized/ disadvantaged population groups in order to identify the barriers and facilitating factors to health services being experienced and perceived by them in their day to day lives. In total, we have conducted 21 FGDs with seven groups of populations, namely- Women, Adolescent girls, Elderly, Disabled, Transgender, Shelter less and the Fishermen community. We used purposive sampling to select the FGD participants. An average of 6-10 people participated in each FGDs. Adolescent female participants were selected from schools and colleges of the respective union. For the list of women, elderly and disabled participants, we sought help from the local social welfare organizations and upazila/ union parishad offices. Additionally, we contacted the local

NGOs working with the transgender and shelter less communities in Dhaka city to reach out to these populations.

A list of the general guidelines used to conduct the FGDs have been provided in the Annex below. A list containing the location and number of FGDs have been provided there as well. It should be noted that for the FGDs with all female participants, the facilitators were female as well.

Consultation workshop

We have organized a total of five consultation workshops (one in each upazila) in Dhaka, Sylhet and Khulna with different stakeholders including government (e.g., Ministry of Health), health care providers, health facility managers, civil society organizations, health systems and policy experts. In addition, a national workshop in Dhaka will be conducted in collaboration with the Health Economics Unit, in order to disseminate the findings of the study and formulate strategies to overcome the existing barriers in future.

Generally stating, the tasks of this study were sequenced in the following order:

1. Desk research and review of documents (including policy guidelines, regulations, etc.), reports and relevant academic literature were conducted in order to identify the knowledge gaps and the key barriers present in the way of achieving equity in health in the selected divisions for this study.
2. Undertook FGDs with identified marginalised groups from all the selected divisions in order to identify the demand-side bottlenecks and their suggestions on how to improve the situation.
3. Exit-point IDAs with health service users attending the selected health facilities were also conducted to assess the effectiveness and problems of health service delivery at that particular facility they were attending.
4. KIIs with health service providers, health facility managers and civil society organizations were conducted to identify the supple side bottlenecks and to gather their recommendations on the overall situation.

5. Then consultative workshops were conducted in each upazila of all the selected divisions followed by the KIIs, in order to validate the KII findings and figure out strategies to overcome the barriers. These workshops also sought opinions on how to create a comprehensive and effective healthcare delivery system in order to achieve health equity in the country.

This report is prepared upon receiving views from both health service users, providers and regulators. We will provide a synopsis that will delineate the most important findings and suggested changes in the healthcare delivery system of Bangladesh. Once accepted, the research team hopes to present the paper at a workshop to be organised by the Health Economics Unit, Ministry of Health and Family welfare, Bangladesh.

3. Findings

This section includes the findings from both quantitative and qualitative methods. The result section starts with findings from the secondary data with concentration index and its decomposition. Then health system bottleneck is identified using the modified Tanahashi framework. Finally, findings from the qualitative methods, and consultation workshop is reported. For each segment of marginalized groups, the results are organized as follows: usual health seeking patterns, perceived barriers and suggestions to reduce those barriers. Then we also report region specific findings.

3.1 Concentration Index and its Decomposition

We observe that there is a significant income (wealth) related inequality present in the utilization of ANC. Higher income is positively associated with higher utilization of ANC, since ANC is more concentrated to the wealthy. The CI coefficient is positive and statistically significant (p-value less than 0.001). While we notice a significant CI for when full dataset (Bangladesh) is used, there is no significant inequality for

divisional estimates though consistent with the national estimate, CI is positive for Sylhet and Khulna division. Since we have small data for those division leading larger standard errors which might have resulted insignificant CIs.

Table 6: Concentration index (CI)

Location	CI	SE	P value	Comments
Bangladesh (all divisions)	.00516759	.00123148	.001	ANC is more concentrated on the high-income group
Khulna division	.00641704	.00470458	0.1729	No significant difference
Sylhet division	.00219286	.00205012	0.2850	No significant difference

We also decomposed the CI index over some relevant variables. It turns out that both users' and their spouse education are positively associated with CI, i.e. higher educated group have taken more ANCs. Interestingly, female headed household is positively associated with more ANCs. Therefore, if women are more empowered in the household, she can take decision by herself which lead to higher utilization. Not being aware of community clinic is negatively associated with CI; that is people who know about the service availability of community clinic in their area more likely to have more ANCs. As shown in the following figure, wealth explains significant portion of the inequalities. A staggering 70% of the equality in ANC can be explained by the wealth variable. That is higher wealth not only positively associated with utilization, it also significantly explains the major parts of variations in utilizations.

Table 7: Decomposition of CI

Variable	Elasticity	CI	Contribution in CI	% Contribution in CI
Education(years)	0.00072522	0.02207753	0.00001601	0.31%
Not aware of community clinic	0.0003926	-0.0553644	-0.00002174	-0.42%
Spouse's education	0.00068332	0.0229124	0.00001566	0.30%

Wealth	0.01041723	0.34342118	0.0035775	69.23%
Female headed HH	0.00165745	0.00848029	0.00001406	0.27%

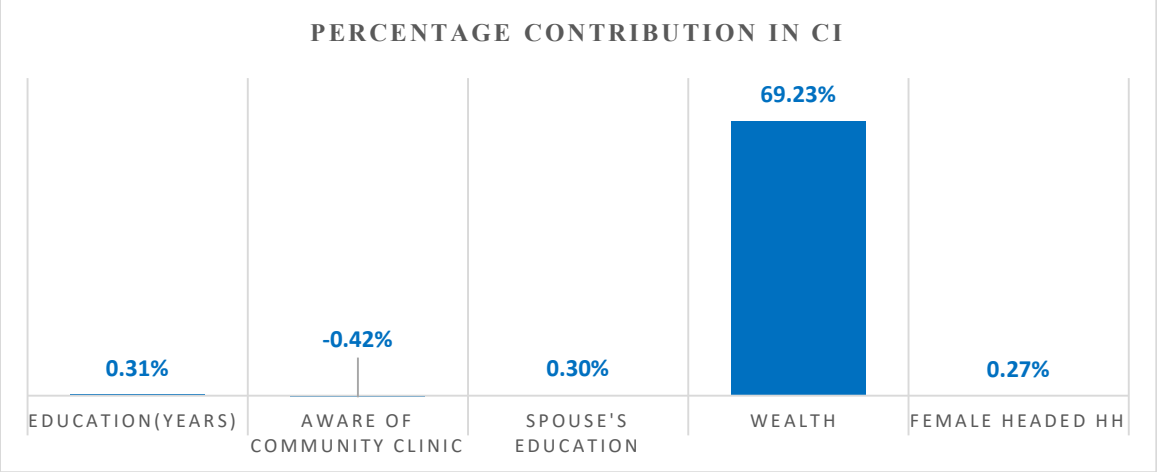


Figure 2: Contribution of socio-economic variables in Concentration Index (CI)

Since ANC service is only used by female, gender dimensions can directly not be observed. Unfortunately, BDHS 2014 does not consist of a variable that possesses both criteria suitable for concentration index—data are ordinal in nature and the data covers utilization of both genders. Therefore, to understand the gender dimension we used Household Income and Expenditure Data (HIES), 2016 data. The data contains a variable on service utilization (whether treatment sought when ill and when they felt needed). For Sunamganj, while 7% male did not seek treatment when they were ill, this number is 11% for the female. That are gender dimensions seems to be important. However, the difference is not statistically significant. Similar trend is observed for Bagerhat district, i.e. difference exists between health seeking behavior between male and female but not statistically significant. In Munshiganj, only 3% respondents did not seek any treatment while they were ill. Therefore, it is evident that individuals at Sylhet has low health seeking behavior and it is even severe for female. When the respondents were asked why they did not seek treatment, other than non-severity of illness, most respondents mentioned that high treatment cost was a barrier, and this reason is more resonant in Sunamganj (37%) compared to Bagerhat (29%) and Munshiganj (25%). In terms of choice of providers, we observe that only 19.54%

respondents used government facility. The reason for choosing government providers are given in the following table.

Table 8: Choice of providers by division									
Division	**Dhaka**			**Khulna**			**Sylhet**		
Reasons	Male	Female	Total	Male	Female	Total	Male	Female	Total
Nearby	24.14	33.33	29.03	30.00	20.00	25.00	0.00	37.50	25.00
Acceptable cost	13.79	9.09	11.29	20.00	15.00	17.50	25.00	12.50	16.67
Availability of doctors	10.34	15.15	12.90	20.00	30.00	25.00	0.00	12.50	8.33
Availability of equipment	13.79	6.06	9.68	10.00	5.00	7.50	25.00	0.00	8.33
Quality of treatment	27.59	27.27	27.42	5.00	10.00	7.50	25.00	25.00	25.00
Referred by relatives	10.34	9.09	9.68	10.00	15.00	12.50	25.00	12.50	16.67
Total	100.00	100.00	100.00	0.00	5.00	2.50	100.00	100.00	100.00

As shown the above table, the proximity to the facility turns out to be an influencing factor in choosing providers in all divisions studied. Availability of doctors is found to be more relevant factor in Khulna. Availability of doctors is of less importance in Sylhet indicating either absenteeism or human resource crisis in that division. This finding is very much consistent with our qualitative findings where we observed that Sylhet division has serious human resource crisis.

3.2 Modified Tanahashi framework and its application

We applied the modified Tanahashi model to estimate the coverage gaps of Expanded Programme on Immunization (EPI) intervention in the study area districts (Sunamganj, Bagerhat and Munshiganj) using the EPI crude coverage data of 2018 (District Health Information System software version 2). Table 9 shows the current EPI vaccination schedule in Bangladesh.

Table 9: Current EPI Vaccination Schedule					
Name of disease(s)	**Vaccine**	**No. of dose(s) required**	**When to give**	**Schedule**	**Route of administration**
Tuberculosis	Bacillus Calmette-Guerin (BCG)	1	After birth	After birth	Injectable
Diptheria, Pertussis, Tetanus, Hepatitis B, Haemphilus influenzae- B	Pentavalent vaccine (DPT + Hep-B + HiB)	3	6 weeks onwards	6 weeks (1st dose) 10 weeks (2nd dose) 14 weeks (3rd dose)	Injectable
Pneumococcal pneumonia	Pneumococcal conjugate vaccine (PCV)	3	6 weeks onwards	6 weeks (1st dose) 10 weeks (2nd dose) 14 weeks (3rd dose)	Injectable
Poliomyelitis	Oral Polio Vaccine (OPV)	3	6 weeks onwards	6 weeks (1st dose) 10 weeks (2nd dose) 14 weeks (3rd dose)	Oral
	Injectable Polio Vaccine (IPV)	2	6 weeks onwards	6 weeks (1st dose) 14 weeks (2nd dose)	Injectable
Measles and Rubella	Measles and Rubella (MR)	2	9 completed months	9 months (1st dose) 15 months (2nd dose)	Injectable

The operational definitions of different coverage dimensions used in this study reflect the programmatic definition and were given after consulting the EPI experts.

- Target population (Population for whom EPI services are intended): Number of children under 12 months of age living in the catchment area who are eligible for BCG vaccine[5]

[5] Target population is estimated as the cross-product of the target population (the number of children who got BCG vaccine) of previous year and growth rate of the area. This target population is applicable for all the other vaccines of the programme (Pentavalent, Oral Polio Vaccine, Pneumococcal Conjugate Vaccine, Injectable Polio Vaccine and Measles-Rubella Vaccine).

- Availability coverage (Proportion of target population for whom EPI services are available): Number of children under 12 months of age for whom BCG vaccines, syringes and other commodities[6] and service providers are available
- Accessibility coverage (Proportion of target population who can access EPI services): Number of children under 12 months of age who had access to BCG vaccines[7]
- Initial utilization/ coverage (Proportion of population who received at least one dose of the EPI vaccines): Number of children under 12 months of age who received BCG vaccine (entry point to EPI coverage[8])
- Continuous coverage (Proportion of target population who continue to receive subsequent EPI vaccines[9]): Number of children under 12 months of age who received Penta-1, OPV-1 and PCV-1 vaccines
- Effective coverage (Proportions of population who received all the doses of EPI vaccines in accordance with the WHO definition of full vaccination[10]): Number of children under 12 months of age who received MR1 vaccine; Number of children under 12 months of age who received 3 doses of Pentavalent vaccines; Number of children under 12 months of age who received 3 doses of OPV vaccines.

'Many of the pregnant women, especially the first-timers, visit their parents' home during the third trimester and remain there till 40 days after the baby is born. During this period, information about the child usually gets recorded by our field worker and the child is considered eligible for BCG. However, the mother might return to her house before the child gets its first vaccine, thus the child becomes 'left out''.

30-Year Old respondent

[6] Health assistants conduct home visits in order to identify children under 12 months of age living in their catchment areas and keep a record of the target population in a register book. The requisitions for vaccine vials, equipment and other logistics are given based on their register.

[7] Children whose details are listed in health assistants' register book

[8] Children are given a card on the day of their first vaccine, which helps in identification and record keeping.

[9] Subsequent to BCG vaccine

[10] Full vaccination was defined as having received all eight EPI-recommended vaccine doses, i.e. one dose of BCG, three doses of pentavalent vaccine, three doses of OPV, and one dose of MR vaccine

Crude coverages of EPI vaccines are shown in Table 10 and the drop-out rates from the first dose to subsequent doses of different vaccines are presented in Table 11. While the KII respondents revealed that the BCG vaccine was universally available and accessible in all the districts, there was a gap more than 5% in BCG coverage, or the initial utilization of EPI services in Munshiganj. The BCG coverage of the district was lower than the national coverage (97.8%) according to BDHS 2014. Major bottlenecks identified were the out-migration of families of registered children and overestimation of target population. This is probably due to the tradition of giving birth while staying at the mother's parental house.

Table 10: Crude coverages of EPI vaccines in 2018 in selected districts

District	BCG %	Penta 1 %	Penta 2 %	Penta 3 %	OPV 1 %	OPV 2 %	OPV 3 %	PCV 1 %	PCV 2 %	PCV 3 %	MR 1 %	MR 2 %
Munshiganj	93.4	96.7	96.3	94.9	96.7	96.3	94.9	95.9	95.8	94.0	92.5	91.4
Sunamganj	99.8	98.8	97.2	96.3	99.0	97.5	97.0	98.9	97.4	96.8	96.9	95.0
Bagerhat	97.5	101.4	99.7	98.7	101.5	99.9	98.8	101.5	99.9	98.9	94.8	90.4

Perceived quality of care was also found to be a determinant for EPI coverage in Munshiganj. The key informants from the district revealed that majority of the people prefer visiting Dhaka for receiving healthcare over receiving the same from Munshiganj, as they consider that the facilities in Dhaka offer better quality services. This contributes to the underutilization of EPI services in the district. Another constraint of initial utilization was reported to be the imbalance in input-mix, for example, stock-out of needles and other logistics. Although there was no evident acceptability issue, religious misconception regarding the vaccines and needles was considered as a potential bottleneck by few key respondents.

Interestingly, the continuous utilization, or the coverages of Penta-1, OPV-1 and PCV-1 vaccines, appeared to be almost 100% in Sunamganj, a district likely to have high drop-out rate due to hard-to-reach areas. On the other hand, Bagerhat has a continuous service utilization of more than 100%, attributable due to in-migration of eligible children. On the contrary, Munshiganj has a 3-4% gap in the coverages of the same vaccines. The main bottleneck was identified to be the wastage of vaccine vials resulting in shortage of vaccine and inadequate logistics.

The effective coverages, or coverages of 1st dose of MR vaccine, a proxy indicator for full vaccination, were respectively 93%, 97% and 95% in Munshiganj, Sunamganj and Bagerhat, which were higher than the national coverage (80%). (Table 11) According to BDHS 2014, the coverage of measles vaccine observed to be lower than the level of coverage for the BCG, three doses of Pentavalent and three doses of OPV. Again, between 2011 and 2014, coverage of measles vaccination decreased by 4 percentage points and coverage of all basic vaccinations decreased by 5 percentage points. This reduction in coverage of measles vaccine is of particular concern, as the low coverage in one vaccine can result in overall reduction of full vaccination coverage. The effective coverages of Penta 3 and OPV 3 were found to be around 95%, 97% and 99% respectively in Munshiganj, Sunamganj and Bagerhat, indicating a 2-3% gap between the utilization of 1st dose and the final dose of the vaccines. Data from BDHS 2014 also revealed that coverage for the pentavalent and polio vaccines declines with the dosage. In case of MR vaccine, the drop-out rate between the two doses (from MR1 to MR2) was about 3-4%. In case of all the basic vaccination, drop-out rates, or the difference in coverage between BCG (the first vaccine of a child) and MR 1 vaccine were 1-3%. The drop-out rate was wider between Penta1 to MR1, the highest gap (7%) was observed in Bagerhat. The gaps in the coverage, either between the subsequent doses of the same vaccine or between two different vaccines, likely to affect the quality of care. Consistent to the finding of BDHS 2014, we also found that vaccination coverages (initial utilization, continuous coverage and effective coverages) did not vary by the sex of the child.

'There are 30 wards in our upazila, so on an average we have to conduct 240 outreach sessions in month. Out of the 39 sanctioned posts of EPI workers, we have only 17 posts filled-in. We have no option other than working doubly hard'

-A Community Health Worker

Table 11: Vaccine drop-out rates in 2018 in selected districts					
District	BCG to Penta3 drop-out (%)	BCG to MR1 drop-out (%)	Penta1 to MR1 drop-out (%)	Penta1 to Penta3 drop-out (%)	MR1 to MR2 drop-out (%)
Munshiganj	-1.6	0.99	4.8	1.9	1.2
Sunamganj	3.5	2.9	2	2.5	1.9
Bagerhat	-1.2	2.8	7.2	2.7	4.6

Lack of awareness of the parents particularly among those of lower socio-economic class about the follow-up vaccines was found to be one of the largest constraints. Also, the lack of counselling and motivation skills of the health assistants sometimes cause difficulties to follow the advice regarding immunization schedule by the parents. Inadequate human resource is an underlying factor, as it results in increased workload of the community health workers, ultimately hampering the duration and quality of interpersonal communication sessions performed during field visits. The other bottlenecks hampering the effective coverage included out-migration of eligible children and lack of vaccine vials and supply.

3.3 Findings from Field Activities

Our field activities have been conducted in Sylhet, Khulna and Dhaka division with different groups of marginalised/disadvantaged population in order to collect primary data. The above-mentioned divisions are selected based on their health sector performance. Thereby, they have been categorized respectively as the: low-performing division, high-performing division, and the high-performing capital(division).

These field activities have addressed the perception of the marginalised and vulnerable groups regarding the common barriers preventing them from accessing and utilizing government healthcare services. Furthermore, their demands and suggestions on what they think is necessary to improve the existing issues and obstacles in the healthcare delivery system were being discussed during these activities.

3.3.1 Findings from Low-performing (Sylhet) Division

Data were collected from two upazilas of the same district in the low-performing division. Among them, Dakhshin Sunamganj upazila was chosen due to its close proximity to the main district whereas Tahirpur upazila was selected for its comparative remote location within the district.

3.3.1.1 Adolescent Girls

Female adolescents (14-15 years old) of different schools of the study area were asked questions regarding their usual practice of healthcare-seeking behaviour and the related barriers or facilitating factors they face in several FGDs.

Usual healthcare seeking pattern

Dakshin Sunamganj upazila does not have a functioning UHC yet. Their UHC is under-construction, therefore the people in the area have to seek healthcare from district, union and community level facilities instead. The adolescents here as well, in the cases of (perceived) minor illnesses seek healthcare from the union level facilities, faith healers and pharmacies. In the episodes of (perceived) major illnesses, they seek

care from government district hospitals, district-level private hospitals/facilities and divisional level government facility. In general, they preferred the private facilities to the public ones because of the clean environment, lesser crowd and absence of under the table payment mechanism (for getting an earlier serial or getting any facility at all) of the former.

On the other hand, adolescent girls of Tahirpur upazila usually seek healthcare from the UHC, UHFWC, and pharmacies. In the occurrences of (perceived) major illness, they also prefer district-level hospitals.

Perceived barriers and facilitating factors in receiving healthcare

According to the respondents in both upazilas, the doctors in government facilities were only present twice or thrice a week in UHCs, causing accessibility barrier. Another barrier faced by these respondents in public facilities is the lack of female providers. Some of the respondents opined, due to lack of female physicians in the government facilities, they preferred over the phone consultation with the drug sellers of the nearby pharmacies for the puberty/menstruation-related complications, as they felt shy around male physicians in this particular matter.

The menstruation discerned as a taboo to such a degree that, they often get the medicine that was prescribed to another person (who can be of a different age group and in some cases married) for similar symptoms, without consulting any healthcare provider. Some of the respondents do not seek health care at all in the occurrences of puberty/menstruation-related complications, as they are ashamed to talk about it. The adolescent girls cannot go to a healthcare centre alone without any parent's supervision; while their male counterparts

> *'It would be helpful for us adolescents if there are a provision of Iron and Folic acid at the government facilities near us. The health workers that visit our home can also provide adolescence related health advice along with the family planning services'*
>
> ***-15 years old Respondent***

can. This in some cases is reported as a barrier.

Another barrier faced by these school-going adolescents that the school time collides with the opening hour of the health facilities. As a result, they have to skip a day at school when they need to get any kind of healthcare. As the health workers who visit households (the family welfare assistant) usually deal with pregnancy, birth control-related services and provide contraception, the unmarried girls are excluded from approaching/talking to them, creating another barrier.

> *'The health worker apa who visits our home generally talks with my mother and aunts. Whenever I wanted to talk to her (for menstruation-related complications) she immediately discourages me to be around the grownups as they are talking about some serious topic'*
>
> ***-14 years old respondent***

Moreover, they have reported the public facilities are often discriminative towards the poor patients. Nevertheless, a general positive attitude was seen amongst a lot of them towards the satellite clinics and the associated health workers.

Suggestions to reduce access barrier

Important recommendations from these adolescent girls were to take strong measures towards ensuring flexible opening hours of healthcare facilities, improving the behavior of the provider towards the young patients, provision of adolescence specific health services on a particular day of the week in government hospitals, training of the family welfare assistants in puberty-related complications, increasing awareness regarding the importance of adolescent healthcare and maintaining a clean environment and toilet facilities in government facilities can increase the healthcare seeking among this age group.

3.3.1.2 Poor Women

Usual healthcare seeking pattern

In Dakshin Sunamgaj Upazila, poor women of the reproductive age group (aged around 18-45) reported that they are used to go to seek healthcare at nearby community clinics and pharmacies in case minor disease and family planning services. In case of major diseases, they have to go either to the district level govt. hospital or to divisional level hospital.

> *'I sometimes go to union level health facilities, but I do not always get the full course of medicines. They say that the supply is limited, but I heard from many people that they sell the medicine to pharmacy.'*
>
> ***-20 years old respondent***

Poor women of Tahirpur of the reproductive age group (aged around 30-45) reported nearby pharmacies, community clinics and UHC as the main source of getting healthcare.

Perceived barriers and facilitating factors in receiving healthcare

> *'I wanted to withdraw a (contraception) method as that did not suit me. I could not gather enough courage to talk to the doctor about my desire after I saw other women were severely criticized and almost forced to have a method of contraception (that is very much unsuitable for her body) for a period of three years. Then I had to lie that my husband is going abroad so I don't need any contraception for a while to get the withdrawal procedure done.'*
>
> ***-35 years old respondent***

Unavailability of a functioning UHC in Dakhshin Sunamganj upazila, scarcity of drugs and equipment at the CCs near the end of the month, long waiting hours, longer travel time to the district hospital and rigid opening hour of the government facilities bound them to seek healthcare from nearby pharmacies. Unavailability of boats during rainy season and broken roads during the dry season makes it difficult to access healthcare services for them. They

mentioned that they have to walk 40 to 60 minutes to get to the nearest government healthcare facility. Though they do not need to pay in CC and the waiting time is short, but the limited opening hours of the CC and the scarce drug supply often force them to seek healthcare elsewhere.

> *'Though my husband supports and permits me to go to hospital during my pregnancy, lack of financial solvency discourages me to go to hospital.'*
>
> ***-21 years old respondent***

However, they mentioned that they did not face any discriminating behaviour by the government doctors because of their socioeconomic status. Although, their financial situation often makes it difficult for them to receive the required healthcare.

In Tahirpur, the women talked about a widespread culture of under the table payment (to get better service) at the government facilities. The harsh behaviour, especially discriminatory behaviour towards poor of the providers of the different stages also create access barriers. The lack of essential medicines (which were supposed to be given free of cost), unclean environment, lack of clean water, ambulance, even stretcher makes the patients suffer. Family planning services also seem questionable to them. If a particular method of contraception did not suit a person, thus she wanted a withdrawal procedure, the patient was highly criticized.

Suggestions to reduce access barriers

General recommendations from the women regarding the health services included training on improving the doctor-patient relationship, availability of female doctors, arrangement of proper ambulance services and clean environment at the government facilities.

In Dakhshin Sunamganj, they demanded that the construction work of the UHC to be completed as soon as possible and actions to be taken to make it a wholesome healthcare facility with all the necessary manpower and equipment for better service delivery.

3.3.1.3 Elderly People

Usual healthcare seeking pattern

Senior citizens of (aged 65-95) usually seek healthcare in government facilities and pharmacies in case of most of the illnesses. The respondents reported that in case of minor symptoms like fever, cold, cough, diarrhoea etc. they usually visit the community clinics and upazila level healthcare facilities. Depending on the perceived severity of the illness, they prefer district and sometimes-divisional level government healthcare facilities.

> *'Doctors are not available at Upazila health complex after 1 PM. That is why those of us who lives in a distant 'Haor' area, we cannot seek treatment from the UHC, as it takes almost 3 hours to come here from our villages.'*
>
> ***-An elderly respondent***

Perceived barriers and facilitating factors in receiving healthcare

Age-related reduction of mobility creates a barrier for the elderlies, so they have to depend on other family members for their transport to a healthcare facility as well as the treatment costs. Often the family members refuse to take them to the hospital due to their time and money constraint, which results in an access barrier for the elderlies.

In Tahirpur Upazila, the roads connecting the villages to the UHC are narrow and broken. From many villages, the only means of transport is by foot or by motorcycle during dry seasons and during rainy seasons, using a boat is the only option. In case of major illness or due to referral by the doctors at Tahirpur UHC, they have to seek treatment from district and divisional level facilities which is a time-consuming and costly affair for them. All of these factors result in their dependency towards the nearby pharmacies.

Long waiting time is a major barrier for the elderly people as well. There is no provision of separate waiting line or sitting arrangements for the elderlies in the government facilities either. Using these inconveniences as an opportunity, some of the

government healthcare facility staff often practices a culture of under the table payment in exchange of an earlier serial to the physician.

Another barrier some of them have reported is the healthcare provider's behaviour towards the patients. According to the respondents, elderly people are often neglected as they are thought to be poorer. Even though patients do not need to pay for most of the services at government facilities, the diagnostic tests are costly and many of the tests are not available at the facilities. Physicians often advises them to go to outside diagnostic centres for the tests, which gets more expensive. Also lack of female providers often poses a barrier for the elderly women. Lack of essential medicines compels them to buy drugs from pharmacies outside, which is a major barrier for all the elderlies as they do not have any active income source and have to depend on others for their cost of treatment.

> *'Whenever I need medical help, I cannot get that without bothering others in my family or neighbourhood. So, I want a mechanism where I will call (through my mobile phone) to the facility and somebody using a local transport will come and take me to the healthcare centre'*
>
> ***- 85 years old respondent***

Suggestions to reduce access barrier

Respondents strongly suggested that the improvement of the doctor-patient behaviour specifically towards the elder people is important. The elderlies find it hard to locate different service rooms/areas in a healthcare facility due to lack of understanding of navigation signs. The elderlies especially the less educated ones wanted a mechanism where volunteers will be assigned with the responsibility to help such patients to navigate through the hospital when required. Due to the reduction of mobility, an 85 years old respondent suggested an innovative mechanism of special assistance based on cell phones for them.

They said separate waiting line and sitting arrangement should be made for them and doctors should treat them on a priority basis. Government should make all sorts of treatment cost (fees, medicine and diagnostic tests) free for the elderlies. They also

demanded that the UHCs need to be made wholesome and more efficient in terms of manpower and services so that they will not have to travel to district or divisional level hospitals anymore.

3.3.1.4 Disabled People

Usual healthcare seeking pattern

The disabled persons of this division reported seeking healthcare in the nearby pharmacies more commonly than government facilities. Apart from pharmacies, many of them take homeopathic or ayurvedic treatment as well.

> *'The roads here are narrow and broken. I cannot walk and I cannot use my wheelchair in these roads either. Getting on and off the boats are very difficult for me as well and I need assistance to do that. Therefore, I have to rely on my family member's mercy to take me to the hospital. But they have work and they do not always have time to take me to the hospital. Due to these inconveniences, I sometimes do not get the treatment I need and suffer by myself. If I go to a pharmacy nearby or to a local homeopathic doctor, it saves my money.'*
>
> ***-Elderly respondent with inability to walk***

Perceived barriers and facilitating factors in receiving healthcare

Transport to the healthcare facility was perceived as a major barrier for almost all of the disabled persons participating in the interviews. As they have to depend on others to take them to the hospital, it often prevents them from seeking healthcare at all. In Tahirpur, the only ways to go to the hospital is by foot, by bike or by boat. These modes of transport are highly inconvenient for them.

Higher travel time and travel cost make them difficult to go to a government healthcare facility. Furthermore, lack of separate waiting line and sitting arrangement, absence of special assistance and toilets for disabled at the government facilities pose difficulties for them to seek healthcare. Although when they visit government healthcare facilities, they are given special attention and usually providers are sympathetic enough to

shorten their waiting time. However, financial instability (as the disability allowance provided by the government is inadequate and the main source of earning is begging) is the major barrier to access healthcare for them. Not all of the government listed disabled persons received the government issued disability card, which makes their travel and treatment cost difficult to bear.

> *'My wife went to the hospital during her pregnancy. One of the hospital staff scolded her getting pregnant asking why she got pregnant when she knows that she is poor and her husband is disabled!'*
>
> ***-Husband of a respondent***

One of our respondents in Dakshin Sunamganj, a visually impaired person told us that he usually seeks care from West Pagla UHFWC as well as Dakshin Sunamganj district hospital. He had the proper knowledge about from where to seek health care and he told that there were no difficulties faced by him to access the health care. Although like the other respondents, he mentioned about the financial barrier while seeking health care too, specially the costs of drugs which need to be bought from outside the hospital. Although the doctors are mostly sympathetic towards them, but some other hospital staff such as, nurses, pharmacists or hospital assistants are not always well-behaved. One responded stated how he encountered a rude confrontation from one of the staffs at the facility. He said such humiliating encounters often prevent them from seeking necessary healthcare.

Suggestions to reduce barriers

They proposed to ensure a separate queue, sitting arrangement and special toilets for the disabled at the facilities for the disabled. Adequate ambulance, wheelchair and ramp facility should be made available at the facilities as well. The respondents also suggested to further increase the health-related government assistance towards the disabled persons (beyond the indoor services), especially towards the outdoor services. They also suggested a similar mechanism as the elderlies of the upazila, where volunteers will assist them to travel to the nearby government facility. Other suggestions were directed at improving the behaviour of the hospital staff towards the disabled, and they demanded to be treated with dignity and respect.

3.3.2 Findings from High-performing (Khulna) Division

Data were collected via FGDs and IDIs from two upazilas in Khulna division. Rampal upazila was chosen due to its close proximity to the main district whereas Sharankhola upazila was selected for its comparative remote location within the district.

3.3.2.1 Adolescent Girls

Usual healthcare seeking pattern

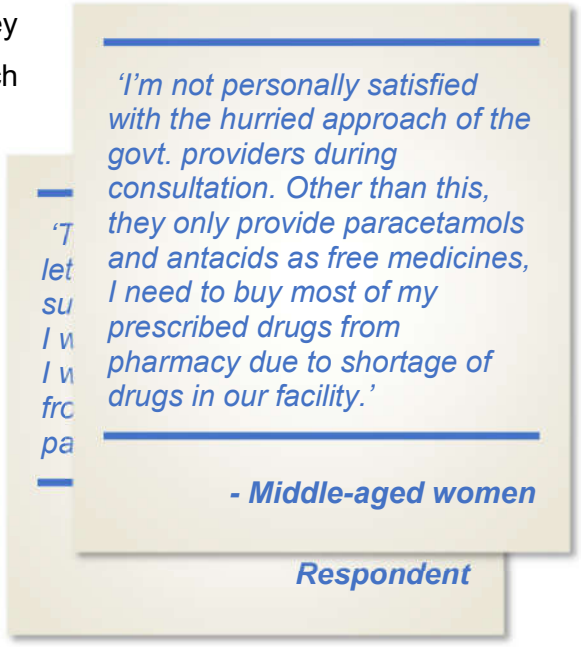
For major illnesses, the adolescents in this division prefer to go to the District hospital and for minor illnesses they seek healthcare from the nearest community clinic or Upazilla Health Complex. The female adolescents of Sharankhola often seek healthcare for (perceived) minor illnesses from nearby pharmacies. For (perceived) major illnesses, private providers are preferred by them.

> *'Hospital pharmacy usually lack of essential drugs after first two weeks of a month, they provide medicines for fever and allergies only and also lack equipment and diagnostic facilities.'*
>
> ***-Adolescent Female Respondent***

Perceived barriers and facilitating factors in receiving healthcare

The roads to the nearest government healthcare facilities are well constructed and transport costs are manageable, resulting in better access and utilization of the public healthcare facilities by the people in the upazilas. However, these facilities are always overcrowded and have long waiting hours. Some of the respondents opined that the doctors of the government facilities cannot give a substantial amount of time to a patient because of the overcrowding. In addition, the privacy of a patient is a prime

issue in these facilities. Other problems they mentioned were similar to Sylhet division, such as- unavailability of female doctors, lack of drugs, no special healthcare arrangement for adolescent girls and non-flexible hospital hours.



Not any kind of adolescent health awareness initiatives have been taken there by the government hospital or the health workers in that area. Female gynecologists are available only at private clinics, none at the government facilities. The scarcity of female doctors has been stated as one of the most common barriers by the female participants in all three divisions, irrespective of age groups.

The awareness related to tetanus vaccination is very low amongst the girls and they do not recall receiving any formal education on this issue.

Suggestions to reduce barriers

When it came to suggestions about improvement of quality of healthcare, the adolescents of high performing division put emphasis on the availability of female doctors in the facilities and the engagement of the field-level female health/ family planning workers in the adolescence related services. The believe it will be more convenient for the field-level health workers to provide them with necessary advice regarding their special needs and refer them to the relevant authority when needed.

3.3.2.2 Poor Women

Usual healthcare seeking pattern

Poor woman (age ranges from 25 to 38) reported visiting UHC for (perceived) minor illnesses and divisional level public hospitals in cases of (perceived) major illnesses.

> *'These doctors are qualified and well-behaved but often unable to determine the causes of disease because of the lack of instruments. Also, there is a lack of medicines in the UHC.'*
>
> ***- 44 years old woman***

Perceived barriers and facilitating factors in receiving healthcare

Similar to the female adolescents of this division, the major issue for the poor women is the shortage of specialist doctors and nurses at the facilities, especially female doctors. They face long waiting time in govt. facilities and they are more satisfied with the service at private clinic as gynecologists available only at private clinic. Lack of breastfeeding corner and separate waiting rooms, scarcity of medicine and diagnostic facilities and unavailability of caesarean section facilities were the other problems stated by the women.

Suggestions to reduce barriers

Ensuring availability of the doctors round the clock, especially female doctors is paramount. A proper waiting room facility with functioning electric fans, hygienic toilets and a separate breastfeeding corner should be established and proper diagnostic facilities should be guaranteed.

3.3.2.3 Elderly People

Usual healthcare seeking pattern

There respondents were aged between 60-86 years, both male and female participants were present at the FGD. Similar to the other group of respondents from this division, the elder population also reported their inclination towards government facilities. Almost all of them mentioned that they usually do not seek healthcare from

the pharmacies. Rather, they go to the UHC and the divisional level hospital (Khulna Medical College Hospital).

Perceived barriers and facilitating factors in receiving healthcare

Along with better roads and transportation in these divisions, no mentionable family or social barriers are being faced by the elderlies in their healthcare seeking process which resulted in an ease of access to healthcare for them. They are in general satisfied with the behavior of the doctors and nurses. The availability of doctors is better here, but the elderlies stated that the lack of orthopedics and cardiac specialist create a problem for them as most of the geriatric illnesses are related to these two specialties.

> *'The hospital cannot provide sufficient medicine for us, we need to buy most of them. We do get treated for minor illnesses, but there are no specialist doctors for heart disease and orthopedic problems.'*
>
> ***- 70 years old Woman***

They also face some common problems as the low performing divisions when it came to some in-facility problems such as long waiting hours, absence of separate queue and special assistance system for the elderly. They reported that in case of some emergencies, it is easier for them to reach a community clinic than the UHC, but the CCs are often closed which becomes an access barrier for them. They complained about shortage of inpatient services (e.g. bed facilities) at UHC and inadequate amount of essential medicine.

> *"The CCs should be located near the local bazaars. And why are they not kept open round the clock with emergency first aids? It would have been very helpful for all of us!"*
>
> ***- 77 years old Man***

Suggestions to reduce barriers

Ensuring availability of specialist physicians according to their need, provision of sufficient bed facilities to fulfil patient's demand and availability of essential medicine for the

elderlies. They also suggested establishing more CCs and keeping them open 24/7 for service.

3.3.2.4 Disabled People

Usual healthcare seeking pattern

Their healthcare seeking pattern is found to be the same as the other groups of respondents of this division (i.e. preference towards government facilities).

Perceived barriers and facilitating factors in receiving healthcare

They as well do not usually face any social or family barrier in the process of seeking care. According to them, the culture of under the table payment is absent and the serial of the patients are well maintained in the government facilities they visit. They are satisfied with the quality and the behaviour of the doctors at these facilities but the lack of instruments and medicines make the situation difficult.

As a result, some doctors of the UHC refer them to their private chambers, but the treatment costs are higher there. They reported the UHC is in general clean but the washrooms are not up to the mark. Though there is a ramp and provision of wheelchairs in some facilities, sometimes they find it difficult to use the wheelchair without any assistance.

> *'There are wheelchairs. There are ramps. But who will pull us? How will we reach to the facility without an assistant? If there were assistants to help is when we visit the facility, it would have been very helpful.'*
>
> ***- An elderly respondent***

Suggestions to reduce barriers

Separate waiting line and recruitment of volunteers for their special needs and assistance needs to be reinforced. They suggestion is to involve the students from the nearby schools/colleges as such special assistants at the facilities.

3.3.3 Findings from the Capital and High-performing (Dhaka) Division

Data were collected from the Metropolitan city and another adjacent district of this division. A few marginalised groups were specially included in this division, such as- transgender, homeless and fishermen groups.

3.3.3.1 Adolescent Girls (Metropolitan City)

Usual healthcare seeking pattern

These adolescents in the metropolitan city area mostly seek healthcare from private providers. Visiting public healthcare centers are quite rare among them. In the episodes of minor illnesses (any kind of pain, cold, acidity) they directly buy medicines over the counter. Although, no one has reported buying un-prescribed antibiotics.

Perceived barriers and facilitating factors in receiving healthcare

No respondent reported facing any social or family barriers regarding healthcare seeking. In general, they enjoy a better financial solvency compared to other divisions, thereby they reported that monetary issues do not pose not a barrier for them in receiving quality healthcare. Rather the obstacles faced by them and their family/acquaintances at government facilities are lack of privacy, limited consulting time (due to the massive loads of patients), unhygienic environment, unhygienic food for the indoor patients and attendants and inappropriate and disrespectful behavior of the non-medical staff. These are the reasons why they prefer to go to private chambers/clinics for better quality of service.

They mention that the overcrowding is another reason to avoid government facilities. Healthcare providers, specially the public ones (who are ridden with enormous workload) often do not pay utmost attention to their problems as per their expectation. These providers rather talk to the attendants/guardians of the adolescents bypassing the patients; which they (adolescent) find inappropriate. Despite having a better

awareness about their general well-being, they as well lack sufficient knowledge regarding tetanus vaccine.

Suggestions to reduce barriers

A number of suggestions came from these adolescents. According to them, to ensure that the medical emergencies will be met properly, the roads and highways within the city should have a separate lane for ambulances round the clock. They strongly suggested to maintain a clean environment at government healthcare facilities, reduce overcrowding of patients and provide healthy and hygienic food to the admitted patients at the hospitals.

3.3.3.2 Poor Women

Usual healthcare seeking pattern

They seek healthcare from both public and private healthcare facilities according to their need, convenience and financial situation.

Perceived barriers and facilitating factors in receiving healthcare

As Sreenagar upazila is adjacent to the capital, the public health facilities are comparatively well-equipped and availability of doctors is well reported here. The roads and transportation are better here as well.

But for the poor women group, overcrowding at the hospitals, long waiting hours and lack of waiting room for the mothers with children pose problems, especially when they take their kids to the hospital.

Therefore, they are more satisfied with the service at private clinic in terms of quality and sometimes rely on pharmacy vendors or self-

> *'I usually have to go through long waiting line at the ticket counter. Long waiting time with my little child is very difficult, especially at the Pediatrics wing since they have no separate room for children.'*
>
> ***- A female respondent***

medication. They mentioned about unhygienic environment in the hospital and overcrowded waiting rooms.

Suggestions to reduce barriers

Ensuring availability of physicians at every sanctioned post (especially, pediatrician for their children) and arrangement of a well-equipped waiting room, particularly for mothers with children.

3.3.3.3 Elderly People

Usual healthcare seeking pattern

The elderlies in Sreenagar upazila reported that people of that locality seek healthcare from nearby government healthcare facilities and pharmacies in case of minor diseases. However, in case of major diseases, they are used to go to national level health facilities like Dhaka medical college hospital instead of district level health facilities as the transportation facilities are more convenient to Dhaka for them. The financially solvent patients also prefer to receive treatment from Dhaka medical college hospital than at the local government healthcare facilities for better quality of service.

Perceived barriers and facilitating factors in receiving healthcare

> *'My sons do not even provide me food, let alone the cost of my treatment.'*
>
> ***-65 years old respondent***

Many of them stated that their family members are often not very supportive about their healthcare. As their mobility is restricted due to ageing and they have no income, they have to depend on their family members for their treatment, thereby it becomes a major barrier for them.

Lack of special assistance system/arrangement for elderly in the government facilities further creates access barriers for them. Although, the posts of the doctors in the government facilities are

mostly filled, but absenteeism from workplace has been observed by the elderlies on a regular basis. They also complained about the behaviour of the hospital staff nurses and some junior doctors, who often show discriminative behaviour towards them. The hurried approach of the doctors towards them and the negligence of the nurses in providing them services were common complaints of the elderlies.

> *''The nurses did not give me clean bedsheets when I was admitted here. But they did it for the rich, well-dressed and influential patients. The doctors were busy and they only gave me treatment based on my symptoms, but did not conduct any physical check-ups. The ward boy was also rude to us and asked for incentives in exchange for services in the hospital.'*
>
> ***- A male respondent***

Suggestions to reduce barriers

The elderlies in this division provided more or less same suggestions as the other division focused on making the government facilities more amiable towards the elderly patients (in terms of both human resources and consumables).

3.3.3.4 Disabled People

Usual healthcare seeking pattern

Data were collected from a total of 11 disabled person (i.e. visually impaired, person with autism, hearing impaired, intellectually disabled, physically challenged). Most of them were aged between 20 to 36 years and had no education at all. Majority of them runs a small business (e.g. tea stall, vegetable vender etc.) with the help of family or friends. They usually seek healthcare from local drug stores/pharmacies for minor ailments and from Sreenagar UHC for major ailments.

Perceived barriers and facilitating factors in receiving healthcare

They stated the major reasons for not going to UHC/government facilities for ailments including inadequate drug supply, lack of special provision/ separate queue and sitting arrangement for the disabled, lack of diagnostic test facility, long waiting time etc.

Furthermore, financial instability is a concerning issue for them while seeking healthcare.

Suggestions to reduce barriers

The suggested issuing a disability card which will ensure priority privilege for them while seeking health care; introducing a separate queue for disabled persons; providing full course of drugs to the disabled, specially to those who faces financial hardship.

> *'The cost of transportation is not worth it, if no free drug is available which is very common. That is why we seek care from the nearby pharmacy and if condition is worse, we go to private hospitals or go to Dhaka rather than the district hospitals. In addition, we are always neglected in the govt. facility due to our poor economic status'*
>
> ***- A male respondent***

3.3.3.5 Fishermen Community

Usual healthcare seeking pattern

From the fishermen community of Sreenagar, 8 respondents participated in the discussion. They mentioned that, unlike the people from the upazlia, they usually do not go to the government facilities for their healthcare, rather going to the nearby pharmacies is their common method of healthcare seeking. For major illness, they usually go to the nearby private clinics in Fultola rather than the district or national level public hospitals.

Perceived barriers and facilitating factors in receiving healthcare

They live close to the river areas in the upazila for their livelihood and there are no nearby government facilities from their houses. There was one FWC nearby, which is non-functional for a while now. It takes longer hours and extra money to get to the UHC, and also the opening hours of the UHC is inconvenient for them, thereby they choose to go to the pharmacies or private clinics instead. They also seem to not have sufficient knowledge or information about the available services in the government facilities.

Seeking healthcare is a costly affair for them. Moreover, the costs to travel and uncertainty regarding doctor's availability and not getting all required medicines free also discourage them. They often have to take a loan with high interest from local sources to pay for their treatment costs. As a result, unless it is a major illness, they usually choose not to seek treatment at all.

Suggestions to reduce barriers

Establishment of a fully functional government facility near the fishermen village, ensuring availability of free medicines and diagnostic facility at the hospital and providing them with government health benefit as a vulnerable group for major illnesses.

3.3.3.6 Transgender people

Usual healthcare seeking pattern

People from the transgender community in Dhaka seek healthcare from pharmacies and private doctor's chambers. They also go to the government hospitals and private clinics, usually when there is a major illness or health issue.

Perceived barriers and facilitating factors in receiving healthcare

The transgender community of Dhaka city had opined a number of barriers they face in the process of receiving any type of healthcare. First, they are not welcomed and often not allowed to government healthcare facilities. The discrimination begins at the ticket counters. No one (starting from the person at the reception desk to the doctors and nurses) properly talks to them due to fear or some kind of stigma. The people standing at the queue feel uncomfortable and sometimes insult them/pass comments.

> *'The way the service providers treat me gives me mental trauma. As if, I am not a human. As if, I came directly out of the zoo.'*
>
> ***-Middle aged transgender respondent***

These heavy social barriers compel them to seek healthcare from the nearby pharmacies and in some cases from private providers. However, in private facilities too, they are very much neglected. Their serial numbers are deliberately kept at the end (although they have come earlier) to discourage them from seeking care or indirectly repulse them. There are a few private entities/ doctors' chambers that treat them well and are popular in the transgender community. The number of this kind of facilities are extremely low. Their access is also restricted in the family planning clinics. They have no access for consultations regarding family planning materials and methods to ensure safe sex (which is essential as they frequently suffer from STD/VD). They opined female doctors are more preferred by the community than their male counterparts are.

> *"Once I went to a doctor with one of my followers who was suffering from a sexually transmitted disease. When the patient started describing the symptoms, the doctor was astonished by the fact that a transgender person can be sexually active. Later he verbally abused us.'*
>
> ***-A transgender respondent***

Things are worse when they seek healthcare for sexually transmitted diseases/venereal diseases (STD/VD). According to the respondents, most of the doctors do not have proper orientation regarding diversity within the transgender community as well as their sexual behaviour. Thus, transgender patients who are suffering from STD/VD face behaviours that are yet more inappropriate and verbal abuses by the providers in such cases are quite common.

As a result, even in the incidences of (perceived) severe illnesses, they are compelled to go to the pharmacies. There are social barriers in the process of seeking care in the pharmacies too. The drug vendors do not want these people in their shop for a substantial amount of time. They have to describe their symptoms as early as possible and leave the shop. This practice generally results in erroneous treatment and the health condition is deteriorated.

The people of the third gender are usually seen to live with the community, not with their family members. Family supports during illnesses are thus rare but subject-to-subject variations can be found. However, if the illness is related to their sexual behaviour, no family support is found, nor expected. On the contrary, the support from the community is very strong. From taking care of the sick fellow to arranging financial support, these people have each other's back.

Suggestions to reduce barriers

A number of specific recommendations came from the transgender group:

- Government healthcare providers should be trained in the area of gender and sexuality, especially about issues associated with the transgender community.
- The national curriculum for medical education should incorporate a proper (practical knowledge-based) orientation of gender diversity; their sexual practices of the transgender population as well as the diseases they are more susceptible to.
- Awareness must be built on how to deal with a transgender person among the medical and non- medical personnel of the government facilities
- To reduce the discrimination towards the third gender community and to increase practical knowledge, the national curriculum should include gender diversity and diversity of people as a whole.
- The people of the third gender need to undergo a health investigation (verifying their gender identity) to avail the government-approved third-gender quota facilities (for government jobs/training). To avoid the harassments regarding this type of examinations, a team consisting of a doctor (MBBS), a psychiatrist and a local transgender leader can be assigned in the public healthcare facilities.

3.3.3.7 Homeless people (Metropolitan City)

Usual healthcare seeking pattern

The common healthcare-seeking practice of the homeless people of Dhaka metropolitan city is seeking healthcare from nearby drug stores and non-

profit/missionary hospitals in the episodes of (perceived) minor illness and from government facilities in the incidents of (perceived) major illness. Pharmacies or the local drug shops are preferred to the formal facilities due to the flexible opening hours and short travel and waiting time.

Perceived barriers and facilitating factors in receiving healthcare

Due to the rigid opening hours of the government facilities, they have to take leave from work to visit a facility, which reduces their income. Sometimes it is hard to manage leave from their employers. Another reported reason for visiting the pharmacies is the discriminatory behaviours of the medical and non-medical service providers towards them at formal facilities due to their social standings. When they visit a government facility, the doctors do not explain the doses of medication; they have to understand it from the drug vendors. The communication gap between them and the provider; partly attributed to the huge workload of the government doctors and partly due to the reported discriminatory behavior discourages the homeless people to seek formal healthcare. The respondents opined they are yet more neglected by the non-medical staff. Furthermore, the wide malpractice of under the table payment at government facilities at various levels along with their regular personal financial hardship makes the situation even tougher.

The problem of navigation inside the government facilities is reported as another obstacle. As most of the people of this group are comparatively less educated, they find it difficult to find different services at different places inside a facility without a designated body to provide this type of information. The main barrier at seeking any kind of healthcare as reported by this group is the high price of medicines irrespective of the providers they select because of the constant poverty. The medicines which should ideally be available at the public health centers are often unavailable, they opined.

Suggestions to reduce barriers

They suggested to ensure good behavior from the doctors as well as other non-medical staff. Flexible opening hours of the government facilities should also be

ensured. A proper information center is also suggested. They requested for an effective mechanism through which all the essential care required for the pregnant women can be received with convenience.

3.4 Findings from Service Providers and Facility Observation

3.4.1 Findings from Low-performing division

Health facilities which were visited in Dakhshin Sunamganj included the UHC (under-construction), one UHFWC, one MCWC and two CCs. Detailed facility observation and KII with the healthcare providers at these facilities were conducted during the visit.

Upazila Level Facilities

Dakshin Sunamganj upazila is a new upazila in Sunamganj district and it was formed in 2012. The population of this upazila is 217,069. There are 24 Community Clinics, 6 Union Health and Family Welfare Centers and one Maternal and Child Welfare Centre and one under- construction upazila health complex (UHC) in the upazila. The under-construction upazila health complex is located near the Sylhet-Sunamganj Highway and is well connected to this highway. All of the post of this health complex has already been created, but not sanctioned yet. Currently, there are no sanctioned healthcare providers or facility staff in the facility other than the UHFPO. As there is no functioning upazila health complex in this upazila, the UHFPO usually holds his temporary office at Sunamganj District Hospital. As the UHC is currently non-functional, the usual practice for the patients

Key challenges in service provision and utilization:

- Shortage of human resources in the health facilities of the upazila
- Communication problem, especially during rainy season.
- Shortage of electricity
- Budget limitation

-UHFPO, Dakhshin Sunamganj

from this upazila is to go to the Sunamganj district hospital for their treatment.

The UHFPO mentioned some important challenges regarding the health service provision in the area, and talked about shortage of human resources as one of the prominent problems among others.

In Tahirpur, there were two hospital buildings in the upazila health complex. The old currently functional building is 31 bedded. The construction of the new 50-bedded building was completed during the time of the visit, but it was not open service provision yet. The service providers expressed concern regarding the negative attitude and behavior of local people towards professional health care providers due to the difficulty in reaching the public healthcare facilities, shortage of human resources and medicine and diagnostic facilities. These issues not only limit the providers ability to provide quality healthcare, but also resulted in the tendency of seeking health care from village doctors by the patients. A summary of the key findings from the facility observation in both the UHCs is given below:

Facility Observation Key Findings: Upazila Health Complex		
Domains	**Tahirpur**	**Dakhshin Sunamganj**
Availability of commodities and logistics	❖ Insufficient drugs ❖ Surgical facilities were not available (Lack of anesthesiologist and consultant) ❖ Non-functional ambulance ❖ Non-functional diagnostic and sterilization equipment (X-ray machine, ECG machine, USG machine, Autoclave etc.)	❖ Hospital building under-construction: ❖ Long travel time from many villages
Availability of human resources	❖ Inadequate ❖ Empty consultant posts (Surgeon, Gynaecologist, Anesthesiologist) ❖ Shortage of support staff (medical technologists, pharmacist, aya) ❖ Lack of ancillary stuff (cleaner)	❖ Inadequate

Geographical accessibility to service delivery points	❖ Newly built 50-bed hospital has not started to function yet; awaiting arrival of necessary logistics and manpower. ❖ Existing 31-bed UHC findings: ❖ Long travel time ❖ Not located near the main road ❖ Broken, narrow roads to the facility	❖ Not applicable
Basic Amenities And Environment	❖ Toilets were unclean during the time of visitation ❖ No ramp for wheelchair in the old building, the new building has ramp. ❖ Separate ticket counter and waiting rooms for men and women; but no special arrangement for disabled/ elderly/transgender ❖ No formal grievance readdress mechanism for the patients	❖ Not applicable

Union level facilities

At the union level, West Pagla Union Health and Family Welfare Center (UHFWC) and Dargapasha Maternal and Child Welfare Center (MCWC) were visited during the study. Both of the facilities are located in the middle of the union. Though the West Pagla UHFWC has well-connected roads and located near the highway, it becomes harder to access the facility during monsoon due to flooding, whereas the Dargapasha MCWC does not have well-connected roads from all the nearby villages. One of the staffs (senior staff nurse) was on attachment, but the rest of the staff were present in West Pagla UHFWC. But during the study, both the medical officer (MO) and family welfare visitor (FWV) from Dargapasha MCWC were either in Sylhet or Dhaka for training purpose and so the health assistant and community skilled birth assistant (CSBA) were providing health care services, which limited the quality of health care for the time being. Dargapasha MCWC staff advertises about the free normal delivery services through miking and home visits, and according to them, almost seventy percent of the normal delivery in the coverage area takes place at the center now. The medical officer of West Pagla UHFWC described drug inadequacy, equipment

shortage and lack of adequate human workforce (especially female healthcare provider) as the three main challenges for providing quality health care.

In **Tahirpur**, Balijuri UHFWC and North Sreepur USC were visited and observed during the study. The first facility was located near the main road whereas the later one was very difficult to access by road. During the rainy season, patients visits the North Sreeepur USC by boat, but in dry season motorcycle, motor van and walking are the only transport mechanism for the patients. Another visited union level facility in Dakhshin Sunamganj was North Sreepur USC. It has a two-storied building but most of the rooms have become unusable over the course of years. SACMO of Balijuri UHFWC mentioned that the posts for pharmacist and aya were vacant for a long period. Due to the lack of cleaning staff, it was difficult to maintain cleanliness in and around the facility. On the other hand, SACMO from North Sreepur USC was the only staff of the health facility. It was very difficult for him to manage the USC activities by himself. Insufficient drugs and inadequate equipment were the main barriers in providing health care, according to both the SACMOs. SACMO of Balijuri mentioned that socio-cultural prejudice and illiteracy were responsible for low use of contraceptives in that area. He proposed to increase the supply of drugs and human workforce, especially female FWV, for proper provision of health care. On the other hand, though patient flow is much higher in North Sreepur USC, all the supportive staff posts were empty during the time of visit. He mentioned that in addition to inadequate drug and equipment, lack of electricity and water in the USC limits quality service provision there. He also suggested to increase budgetary allocation as well as drug supply and human workforce, especially female providers, is a must for ensuring proper health care for its population.

Key Facility Observation Findings: UHFWC/MCWC/USC		
Domains	**Sharankhola**	**Dakhshin Sunamganj**

Availability of commodities and logistics	❖ Shortage of medicine ❖ No inventory list availbale ❖ Shortage of equipment (i.e. weight machine, glucometer)	❖ Shortage of medicine (i.e. ORS, paracetamol syrup) ❖ No inventory list available ❖ Shortage of equipment (i.e. dressing) ❖ Inadequate sterilization facility
Availability of human resources	❖ Two vacant posts of MO for a long period. ❖ Shortage of support staff (Pharmacist, cleaner) ❖ FWV (female) were on leave during the time of visitation	❖ Shortage of support staff (pharmacist, aya) ❖ Cleaner appointed by outsourcing; cost borne by facility staff ❖ Female service provider not always available ❖ No gender training of health care providers
Geographical accessibility to service delivery points	❖ Situated by the main road of the union ❖ Long travel from some of the coverage areas; have to use boat during rainy season	❖ West Pagla UHFWC has well-connected roads but becomes harder to access during monsoon ❖ Dargapasha MCWC does not have well-connected roads from all the nearby villages
Basic amenities And environment	❖ Old building, renovation required; often gets flooded during rainy season ❖ Inadequate privacy of the patients ❖ No separate toilet for female ❖ No special arrangement for elderly/ disabled/ pregnant women (No ramp for wheelchair) ❖ No breastfeeding corner	❖ No separate toilet for female ❖ No special arrangement for elderly/ disabled/ pregnant women (No ramps for wheelchair) ❖ No breastfeeding corner

Ward level facilities (Community clinics)

At community level, Inatnagar, Sadarpur and Baliaghat community clinic in Dakhsin Sunamganj upazila was visited and observed during the study. It has well-connected roads but is a bit away from the main road and located at the eastern side of the union. According to the CHCP of the facility, the scarcity of the drugs and medicines was deemed as the main challenge in service delivery. None of the health care providers we interviewed received any training on gender issues. Almost all of them also did not receive refresher training during their service period.

Key Findings from Facility Observation: Community Clinics

Domains	Tahirpur	Dakhshin Sunamganj
Availability of commodities and logistics	**Kalibari:** Shortage of functioning equipment (i.e. glucometer) **Dakkhin Southkhali:** Shortage of functioning equipment	**Sadarpur:** Shortage of functioning equipment (No thermometer, weighing scale, glucometer, birthing table) **Inatnagar:** Shortage of functioning equipment (No thermometer, glucometer, birthing table)
Availability of human resources	❖ Very short foundation training of the CHCP ❖ Lack of refresher training **Kalibari:** FWV (Female) is on attachment from another CC, therefore only present there 3 days a week. **Dakkhin Southkhali**: Single provider (CHCP)	❖ Single provider ❖ Very short foundation training of the CHCP ❖ Lack of refresher training
Geographical accessibility to service delivery points	**Kalibari:** Remote location, broken roads and not well-connected to the facility **Dakkhin Southkhali**: Inconvenient communication; motorbike is the main source of transport due to road conditions	❖ In general, the facilities have connecting roads, but they are a bit away from the main road and some facilities are difficult to access by road during rainy season.
Basic amenities And environment	**Kalibari:** ❖ No special arrangement for elderly/ disabled (No wheelchair) ❖ Delivery room present, but no separate breastfeeding corner ❖ No separate waiting room or washroom facility for women **Baliaghat, Uttar Sreepur:** ❖ Ramp present, but no wheelchair facility for elderly/ disabled	**Sadarpur:** ❖ Complete normal delivery service not available ❖ No special arrangement for elderly/ disabled ❖ No power supply (solar panel stolen) ❖ Water supply: 1 tube-well, but out of order ❖ No drinking water facility for the patients **Inatnagar:** (Findings are same as Sadarpur) ❖ Not located near the main road ❖ Inconvenient communication

Baliaghat CC was found to be the only health care facility in Dakshin Sunamganj which has a ramp for disabled, but did not have any wheel chair facility. The CHCP's suggestion were regarding issues such as increasing the supply of drugs, employing volunteers for counselling of patients, and repairment and expansion of the existing building.

In Tahirpuir, Kalibari, Dakhshin Southkhali and Baliaghat CC were visited. Most of these facilities have remote and inconvenient location and connecting roads were broken and hard-to-reach. There was severe lack of manpower and the CHCP stated that they were often overburdened with tasks due to lack of supporting staff at the facilities.

3.4.2 Findings from High-performing Division

Health facilities which were visited in Rampal included the UHC, one UHFWC and two CCs. Detailed facility observation and KII with the healthcare providers at these facilities were conducted during the visit.

Upazila Level Facilities

At Rampal UHC, the residential medical officer was in charge of the facility at the time of the visit by the field research team. There is currently a 19-bed hospital at the UHC. There is an old 31-bed hospital which has now been declared abandoned and found to be in unusable condition during the visit. The UHFPO stated that they have good political, administrative and community support from the authorities. But there is a general lack of awareness of people about available health and family planning services. He also mentioned that there is underutilization of PNC services owing to lack of family support and general awareness among the women in the area.

In Sharankhola, the 50 bedded UHC was also being visited. Contrary to Rampal, here the service providers talked about inadequate political support and often undue

influence of some local politicians and reporters affecting the service delivery in the public facilities.

Below a summary of the key findings from the facility observation from both the UHCs is provided.

Key Findings from Facility Observation: Upazila Health Complex		
Domains	**Rampal**	**Sharankhola**
Availability of commodities and logistics	❖ Adequate supply of drugs (80-85% coverage, including antibiotics such as Ceftriaxone); but shortage of vaccine present ❖ Ambulance service available, but in worn-out state ❖ Lack of x-ray, USG and ECG facilities, anaesthesia and surgical instruments (e.g. sucker machine) at OT ❖ Space constraints for providing special support for marginalized groups, e.g. elderly or disabled health services	❖ Insufficient drugs (26 items instead of 29 items) ❖ Worn-out ambulance ❖ Non-functional diagnostic and sterilization equipment (ECG, USG machine, Diathermy, Autoclave etc.) ❖ Unavailability of X-ray machine, anaesthesia machine, defibrillator, ventilator ❖ Non-functional logistics (desktop and laptop computer)
Availability of services	❖ Major surgical procedures (requiring G/A) not done ❖ Inadequate capacity for mass casualties, RTA and industrial injuries ❖ Unavailability of certain diagnostic facilities, e.g. x-ray, ECG etc. ❖ Separate ANC and IMCI services available with female service provider ❖ Caesarean section facility available, but no female gynaecologist	❖ Inadequate staff ❖ Empty consultant posts (Surgeon, gynaecologist, anesthesiologist) since 1991 (year of establishment) ❖ No female doctor ❖ Shortage of support staff (medical technologists, pharmacist, aya) ❖ Lack of ancillary staff (cleaner) ❖ No gender training
Availability of Human Resources	❖ Inadequate staff ❖ Shortage of consultant doctors (Pediatrician, Gynecologist, medicine) and medical officers ❖ No female consultants/medical officers ❖ Shortage of support staff (medical and lab technologists, pharmacist, aya, ward boy) ❖ Lack of ancillary staff (cook, security guard, MLSS) ❖ No gender training	❖ No operation facilities due to lack of consultant surgeon and anaesthesiologist ❖ No C-section due to lack of Gynaecologist and anesthesiologist pair ❖ Services cannot be provided 24*7 ❖ No diagnostic test facility ❖ Separate ANC and IMCI services available with female service provider ❖ Telemedicine services available
Geographical accessibility to service delivery points	❖ Good accessibility by road during dry season; difficult during rainy season ❖ 6 out of 10 unions are more than 10 km away	❖ Geographically disaster-prone area (hugely affected by SIDR, Aila) ❖ UHC not located at the center of the Upazila

		❖ Long travel time (presence of river bodies) ❖ Limited mobility after sunset
Basic Amenities and environment	❖ 31 bedded old hospital building declared 'abandoned'; currently the 19-bedded annexe building is functioning as the main hospital ❖ Toilets were unclean during the time of visit ❖ No separate waiting rooms for men and women, ❖ No special arrangement for elderly/transgender; Services for disabled persons are provided at RMO's chamber ❖ Privacy of patient could not be maintained due to overcrowding	❖ Geographically disaster-prone area (hugely affected by SIDR, Aila) ❖ UHC not located at the center of the Upazila ❖ Long travel time (presence of river bodies) ❖ Limited mobility after sunset

Union-level facilities

During the visit to Baintola UHFWC in Rampal, several problems were encountered in terms of the available facilities in terms of both human and physical resources. The providers (both SACMO and FWV) mentioned that vacancy of the 'Aya' post resulted in poor cleanliness of the facility. Both of them mentioned inadequacy of drugs and functional equipment as well as no mechanism for maintaining queue, resulting in lack of privacy of the patients as the main challenges while providing health care to the people. They also reported not receiving any specific gender training during the period of their service. Notably, compared to the low-performing division's union-level facilities, here the shortage of medicine was not severe, according to the healthcare providers in charge.

In Sharankhola, Southkhali UHFWC and Tafalbari USC are located at the same building and provide service with collaboration. Sanctioned posts are for one UHFWC and the post of SACMO and 'Aya' were filled up during the study. The transportation to the facility gets harder during the rainy season as mentioned by the patients as well as the providers. Drug inadequacy and lack of functional equipment were the main barriers in providing health care as described by both the SACMO and FPI. But the providers mentioned giving priority to the elderly and disabled while rendering services. Waiting room facility was satisfactory with a fan, but provision of pure drinking water was not found. There was a delivery room, but it did not have the necessary equipment for providing normal delivery services.

Additionally, absence (due to vacancy) of MLSS results in lack of maintaining the queue and privacy of the patients. As a result, the women and adolescent girls often hesitate to share their problems with the SACMO in the presence of other patients in the same room. SACMO recommended to ensure proper human workforce, adequate drug supply and functional equipment for the betterment of health care. Same situation prevails in Dhanshagor UHFWC too. Only the SACMO and the security guard were posted in the facility during the time of the visit. It also suffers from inadequacy of drugs and functional equipment, as well as lack of human workforce. SACMO recommended to ensure proper human workforce, adequate drug supply and functional equipment for the betterment of health care in that facility. Both the SACMOs did not receive any gender training during their service period.

Key Findings from Facility Observation: UHFWC/USC/MCWC		
Domains	**Rampal**	**Sharankhola**
Availability of commodities, logistics and services	❖ Shortage of medicine was not severe ❖ Shortage of equipment like BP machine	❖ Shortage of drugs due to shortage of allocation ❖ Lack of sterilization equipment (autoclave) ❖ Shortage of dressing equipment ❖ Currently, no delivery services (NVD) available
Availability of human resources	❖ **Rampal sadar:** - One SACMO - One Pharmacist - Vacant post of MO - No MLSS, No Aya ❖ **Baintola:** - One SACMO, One FWV - One Aya (But on deputation to UHC), One MLSS	❖ **Tafalbari USC:** - one SACMO, no FWV - Lack of support staff (Pharmacist, MLSS) - Lack of ancillary stuff (Cleaner) ❖ **Dhansagar UHFWC:** - One SACMO, One night guard; No FWV - Shortage of support staff (Pharmacist, aya, cleaner) ❖ **Southkhall UHFWC:** - One SACMO, One aya - No pharmacist, No MLSS

Geographical accessibility to service delivery points	❖ **Baintola:** - Beside main road - Difficult to access for only one village (vudordanga) - Located at north-eastern side of the union - Remain under water in rainy season - No specific indication ❖ **Rampal sadar:** - Situated near the main road and well-connected to most of the adjacent areas; 3 minutes away from Rampal bus stand	❖ Roads leading to the sub-center is broken, narrow and difficult to access by motor vehicles ❖ Difficult to access during rainy season due to road conditions
Basic Amenities And Environment	❖ No special arrangement for elderly/disabled ❖ No separate sitting arrangement ❖ No fans in waiting area ❖ No separate toilet for female ❖ No ramp & wheelchair ❖ No ANC and PNC services were available at Rampal Sadar USC ❖ No proper signs and indication in and around the facility	❖ Inadequate patient privacy ❖ Queue system for patients is not in place due to lack of support staff ❖ No breastfeeding corner ❖ No special arrangement for elderly/ disabled/ pregnant women (No ramp or wheelchair) ❖ No water supply for the washroom, No separate washroom for female ❖ Current washroom needs urgent maintenance

Community Clinics

Both the Baruipara and Vaga CC were located a bit away from the main road but has well-connecting road and located at the middle of the union. Both the facilities did not have any special provision for elderly, disabled, women and adolescent girls, but the CHCPs mentioned that they personally provide priorities to the elderly and disabled. In the waiting room, there was separate sitting arrangement for the women. Both the facilities have a waiting room but with no fan and there was lack of pure drinking water supply too. Although Vaga CC had electricity, Baruipara CC did not. Both the CCs are well-staffed and there was no vacant position, except for the FWA in Baruipara. The CHCP of Vaga CC had no gender training, but the one from Baruipara had a one-day training on gender issues at UHC where she gathered knowledge about different ways of treating women and adolescent girls. The CHCPs recommended to repair the clinic

building and to ensure pure drinking water and electricity for improving the quality of health care services.

Dakshin Southkhali CC in Sharankhola was near the main road, but the connecting roads were not in suitable condition to travel. The facility had one CHCP and one HA oat the time of visit and the post of FWA was vacant. But, one FWA from another facility visited the facilities once every week which was inadequate compared to the need of the patients. There was no post for Aya or cleaner in the CC, which was the main reason for poor cleanliness of the facility. The CHCP received a short foundation training, but they reported receiving no refresher training or gender training afterwards.

The CHCP proposed to sanction a post for a cleaner in the CC considering the necessity. The facility did not have any water supply either. The providers also complained of inadequate drug supply and absence of functional equipment in the facility, which needs to be improved for better service delivery in their opinion.

A summary of the key findings from the facility observation in the CCs from Rampal and Sharankhola is given below.

Key Findings from Facility Observation: Community Clinic		
Domains	**Rampal**	**Sharankhola**
Availability of commodities and logistics	**Baruipara:** • Shortage of medicine **Vaga:** • No shortage of drugs • Available surgical kits, normal delivery kits, BP, weight machine	**Dakkhin Southkhali:** ❖ Shortage of drugs, especially metronidazole, amoxicillin and calcium; ❖ Lack of functioning equipment (i.e. weight machine, BP machine, glucometer) **Kalibari:** ❖ Shortage of drugs (Supplied drugs are usually out of stock within 20th of the month)

		❖ Lack of functioning equipment (i.e. weight machine, BP machine)
Availability of human resources	**Baruipara**: ▪ Female CHCP ▪ Vacant post of FWA ▪ A one-day gender training programme being conducted **Vaga:** • Lack of adequate refresher training • No gender related training • Female CHCP	**Dakkhin Southkhali**: ❖ one CHCP (female); one Health Assistant (female); ❖ one FWA (Female) is on attachment from another CC, therefore only present there only one day per week.
Geographical accessibility to service delivery points	**Baruipara:** • Beside main road • A tea stall is in front of the CC **Vaga:** • 200-300 meter away from main road • Convenient communication; Walking or van is the main source of transport due to road conditions • No specific sign or indication of CC	**Dakkhin Southkhali:** ❖ 700-800 meter from main road, connecting road is narrow and inconvenient **Kalibarii:** ❖ Very remote, inconvenient communication due to broken, muddy roads; Easybike or van is the main source of transport due to road conditions
Basic Amenities And Environment	❖ No special arrangement for elderly, disabled, transgender or adolescent ❖ No ramp or wheelchair ❖ No separate waiting room or washroom facility for women ❖ No provision of drinking water	❖ No special arrangement for elderly/ disabled (No ramp, No wheelchair) ❖ Delivery room present, but non-functional; no separate breastfeeding corner ❖ No separate waiting room or washroom facility for women ❖ Special arrangement for counselling of the adolescents

3.4.3 Findings from the Capital and High-performing Division

Upazila Level Facilities

Sreenagar Upazilla Health Complex in Munshiganj is a 50-bedded hospital and is not exactly located at the center of the Upazila. The facility's coverage area included 14 unions and 42 wards. The condition of the roads towards the facility were not very well-constructed, but had variety of transport methods to reach the facility. Absence of several specialists in sanctioned posts were pointed out as a major reason why patients prefer to go to private facilities in the area rather than the UHC. Shortage of doctors also resulted in increased workload for the remaining service providers in the facility. The providers stated that privacy of patient could not be maintained in the facility during treatment because of the patient overload. Moreover, the wealthier group of patients preferred to go to the capital city for their treatment due to its close proximity and available transport to and from the upazila.

The UHFPO reported having continuous monitoring from higher level and financial support from local wealthy donors. He also mentioned that local donations and welfare funds help with outsourcing of support staff. Although, he did express his concern about the ineffectiveness of the referral system (from CC to UHC, from UHC to district hospital) as a barrier towards providing quality healthcare.

Union-level facilities

At union level, Vaggakul USC was visited during the study which is located at the middle of a local bazar. It had proper signs and indication, but no distinctive boundary walls were present around the building. The roads through which the patients travel to the facility is severely broken and narrow, and in need of immediate repairment. The building had only one large room which was simultaneously used as the waiting room, drug storage room and provider's (SACMO) room. As a result, the facility was unable to ensure privacy of the patients. One medical officer is posted in this facility, but is on attachment at the UHC. Therefore, SACMO is the only health care provider in the facility. The posts of pharmacist and MLSS were also vacant. It was quite difficult for him to maintain the patient queue, deliver healthcare service, provide drugs, and ensure cleanliness all by himself only. The SACMO did not receive any training on gender issues.

The USC did not have any shortage of drugs, according to the SACMO, but it did have shortage of functional equipment (i.e. weight machine, autoclave/boiling machine etc.) in the facility. SACMO provided recommendations regarding infrastructural development of the USC, especially providing a boundary wall, and ensuring availability of human resources for the betterment of health care service delivery.

Community-level facilities

At the community level, Mandra Charipara CC was also visited during the study which is located in the Vaggakul union. There were no indicative signboards at the main road towards the facility, but the building had one signboard in the front. Lack of cleaner and aya in the CC resulted in poor cleanliness of the facility. The CHCP told us that he provided counselling to the women and adolescent based on their needs, and gave priority to the disabled and elderly from humanitarian perspective. All of the three provider posts (CHCP, FWA, HA) were filled in the CC at the time of visit. The CHCP got three months of basic training at the time of joining and later received refresher training of 15 days twice. But she did not receive any gender training. The CHCP discussed about the lack of functional equipment (e.g., weight machine, BP machine etc.) in the facility. She proposed either to train and motivate the CG and CSG or to abolish these groups and ensure maintenance and supervision of the CCs by the government. She also proposed to sanction posts for aya and security guard for each CC, as she believed that it would help in better maintenance of the facilities.

Overall, the healthcare providers talked about good political and community support in the upazila. But they feel that the lack of awareness of people about available health and family planning services (i.e. fishermen) resulted in their tendency to seek health care from pharmacy and private facilities in Munshiganj and Dhaka rather than the public facilities in the upazila.

The key facility observation findings from multiple healthcare facilities from the ward, union and upazila level healthcare facilities of Sreenagar upazila has been presented in the table below.

Key Findings from Facility Observation			
Domains	**Upazila Health Complex**	**Union-level facilities**	**Community Clinic**
Availability of commodities and logistics	❖ Ambulance service available ❖ Insufficient drugs, especially antibiotics ❖ Space constraints for providing special support for marginalized groups, e.g. no separate space for elderly or disabled health services	❖ No shortage of medicine reported in Vaggakkul USC; moderate shortage in Sreenagar ❖ Shortage of equipment were seen in both facilities	**Doyhata:** ❖ Near about 30% shortage of medicine ❖ No Glucometer and height machine **Mandra charipara:** ❖ Shortage of drugs, especially metronidazole, amoxicillin and calcium ❖ Lack of functioning equipment (i.e. weight machine, glucometer)
Availability of services	❖ Quality services cannot be provided 24*7 because of EMO shortage ❖ Diagnostic test facility is not functional sometimes ❖ Separate ANC and IMCI services available with female service provider ❖ Caesarean section facility available		
Availability of Human Resources	❖ Inadequate staff ❖ Shortage of consultant doctors and medical officers ❖ Shortage of support staff (medical technologists, pharmacist, aya, ticket counter	**Sreenagar:** ❖ One MO (But on deputation to UHC) ❖ No MLSS ❖ No female healthcare provider ❖ No gender training **Vaggakul:** ❖ One MBBS (On	**Doyhata:** ❖ No Health Assistant ❖ Male CHCP ❖ No gender training **Mandra charipara:** ❖ one CHCP (female); one Health Assistant

	attendant) ❖ Lack of ancillary staff (cleaner), electricians and junior mechanic.	deputation to UHC) ❖ One SACMO ❖ No Pharmacist, No MLSS, No Aya	(female), one FWA (Female)
Geographical accessibility to service delivery points	❖ UHC not located at the center of the Upazila but at the center of union	**Sreenagar:** ❖ Lack of proper indication at the entrance; difficult to access ❖ Located in market area, which creates a barrier for the vehicles to enter into the Centre **Vaggakul:** ❖ 700-800 meters from the main road; connecting roads are narrow and broken ❖ Roads leading to the sub-center is broken, narrow and difficult to access by motor vehicles ❖ Difficult to access during rainy season due to road conditions	**Doyhata:** ❖ 400-500 meters from main road; only accessible by foot. ❖ Located at higher ground which creates difficulty in access for pregnant mother, disabled and elderly people. ❖ Formally this CC is for ward 7, 8 and 9, but it is located near ward 3; Comparatively remote for the people of ward 7 and 8 **Mandra charipara:** ❖ Very remote, inconvenient communication; Walking or van is the main source of transport due to road conditions
Basic Amenities And Environment	❖ Toilets were unclean during the time of visit ❖ Separate waiting rooms for men and women; but space was not adequate ❖ No special arrangement for disabled/ elderly/transgender ❖ Ineffective adolescent corner ❖ Privacy of patient could not be maintained due to overcrowding	**Vaggakul:** ❖ No electricity ❖ Inadequate privacy of the patients, no separate sitting arrangement ❖ Only one toilet outside the building **Sreenagar:** ❖ No special arrangement for elderly/disabled ❖ No separate sitting arrangement ❖ No separate toilet for female	❖ No special arrangement for elderly/ disabled (No ramp, No wheelchair) ❖ No separate waiting room or washroom facility for women ❖ No breast-feeding corner

	❖ Proper sign and indication ❖ Separate breastfeeding corner	❖ No ramp & wheelchair ❖ One breast feeding corner for family planning wing	

3.4.4 Findings from CSO members (All three divisions)

Several CSO members (e.g. Union Parishad members, chairmen, school teachers, community leaders etc.) from all three divisions are included here. They provided an overall scenario on the healthcare seeking behaviour and health system barriers in their respective areas. They also provided some suggestions based on their personal observation on the existing issues in healthcare delivery and utilization in the divisions.

Usual healthcare seeking pattern

In general, there was not much regional variation regarding the healthcare seeking behaviour or the existing barriers in receiving healthcare according to their statement. In all the upazilas, people with limited financial means usually go to the nearest primary level government healthcare facilities or pharmacy vendors for their treatment. On the other hand, affluent patients prefer to go to private clinics or divisional level hospitals for their illnesses. In remote areas, people also depend on traditional healers, but the amount is comparatively low in their opinion.

'There is extremely unhygienic environment in washroom facilities, besides we face inadequate patient privacy during treatment'

-School Headmistress, Rampal

Perceived barriers and facilitating factors in receiving healthcare

One of the Union Parishad members from Sharankhola opined that despite having good indicators of health, there are a few

challenges in delivering proper health care in this area. The performances of the field level health workers are not up to the mark. Proper on the job training can significantly develop the performances.

According to a respondent from Tahirpur upazila, a lack of proper roads and transportation system hamper the process of delivering emergency healthcare and create major access barriers for the people in the area. According to him, appropriate diagnostic facilities are not available at the upazila level which results in further difficulties for the patients living in remote villages in the upazila.

Although, a school headmistress from Rampal talked about shortage of drugs and unavailability of necessary equipment for diagnostic facilities at upazila level, e.g. x-ray machine, ambulance, ultra-sonographer, ECG. Long waiting line and unclean environment in these facilities are amongst other problems in her opinion. These seems to be the common problems in all three divisions according to the CSO members.

Interrupted power supply and inadequate sitting arrangements in the hospital generates more sufferings for patients. A school teacher in Sreenagar complained that the specialist doctors are not available in the UHC throughout the week and they only come to the hospital 2-3 days per week. As a result, often patients come back from the UHC without receiving treatment and that is why many patients prefer to go to private clinics or chambers where they can receive prompt treatment.

Suggestions to reduce barriers

Improving the roads and communication system along with strengthening the diagnostic facilities can considerably improve the situation and attract more people towards using government health services. Increasing the capacity of the hospital in terms of number of beds, ambulance services and diagnostic test facilities are also required for the growing number of populations in the area. They also urged to increase the human resource and monitoring capabilities in govt. health facilities for better service delivery.

3.5 Findings from Consultative Workshops

As it is apparent from the findings of this study, although there are some significant differences between the high performing and low performing divisions in terms of financial status, transportation and availability of human resources, still some common bottlenecks in healthcare delivery system in all three divisions persist till this date. Financial hardship and ill-equipped government facilities have been discussed about the most as the barriers towards achieving desired healthcare for the marginalized and disadvantaged population, irrespective of their location.

Several consultative workshops were conducted in all three divisions in the presence of various stakeholders to discuss and validate the findings obtained from our field research activities. On April 23 and 24, 2019 two consultative workshops were being held in Dakhshin Sunamganj and Tahirpur upazila of Sylhet. The first workshop was held at Upazila Nirbahi Officer's (UNO) conference room and the second one at the UHFPO's office at the Upazila Health Complex. The workshop in Sreenagar, Mushiganj was held on May 15, 2019 at Upazila Nirbahi Officer's (UNO) conference room. The workshops in Khulna were held on June 16 and 17, 2019 at respective Upazila Nirbahi Officer's (UNO) conference room in Sharankhola and Rampal upazila.

All of the participants in these workshops agreed upon the findings obtained via primary data collection. Upon discussion, they provided important recommendations on how to overcome the existing supply and demand side bottlenecks within the health system and improve the health service delivery status, especially for the marginalized and disadvantaged population of the country. A summary of the key recommendations obtained from the consultation workshops is stated below.

3.5.1 General Recommendations from the consultation workshops

Healthcare facilities: Access and environment

- Establishment of proper signs and indications outside and within the facilities in order to keep them organized and help the patients to navigate through the facilities without confusion. For elderly, disabled and illiterate patients, assigned hospital staff should be in place for assistance.

- Additional staff employment is necessary in order to maintaining separate queues for men, women and people with special needs (elderly, disabled, transgender) and make the process organized and hassle-free for both patients and doctors.

- Sanctioning adequate budget for recruitment of cleaning staff at the government facilities in order to improve the cleanliness and hygiene of the facilities.

- Improvement of food quality for IPD patients should be ensured by the hospital and as well as administrative authorities in the upazilas.

- Connecting roads to the facilities need to be improved and adequate ambulance service should be in place for the convenient transport of the patients to the nearby facilities. Special transport mechanism for the elderly and disabled needs to be implemented as well.

- All old and non-functional facilities need urgent renovation and maintenance.

HRH (Human Resources for Health)

- Security of the healthcare facilities, its staff and the patients need to be insured by the government. Developing proper infrastructure and recruitment of adequate security staff are necessary to achieve that.

- Another major recommendation from this workshop was to create a post for a specialist doctor at upazila level for treating mental health problems. In fact, all healthcare providers in the primary level healthcare facilities should be provided with basic training on how to deal with mental health issues.

Medicine and diagnostics

- Adequate supply of essential drugs and diagnostic equipment is paramount for all levels of facilities. Drugs should be supplied on a need-based basis and areas with higher population density require additional supplies of drugs and equipment. Quality of drugs supplied in the government facilities are often found to be subpar, hence procurement system should be strengthened in order to prevent supply of low quality and expired drugs.

- It was also stated that the low quality of drug and equipment procurement occurs at the national level. He proposed to introduce local level procurement, at least to some significant portion of the whole procurement. UNO in that area supported this recommendation of introduction of local procurement. All of the participants in the workshop agreed upon the fact that the control over the procuring agency, transparency and proper monitoring are required for better quality procurement.

- Provision of full course of antibiotics for the patients need to be made mandatory. Otherwise, the patients will develop antibiotic resistance. Awareness on this issue should be established with utmost importance.

- Procurement of diagnostic equipment only is not enough. Most of the facilities had empty posts of pathologist, radiologist and such support staff. This situation needs to be changed. Qualified staff needs to be recruited in order to provide constant diagnostic test facilities to the patient.

- Filling up the consultant (gynae and obs.) posts along with an anaesthesiologist should be ensured at every upazila level healthcare facilities so that caesarean section deliveries can be conducted in the UHC.

- It was proposed to sanction at least 3 EMO posts at the UHCs, so that they can provide treatment on eight hours shifts basis, thus preventing work overload for the EMOs and ensuring continuous presence of the doctor in his post.

- Participants also suggested that the posting of native medical doctors and hospital staff at their respective districts or upazilas will minimize the issues of transfers and absenteeism from current workplace.

- It was suggested that shortage of support staff like cleaner, security guard etc. can locally be solved, if the union/upazila parishad provides a few of these staff from their management to the UHC/union level facilities.

Training and awareness building programs

- Mandatory gender training and refresher training should be arranged for the healthcare providers at every level of healthcare. Behavioral training curriculum should also be introduced in order to improve doctor-patient relationship. Special training and awareness programmes on disabled and transgender population should be introduced for the providers and hospital staff as well.

- Starting a calendar event for adolescent health education and awareness program, especially for female adolescents, was one of the major recommendations from this workshop. The taboos around pubertal issues need to be reduced, thereby allowing the adolescents the platform to get their necessary healthcare. Such initiative will require good coordination between the upazila education officer (both primary and secondary), upazila women affairs officer and UHFPO under the supervision of UNO.

- Participants from the social welfare officer recommended that awareness building program regarding health seeking behavior and health education can be conducted during VGF food cards distribution events. Another primary education officer proposed to introduce a nationwide formal health education program aimed at adolescent girls, such as- Vitamin A campaign, Vaccination program etc. He also proposed to introduce adolescent health club at the local schools for creating health awareness among them from an early age.

Intersectoral Co-ordination and Governance

- It was proposed to introduce bottom-up projection instead of top-down approach while allocating the resources for different tiers of health facilities. He believes this will result in better distribution of resources and help the facilities to maintain better quality of services.
- Co-ordination among different sectors from local and government bodies in the area is significant in improving the health system in the area.
- Participants from the administration stated that by including the community leaders actively in the policy making process and thus increasing awareness among the general mass about their rights of healthcare could act as an important facilitating factor for better performance in healthcare facilities and improve the health indicators of this area.
- Along with that, good governance and transparency of the authorities are necessary to maintain an efficient and effective healthcare delivery system in the area.

Others

- Consultants expressed concerns regarding the prescription of antibiotics by the CHCP, because according to regulations, antibiotics can only and must be prescribed by the registered medical doctors. There exists policy conflict regarding this issue, therefore the suggestion was that the CHCP should discourage the use of antibiotics without proper prescription from a registered medical doctor.
- Civil Surgeons made recommendations such as- ensuring presence of doctors at the facilities during duty hours, discouraging the mechanism of attachment to other facilities, introducing adolescent and disabled corner in each UHC, and weekly visit of MO to union sub-center to overlook the activities and report the status to UHFPO

in order to improve the absenteeism issues and overall quality of the healthcare services.

- Creating an emergency fund for the poor and helpless at the UHC was another common recommendation from the workshop. A committee will be formed to maintain this emergency fund in which the UHFPO, upazila chairman and the UNO may become the signatory. Upazila parishad as well as UNO office may allocate resources to this fund as well as via community mobilization, more funds can be added to this initiative. But necessity and transparency must be ensured during utilization of the fund.

3.5.2 Region-specific Recommendations

1. Dakhshin Sunamganj, Sylhet
The UHC in Dakhshin Sunamganj is under-construction for a longer period which makes it very difficult for the patients in the upazila to seek quality healthcare. Proper authorities should intervene in these matters and take prompt actions to make it functional as early as possible.

2. Tahirpur, Sylhet
The very poor roads and transportation system in the area poses a major barrier for the people to access healthcare. During rainy season, boats are the only mode of transport and during dry season, only motorbikes can access some villages. Moreover, the roads leading to the UHC in Tahirpur is so broken and narrow that it is highly difficult for large vehicles and ambulances to enter the premises. These difficulties need to be resolved on a priority basis, otherwise having a well-built UHC will not narrow down the access barriers for the patients and deprive the people from quality healthcare services.

3. Rampal, Khulna

The 31 bedded old hospital building has been declared 'abandoned and currently the 19-bedded annexe building is functioning as the main hospital of the UHC. This is not sufficient to fulfil the healthcare need of the people of the upazila and the UHC is unable to provide indoor services to many patients due to shortage of beds. Therefore, increasing the capacity and manpower of the UHC accordingly needs to be done as soon as possible.

4. Sharankhola, Khulna

Sharankhola has been officially excluded from the list of 'remote' upazilas and does not enjoy certain benefits that came with the entitlement. But the transportation and roads are still not well built and especially during rainy season, it becomes quite hard-to-reach for the people living in the peripheral areas of the upazila.

Also due to its location close to the mangrove forest, there are often animal attacks (e.g. snake, tigers) in the locality, especially after dark. Thereby, the mobility of the people become restricted after dark due to lack of safety. Moreover, they are still a disaster-prone zone due to their close proximity to the Bay of Bengal.

The financial status of the general people is below average and most of the vulnerable groups suffer from financial hardships. Considering the situation, such issues need to be brought into attention and necessary actions needed to be taken to resolve them by the government.

5. Sreenagar, Munshiganj

FWC in Baghra is being used as a police camp currently instead of a health facility which is hampering the healthcare delivery in the area. It needs to be renovated and make functional again.

Moreover, Munshiganj has a comparatively wealthier quintile of influential businessman and politicians. Many of them are willing to make donations for healthcare improvement of the population in the area. Making a committee to attract such donors and use their resources in a

planned manner for the development of health sector in the upazila in order to providing low cost (if possible, free of cost) healthcare to the marginalised population can be done.

4. Conclusion and Recommendations

Based on both quantitative and qualitative findings, it is clear that inequity in the health service utilization is pervasive. In addition, various marginalized groups are discriminated in getting services. Few alarming practices were also observed. For instance, an overwhelming majority of respondents sought healthcare from the pharmacies. Even though government is attempting to improve the health service delivery in the local level, it turns out that severe confidence crisis still persists. Timing of the service availability seems to be a significant barrier for service utilization especially the adolescents and working people find it difficult to manage time to visit facility since the facility timing collides with their school/work timing. Moreover, people who come from very distant and hard-to-reach areas, often cannot reach hospital within the hours of operation.

The study confirms some existing and known problem in the health sector—widespread human resource gap, male-distribution of existing resources and so on. The study includes the known limitations in the discussion since these existing well-known problems still remain as barriers to quality service provisions. These barriers need to be addressed first to improve the service. The study not only reconfirmed many old and existing problems in the health, more barriers pertaining to the specific marginalized group were also brought in the forefront. Here are a few glimpses of those:

- Transgender population face, as claimed by themselves, discrimination due to stereotype thinking of physicians. While they were agony, instead of being treated with dignity, often they experienced humiliation. This attitude often discourages them visiting formal providers. Rather they take care from the drug stores.
- Fisherman are reluctant to visit govt. facility because they perceive that they were not treated well and they perceive this is due to their low socio-economic status. Moreover, they think medicine will not be available, and the visit only for

consultation does not justify their visit.

- Adolescents are not comfortable in visiting the public facility due to the conflict between their class time and hospital operating hours.
- Elderly people often fail to avail the care because no one was there to take them to facility. This clearly demonstrates that only having a fully furnished and well stuffed hospital is not enough to ensure care for elderly
- Disable people face serious problem in accessing healthcare in each step.
- Finally, in many cases it is observed that gender dimension is of lesser issue as opposed to socio-economic conditions.

Based on the respondents' suggestions and upon consultation with the stakeholders, and based on the final consultative meeting, the current study provides some recommendations with regards to reducing access barrier in public health facilities, especially for vulnerable and marginalized groups of population.

4.1 Recommendation for health facilities and healthcare providers

- Improving the doctor-patient relationship and overall attitude of the facility staff towards the patients for better patient satisfaction and quality of service delivery. Almost all marginalized groups state that they did not receive a good behaviour from the providers. Providers should good training on the importance of good behaviour with patients.
- Outsourcing of support staff rather than internal appointment to solve the crisis of support staffs especially in a facility where a serious crisis of human resource remains.
- Local level procurement of medicines to ensure availability of adequate drugs in good quality and at a reasonable price for the patients.
- Creation of emergency fund with community support can be adopted to provide support especially the extremely poor, disable and elderly especially those who cannot afford healthcare otherwise.
- Appointing at least some healthcare providers to their native districts in order to tackle the issue of transfers and absenteeism can be tried as pilot basis.

- Making the facilities women, adolescent, elderly, disabled and transgender friendly in order to reduce the access barriers for these marginalised and vulnerable groups.
- Increasing the capacity of the facilities (both in terms of physical and human resources) based on the updated population growth.
- Strong monitoring and evaluation system for the government facilities to improve productivity, effectiveness and overall quality of the healthcare system.

4.2 Recommendation for specific groups (Marginalized/Disadvantaged)

Adolescent

- Ensuring after school hour availability of doctors. As an alternative, school health camp can be organized with periodic interval say each month or so.
- Awareness campaign targeting the adolescents and parents of adolescents to reduce the cultural barriers in receiving health services especially related to adolescence
- Over the phone consultation without physical presence can be allowed for certain cases

Poor women

- SSK type model can be implemented for poor women
- Discounted price for drugs can be charged for the poor women. Similar practice is observed for Surjer Hashi Network facilities. People women will get discount card and using this card they can purchase the drugs at a discounted price from designated stores.

Elderly people

- Over the phone consultation can be allowed in certain cases.

- If possible, ensure the transport facility for the elderly with the help of other government bodies such as department of social services, and through support from the emergency fund.

Disabled people

- Over the phone consultation can be allowed in certain cases.
- If possible, ensure the transport facility for the disable persons with the help of other government bodies such as department of social services, and through support from the emergency fund.

Transgender community

- Doctors need to have special gender training on transgender issue
- More public health and sociological and clinical psychological training can be organized for the physicians.

Fisherman community

- A satellite clinic facility should be made available for this group
- Strengthening community clinic might be useful

Homeless people

- Flexible office (hospital) hours might be useful or mobile camp can be practiced.
- Discounted price for drugs can be charged for the homeless people. Similar practice is observed for Surjer Hashi Network facilities. They will receive discount card and using this card they can purchase the drugs at a discounted price from designated stores.

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Annex

Table 1: Location, number and participants of FGDs		
Location	**Number**	**Participant Groups**
Dhaka Metropolitan area, Dhaka	3	Adolescent girls, Homeless/floating people, Transgender
Sreenagar, Munshiganj, Dhaka	5	Poor women, Adolescent girls, Elderlies, Fishermen, Disabled
Rampal, Bagerhat, Khulna	3	Poor women, Adolescent girls, Elderlies, Disabled
Shoronkhola, Bagerhat, Khulna	3	Poor women, Adolescent girls, Elderlies, Disabled
Tahirpur, Sunamganj, Sylhet	3	Poor women, Adolescent girls, Elderlies
Dakshin Sunamganj, Sylhet	3	Poor women, Adolescent girls, Elderlies
Total	20	

Table 2: Guide for Semi-Structured Key Informant Interviews

INSTRUCTIONS TO INTERVIEWERS

Important information about using this interview guide:

1. **This guide should be used with all national and sub-national-level partners (i.e. Health service managers from districts and civil society organizations).**
2. **ALL questions contained in this guide must be asked during the interview EXCEPT where stated otherwise.**
3. **Read this script before beginning the interview. Check the appropriate boxes below before proceeding.**

Thank you for your willingness to participate in an interview about Equity in Health with a special focus on Gender Inequities in Bangladesh. These questions are being asked as part of a learning exercise about barriers and facilitating factors to access across the continuum of care and their implications for access to services for the people. There are no right or wrong answers to these questions. Your name will not be linked to any information that you individually provide. This is not a test of your knowledge, if you do not know an answer to a specific question that is okay. You can skip any questions you want, and you can end our conversation at any time. I will take notes, and if it's okay with you, I would like to audio record, so I can focus more on our discussion and fill in my notes later. If you don't want me to record or want to stop the recording at any time, that is completely okay, just let me know. Do you have any questions before we get started?

Do I have your permission to begin this interview? O Yes O No
(THANK RESPONDENT & STOP HERE)
Do I have your permission to audio record? O Yes O No
(TURN OFF AUDIO RECORDER)

Interview being conducted at (check one):
O District Hospital
O Upazila Health Complex (UHC)
O Maternal and Child Welface Centre (MCWC)
O Union Health and Family Welfare Centre (UnHFWC)
O Union Sub-centre

O Community clinic
O Other:

Background information about the respondent:

- Name:
- Age:
- Designation:
- Educational Qualification:
- Years of job experience:

Capacity of health facility:

1. What are the health services available at your facility?
2. What considerations/ arrangements, if any, are in place for providing health services for the following group:
    i. Women
    ii. Adolescent girls
    iii. Disabled
    iv. Elderly people
    v. Third gender

3. Overview of HR capacity: [Ask for the HR list]

    a) How many staffs are sanctioned (expected) to work in this facility?
        i. Professional health care providers
        ii. Auxiliary staff
        iii. Ancillary staff
    b) How many are currently posted?
        i. Professional health care providers
        ii. Auxiliary staff
        iii. Ancillary staff
    c) How many are currently working? [Probe for full time and part time workers]
        i. Professional health care providers
        ii. Auxiliary staff
        iii. Ancillary staff

4. What, if any, gender trainings are provided at this facility?
    a. How often, if at all, are these trainings delivered? [Ask for training materials, documents, policy]
    b. Who, if anyone, participates in these trainings?

5. Overview of available medicine, logistic and equipment [Ask for inventory list]

6. What are your overall impressions of the health service utilization of your district/ upazila/ union?

7. What would you consider to have been the most important successes of health service delivery of your district/ upazila/ union, and why? [Probe for concrete examples.]

Supervision and monitoring:

8. How many external supervision (from upper level) on your services were done during last 6 months/ one year?
9. How well is the internal monitoring system working/functioning? [Probe: What is working well and why; what is not working well and why?]
10. How well is the grievance readdress mechanism functioning at this facility?

Challenges and opportunities:

11. What would you consider to be the three most difficult challenges that you encounter during health service provision? How did these affect service delivery? [Probe for concrete examples of barriers and challenges faced to service delivery.]

12. What would you consider to be the three main factors that have facilitated health service provision for you? [Probe for concrete examples of people, systems, environments, etc. that facilitate service delivery.]

Table 3: Checklist for IDI

Sl.	Questions
1.	Name:
2.	Age:
3.	Gender:
4.	Why have you visited this facility today?
5.	Where did you hear about this facility?
6.	Do you generally seek healthcare from this facility? a) Yes b) No
7.	How much time does it take to get to this facility from your residence?
8.	How much does it cost to get to this facility?
9.	Who are the health care providers in this facility?
10.	Is this the nearest health facility from your house? a) Yes b) No
11.	If the answer is 'No', why do you come there?
12.	If the answer to Question 10 is 'No', then why don't you seek care from the nearest health facility?

13.	If the answer to Question 10 is 'No', then what are the changes you would suggest that can make you go your nearest health facility?
14.	What type of care generally do you seek from this facility?
15.	Do you have to pay for the fees, drugs and laboratory tests here? How much? (Informal cost calculation)
16.	What are the problems you face in this facility? • Dignity • Confidentiality • Autonomy • Prompt attention • Clear communication • Access to social support networks • Quality basic amenities • Choice of health care provider • Treatment cost • Distance • Socio-cultural barriers
17.	What are the changes you would suggest to improve the perceived quality of care in this facility?
18.	Would you like to recommend this facility to your family members or acquaintances? a) Yes b) No
19.	If the answer is 'No', then why?
If the answer to Question no. 5 is 'No', then ask the following questions.	
20.	Where do you generally seek care in episodes of illness (major and minor)?
21.	How much time does it take to get to that facility from your residence?
22.	How much does it cost to get to that facility?
23.	What type of care are generally being provided in that facility?
24.	Who are the providers in that facility?
25.	Is that the nearest health facility from your house? If not, why do you go there?
26.	Any other remarks:

Table 4: Guidelines for FGDs

1. **Name of the Participant:**
2. **Age:**
3. **Gender:**
4. **Usual healthcare seeking practice:**

- **Place (Major/ minor illness)**
- **Mode of transport**

- **Travel time**
- **Waiting time**

5. **Problems in that facility:**

- **Dignity**
- **Confidentiality**
- **Autonomy**
- **Prompt attention**
- **Clear communication**
- **Access to social support networks**
- **Quality basic amenities**
- **Choice of health care provider**
- **Treatment cost**
- **Distance**
- **Informal costs**

6. **Where did you hear about the facility?**
7. **What are the changes you suggest to improve the perceived quality of care in this facility?**

<u>Focus Group Specific Guidelines:</u>

Adolescent Girls

- Puberty
- Mobility
- Vaccine
- General
- Gender of the doctor

Women

- Reproductive
- Family barrier (permission, financing, support etc)
- Mobility/ company
- Contraceptive
- Gender of the doctor

Disabled

- Access/ mobility
- Behaviour

Elderly

- Mobility/ company
- Family barrier
- Behaviour

Transgender

- Access
- Behaviour
- Gender of the doctor (barrier)

Homeless

- Access
- Behaviour