REPOPRT

ON

Promoting Sustainable Conducive Environment for Female Health Workforce for a Gender Equitable Health System

Gender, NGO and Stakeholder Participation Unit (GNSPU)
Health Economics Unit
Health Services Division
Ministry of Health and Family Welfare
14/2, Topkhana Road (3rd Floor), Dhaka-1000

Conducted By

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Package No. SP-09

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Conducted By
S.N Associates (SNA)

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The objective of the study is to unveil adoptable ways, potential challenges and measures to mitigate them in order to promote sustainable conducive working environment for female Health Work Forces. The specific objectives are: i) To identify the distribution pattern of female Health Work Forces across the Health Facilities, ii) To define factors influencing quality service delivery by female Health Work force, iii) To ascertain existing process of capacity enhancement and empowerment for female Health Wok force, iv) To prepare an evidence base for policy advocacy on future plans to encourage and retain female HWFs in hard to reach areas.

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ABBREVIATION

AHI	Assistant Health Inspector
ARI	Acute Respiratory Infection
BBS	Bangladesh Bureau Of Statistics
CC	Community Clinic
CHCP	Community Health Care Provider
CS	Civil Surgeon
DCS	Deputy Civil Surgeon
DDFP	Deputy Director Family Planning
DGHS	Directorate General of Health Services
DGNM	Directorate General of Nursing and Midwifery
DH	District Hospitals
EOC	Emergency Obstetric Care
FGD	Focus Group Discussion
FWA	Family Welfare Assistant
FWV	Female Welfare Visitor
GII	Gender Inequality Index
GNSPU	Gender, NGO and Stakeholder Participation Unit
HA	Health Assistant
HI	Health Inspector
HPNSP	Health, Nutrition and Population Sector Program
HWFs	Health Workforce
KII	Key Informants Interview
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
QCO	Quality Control Officers
SACMO	Sub-Assistant Community Medical Officer
SDGs	Sustainable Development Goals
UH&FWC	Union Health & Family Welfare Center
UHC	Upazila Health Complex
UN	United Nations
UNDP	United Nations Development Program
WHO	World Health Organization

EXECUTIVE SUMMARY

In Bangladesh, growing demand for health care services put enormous pressure on health workforces. Human resources for health experts have noted that gender imbalances are a major challenge for quality health services. The gender inequality operates multifaceted ways through the health workforces, encompassing constructs and discrimination. Again, gender balance in workplaces is essential for gender sensitive dealings with female patients. The health workforces' ratio is yet to be equitable for both men and women. An assessment of suitable and sustainable gender balance among health workforces are essential to create an equitable health system. The objective of the study is i) to identify the distribution pattern of female health work forces across the health facilities; to define factors influencing quality service delivery by female health work force; to ascertain existing process of capacity enhancement and empowerment for female health work force.

Both qualitative and quantitative information were collected to meet the objective of the study. The quantitative investigation was conducted by female health workforces in-depth interview at facility level. The study was carried out in randomly selected twelve upazilas of six divisions. Total numbers of one hundred sixty six female health workforces (one hundred forty nine non-physicians and seventeen physicians) were interviewed. For qualitative information fifty seven Key Informants Interview (KIIs), twelve Focus Group Discussion (FGDs) were conducted and thirteen facilities were physically investigated for qualitative information.

The age of one-third of the female health workforces were near about above 45 years. Every one in five respondents was below 30 years of age. The female health workforces are working at current place on an average 10 years. The results revealed that overall, male and female participation in health work forces were 40% and 60% respectively. The female health workforces in non-doctors were 68% and in doctors were 33%. There was unequal distribution by gender in various career tracks (i.e., doctors and non-doctors). Male are dominating in managerial position such as Superintendent, Director, Civil Surgeon (CS), Deputy Director Family Planning (DD-FP), Deputy Civil Surgeon (DCS), Upazila Health & Family Planning Officer (UH&FPO) and Residential Medical Officer (RMO), while more men were in consultant and junior consultant (68%) and Medical Officer (MO) (61%). On the other hand, all health workforces are female in midwife, Family Welfare Assistant (FWA) and Family Welfare Visitor (FWV) (100%), and nursing[1] (89%) in Community Health Care Promoter (CHCP) (51%), while more men were employed in Health Inspector (HI) (92%), Assistant Health Inspector (AHI) (70%), Sub-Assistant Community Medical Officer (SACMO) (66%) and technician (84%).

The study identified factors such as the competency gaps of health workers, health worker views of their performance and perceived barriers or challenges, key determinants of health worker's working environment, and perceived level of support that regulatory bodies provide to health workers effect on their performance. Overwhelming majority of service providers both doctors and non-doctors reported having attended training. The high rates of attendance in training courses indicate that many health workers are receiving updates to their knowledge and skills. The main reason for not attending the training were the discrimination of the higher

[1] Staff Nurse and Brother

authorities, the female workers were pregnant respectively. Medical doctors have on an average 5 tasks while non-doctors have 7 with 2 non-assigned tasks. Four in ten got written recognition of their good performance and only few are benefitted financially.

Most of providers subjected to harass by verbal abuse, followed by mental torture. The health care provider also harasses by eve teasing, mental torture, and sexual abuse and discriminated by financial aid. Sixty percent providers have to provide service at night. Only 30% of them have accommodation to stay at night. Overall, 50% of the providers have separate toilet facility, 5% have prayer room and 13% have separate breastfeeding corner. Few of these are good condition. Those who have no separate room in the workplace, they used to accomplish this work in sharing doctors room, own home, going staff quarter nurses room, nearest house, in office room hanging on a curtain.

Almost 9 in 10 females providers have to fulfil financial and child rearing, care for parents, Father or mother in law. Qualitative investigations revealed that provider's relation with community is not satisfactory. Community people often threaten them if they do not get medicine. Many health workers do not report job discrimination or sexual harassment for fear of losing their jobs, being transferred, or being demoted. Majority of key actors ensured the equal participation of female worker. Problem of exclusions, restrictions or distinctions is made on the basis of pregnancy, childbirth, or related conditions.

The study identified some barriers that hinders the quality service delivery in health facility such as shortage of doctors and nurses in the hospital, Lack of midwife, separate toilet facility for female providers, shortage living room at night, changing dress, breastfeeding corner /room, lack of supporting staff (guard, ayah) and the influence of local leader and middle-man. In hard to reach area the situation is more deplorable. There is shortage of supplies. Many doctors and staff do not stay at the station. Due to shortage of supporting staff providers have to clean the bathroom and office room outside of their work. Most of the time they have to work more than 8 hours. In the haor area it is very difficult to navigate during the rainy season. The women threatened to walk at night. During the FGD, health workers realized that there was less agreement between their expected roles and the actual responsibilities they performed. Data explains that what is expected from health worker does not at least officially reflect their actual duties.

The findings confirm there are several important observations for quality service provision that can be made based upon the data collected as of this study. First, the health workers observed satisfaction were not at levels desired. Second, health workers reported having clear job expectations; however, fewer health workers reported having a written job description, finally, health workers are receiving supervision, yet the quality of the supervision received somewhat need to reviews. Doctors and nurse play key roles in ensuring that clients what is needed to provide high quality health care. Data indicates that doctors and nurse both need more support to be effective in their jobs. Several areas of concern emerged under the facility standard. These included shortages of health workers, inadequate support for training, insufficient supervision for workers, lack of written job descriptions, and a lack of infrastructure related facility for female health workers in health care system.

The perception of gender issues are: health training is not flexible with respect to family constraints; female clients do not want to be treated by male provider; some female provider left in male wards alone, especially at night, fear that male patients will attack them. Results add further evidence that equal opportunity for employment are constrained by gender in health system, including forms of discrimination based on pregnancy and family responsibilities, sexual harassment, and working position. Evidence of gender constraints shows the need to actively promote equal opportunity in health facility with respect to specific barriers to entry, performance, and retain female provider in health system. Along with the findings, a set of recommendations is given to improve the quality of service for health care providers are as follows.

Objective	Recommendations	Way Forward
To identify the distribution pattern of female health work forces across the Health Facilities	• Ensure equality and equity in recruitment and distribution of female health work forces across the all facilities. • Ensure 30% of female doctors • Ensure at least 30% female participation in decision making process	• Revise and implement the recruitment policies in health system for equal opportunity in recruitment in health system • Develop guideline for deployment of female health work forces
To define factors influencing quality service delivery by female health workforces	• Ensure appropriate physical facilities for each and every health facilities (district hospital to community clinic) for female health workforces • Reduce family barriers and ensure quality of life (like-quality education for children of female health work forces, accompany with husband/ guardian of female health work forces, secured residence arrangement for female health work forces etc.) specially at Upazila level • Strengthen supportive supervision and monitoring to doctors and non-doctors • Ensure prevention of sexual harassment • During the night duty transport facility and rest room should be ensure for female health workforces. • Ensure safe road communication	• Renovation and extension of existing health facilities to align with more women friendly provisions • Enforcement of existing law of emphasizing education facilities for children of female health workforces • Enforcement and update of the supervision policy • Establish women friendly environment • A committee should be form for the prevention of violence against women. • Allocation more vehicles in each hospital specially upazilla level
To ascertain existing process of capacity enhancement and empowerment for female Health Wok force	• Increase training opportunities for 10% of female health workforce • Ensure advance or refresher training for all female providers. • Ensure female participation in all capacity development program • Ensure regular promotion and recognition of work	• Develop and update training plan for 10% of female health workforces. • Ensure develop relation between stakeholders and management committee.
Future plan for retain female health work force in hard to reach areas	• Proper transportation and road communication need to be develop in hard-to reach areas. • Provide incentive of those female workers doing better performance in the hard to reach areas. • Ensure housing and opportunity of education.	• Develop need based policy for transportation and road communication in hard to reach areas. • Increase housing and education facility • Develop special incentive for hard to reach areas for female health workforces. • System should be develop for promotion and recognition of work

Chapter 1
Introduction

1.1 Background:

Globally, there is a growing demand for health care with the growing population. The growing need for affordable and accessible health care services has increased the complexity of challenges we face in terms of the changing patterns of disease, natural disasters and climate change. There is a global shortage in the health and social workforce with non-uniform distribution in terms of geographical locations (e.g. urban and rural settings) and areas of specializations which make the situation worse (WHO 2018). Thus health systems are in a problem with the growing demand and the shortage of health work force. The lack of health workforce undermines the prospects of achieving health-related Sustainable Development Goals (SDGs). A shortfall of almost 18 million health workers is projected by 2030 primarily affecting low- and lower-middle income countries (Betron et al 2019). This projected global deficit, coupled with rising demand to create approximately 40 million to 67 million new health and social care jobs by 2030, uniquely positions the health and social sector to offer substantial and tangible opportunities for decent work, gender equity and greater women's labour participation. Bangladesh is no exception in this regard and it is one of the countries with 'severe shortages' of health workers (WHO 2006). Given the shortage of supply of qualified health care providers in Bangladesh, patients, especially the poor and the disadvantaged, mostly seek health care from the nonqualified providers in the informal sector (Ahmed et al 2011).No. of registered physicians per 10,000 populations is 6.33; no. of doctors working under DGHS per 10,000 populations is 1.28 and no. of nurse and midwife working under DGNM per 10,000 populations is 2.1 (DGHS 2018, DGNM 2018).

Today, when women constitute about half of medical students in several Western societies, statistics still show that women physicians are underrepresented in high-status specialties like surgery and clustered in specialties characterized by relatively low earnings or Prestige (Diderichsen et al. 2013) Women make up the vast majority of those working in the field of global health; however, they are underrepresented within top institutions, in global policy and governance forums, in thought leadership panels, and across decision-making structures in the public and private sectors (Dhatt et al 2017). Gender biases and inequities persist for women in the health and social care workforce around the world. Recently, global health and workforce strategies are recognizing the critical importance of addressing the gender challenges of the health and social workforce as key to achieving the SDG target of Universal Health Coverage by 2030, and maximizing women's economic empowerment and participation (WHO 2018).Stagnating rates of women's labour participation are deplorable; however, the health and social sectors offer a solution, as women's participation in these sectors is higher than in any other sector.Women comprise 70% of health workers and contribute US$3 trillion annually to global health care, half of which is in the form of unpaid care work (Langer et al 2015).

The challenges to gender-transformative change in the health workforce can be traced to women's relative absence from decision making and leadership positions. Progress on gender parity in leadership varies by country and sector, but generally men hold the majority of senior roles in health from global to community level. Global health is predominantly led by men: 69% of global health organizations are headed by men, and 80% of board chairs are men. Health systems were stronger when the women who deliver them have an equal say in the design of national health plans, policies and systems. Female representation in decision making positions remains low, with the most recent review indicating that only 25% of global health Organizations have gender parity at senior management levels, and 20% of organizations have gender parity in their governing bodies. The absence of gender parity in health-care leadership

is not due to lack of interest, difference in career commitment, or years of education; it is due to systemic gender bias, scarcity of opportunity for advancement, and a glass ceiling that exists within health care just as in others actors (Newman 2014).

The growing demand for health care services globally put enormous pressure on healthcare providers. Health policy researchers identified a close correlation between the concentration of qualified health workers (doctors, nurses, dentists and midwives together) and key health outcomes (Ahmed et al 2011). According to Bangladesh Medical and Dental Council, between 2006 and 2018, there were 25,739 registered male doctors (47 percent) and 28,425 female doctors (53 percent) in the country (Palma 2019). Over recent years, international health policy experts continued to reiterate the potential advantages of investing in human resources for health as the critical determining factor for the health of the population besides other socioeconomic, behavioural and environmental factors.

Human resources for health experts have noted that health workforce gender imbalances are a major challenge for health policymakers (Zurn et al 2004).The gender inequality is in multifaceted ways as it operates in and through the health workforce, encompassing constructs such as gender equity, equality, differentials, gaps, imbalance, parity, bias, skewness, and discrimination. There appears to be no unified, holistic conceptual understanding to frame significant gender inequalities as they operate in the health workforce and examine possible workforce and health systems consequences. Women participation in labour force is low in Bangladesh (BBS 2019). 36% females are in labour force compare to men (81%).Proportion of women in managerial positions is 12.9% (BBS 2019). Rank of Bangladesh on UN Gender Inequality Index (GII) is 135 (UNDP 2019).

1.2 Objectives of the Study:

This study aims to unveil adoptable ways, potential challenges and measures to mitigate them in order to promote sustainable conducive working environment for female health work force. The study is also expected to explore modalities of resource distribution across the hierarchy in order to enable female health work force to achieve high moral esteem to deliver quality health care. The specific objectives of the study are:

1. To identify the distribution pattern of female health work forces across the health facilities
2. To define factors influencing quality service delivery by female health work force
3. To ascertain existing process of capacity enhancement and empowerment for female health work force
4. To prepare an evidence base for policy advocacy on future plans to encourage and retain female health workforce in hard to reach areas

1.3 Rationale:

Bangladesh suffers from a critical shortage of health workforce compare to WHO criteria (fewer than 23 physicians, nurses and midwives per 10000 populations). The Nurse-midwives: Doctor Ratio in Bangladesh is among the lowest group in the world. It is also noteworthy that one-fifth of the registered doctors produced by the country are not on the health workforce of Bangladesh. Given the acute shortage of doctors and the fact that most of these doctors were products of public institutions the situation requires suitable remedial measures. The 2011 National Health Policy suggested the formulation of a health work force (HWF) strategy that mitigates the current skill mix imbalance and the lack of incentives in order to address

shortages and uneven distribution of health workers. In late 2014, in preparation of the HWF strategy, the Ministry of Health & Family Welfare (MoHFW) sought perspectives from a range of stakeholders (MoHFW 2008).

To address the issue, Ministry of Health and Family Welfare (MOHFW) Bangladesh developed and finalized the country's Health Workforce Strategy in 2015. It emphasis to create and maintain a conducive working atmosphere to enable HWFs deliver their best. The MoHFW, being the largest employer of female workforce in the country, continues to encounter the challenge of retaining HWFs especially doctors and nurses in rural hard-to-reach areas. Distributions of health workforce (nurse-midwives and doctors) are greatly varied among geographic locations. Dhaka district has shared only 8% of all pregnancies in Bangladesh, but among the service providers 31% of the nurse-midwives and 37% of doctors (including general practitioners and specialists) are in Dhaka (Chilvers 2014).

Again, gender balance in workplaces is essential for gender sensitive dealings with female patients. The MoHFW still lacks a written code of conduct to avoid workplace harassment. The DGHS health workforce ratio is yet to be equitable for both men and women. A suitable and sustainable gender balance among HWFs is essential to create an equitable health system.

MoHFW has established Gender, NGO and Stakeholder Participation Unit (GNSPU) to represent and oversee implementation of gender main streaming activities in HPNSP sector. In close adherence with its mandate, the GNSPU intends to undertake the study aiming at unveiling adoptable ways, potential challenges and measures to mitigate them in order to promote sustainable conducive working environment for female HWFs. The study is also expected to explore modalities of resource distribution across the hierarchy in order to enable female HWFs to achieve high moral esteem to deliver quality health care.

Several studies have been conducted globally on gender and workforce structure, gender and wages, work place safety and quality of life among health workers (Zurn et al 2004; George 2007; Vecchio et al 2013; Deussom et al 2012; Kheiraoui et al 2012). Gender and human resource for health (HRH) experts have argued for more research and sex-disaggregated data to strengthen understanding of gender equality in developing countries (George 2007; Gupta & Alfano 2011; Reichenbach 2007). The lack of comprehensive, nationally representative high-quality data on HRH in the formal and informal sectors in Bangladesh. This may be a reason for limited attention to gender discrimination on the part of HRH stakeholders (13).

The findings of this study will help to improve institutional HRH governance by equalizing opportunity and promoting gender equality in health care providers and their workplace. This study entails developing workplace policies, adapt action policies to health worker recruitment and promotion, raise awareness of gender discriminations such as sexual harassment and eve teasing in the health workforce through training; formulate policies retaining HWF in hard-to-reach area in the country.

Chapter 2
Methodology

2.1 Study Design:

The study was a cross-sectional survey. Both qualitative and quantitative information were collected to meet the objective of the study. The quantitative investigation was female service provider's in-depth interview at facility level (face to face) and in qualitative approach, Literature review; Observation, Key Informants Interview (KII) and Focus Group Discussion (FGD) were done in the facility and administrative level to collect relevant information.

2.2 Study Area and Population:

The study covered six administrative divisions (Chattogram, Dhaka, Khulna, Mymensingh, Rajshahi and Sylhet). To meet the objectives, the study gathered information from two types of population- service providers (Female) and health care manager or stakeholders. A workshop for the validation of methodology was conducted at HEU on February 2020. In this workshop the sample divisions were selected for this study based on the high (Dhaka, Khulna and Rajshahi) and low (Chattogram, Mymensingh and Sylhet) performing areas. Moreover, the workshop participants finalized the following study respondents.

1. Service provider: Female health workforce Consultant, Residential Medical Officer (RMO), Medical Officer (MO), Sub Assistant Community Medical Officer (SACMO), Health Inspector (HI), Assistant Health Inspector (AHI), Family Welfare Visitor (FWV), Family Planning Inspector (FPI), Senior Staff Nurse, Nurse, Midwife, Community Health Care Promoter (CHCP), Health Assistant (HA) and Family Welfare Assistant (FWA).

2. Health Care Managers, policy makers and Stakeholders Civil Surgeon (CS), Deputy Civil Surgeon (DCS), Deputy Director Family Planning (DDFP), Upazila Health & Family Planning Officer (UH&FPO), Upazila Family Planning Officer (UFPO), Upazila Parishad Chairman, Upazila Parishad Vice Chairman, Union Parishad Chairman, Female Union Parishad Member)

2.3 Quantitative investigations:

Sample design and sample size: For collecting the quantitative information, service providers interview were conducted. A purposive sample of female health workforce was selected for the study. The study addresses district and below level public health facilities such as:

- District Hospitals (DHs),
- Upazila Health Complexes (UHCs)
- Union Health & Family Welfare Center (UH&FWC)
- Community Clinic (CC)

In the study coverage, six districts (Narsingdi, Khagrachari, Netrokona, Hobiganj, Chuadanga, Chapai Nawabganj) were taken from six divisions. From each of the district two upazilas were purposively taken. So, a total of twelve upazilas were under the study. From the selected district, one District Hospitals (DHs), two Upazila Health Complexes (UHCs), two Union Health & Family Welfare Centers (UH&FWCs) and two Community Clinics (CCs) were purposively selected. To meet the objectives of study, one hundred sixty six service providers

were interviewed. Information were collected from Consultant, Residential Medical Officer (RMO), Medical Officer (MO), Sub Assistant Community Medical Officer (SACMO), Health Inspector (HI), Assistant Health Inspector (AHI), Family Welfare Visitor (FWV), Family Planning Inspector (FPI), Senior Staff Nurse, Nurse, Midwife, Community Health Care Promoter (CHCP), Health Assistant (HA) and Family Welfare Assistant (FWA). In the study out of one hundred sixty six sample providers (one hundred forty nine non-physicians and seventeen physicians) were interviewed. In all the facilities, a purposive selection procedure followed based on availability of providers present at the study period (Annex I, Table 1).

2.4 Qualitative investigations:

2.4.1 Desk Review/Documents review:

Reviewing major study/research available in Bangladesh, relevant documents and literature etc.

2.4.2 Key Informants Interview (KII):

To attain the objective of the study, fifty seven Key Informants Interview (KII) were conducted. KIIs were conducted with Civil Surgeon (CS), Deputy Civil Surgeon (DCS), Deputy Director Family Planning (DD-FP), Female Union Parishad Member, Upazila Health & Family Planning Officer (UH&FPO), Upazila Family Planning Officer (UFPO), Union Parishad Chairman, Upazila Parishad Chairman and Upazila Parishad Vice Chairman. The list is given in Annex I, Table 2.

2.4.3 Focus Group Discussion (FGD):

Focus Group Discussion was arranged in each upazila. Total numbers of twelve Focused Group Discussions (FGD) were conducted in the study UHCs. These FGDs were conducted with service providers (Doctors/Nurse and midwife). Each FGD was conducted with 8 -10 female participants. The FGD participants were recruited whose were not in questionnaire interviewed.

2.4.4 Physical Observation through Checklist:

Thirteen facilities were physically verified through checklist. These are:

- Three District Hospitals
- Six Upazila Health Complexes
- Two Union Health & Family Welfare Centers
- Two Community Clinics.

2.5 Questionnaires, check-list and guideline:

Four types of different data collection instruments have been developed for the purpose of the study. These instruments are:

1. In-depth interview questionnaire for service provider (Semi structure)
2. Focus Group Discussions (FGD) guideline
3. Key Informant Interview (KII) questionnaire (Semi-structure)
4. Observation checklist for taking physical and personal facility for female health workforces

2.6 Pre-testing and Finalization of Questionnaires:

The pre-test of all the study questionnaires were conducted in Manikganj and Gazipur District out of sample District. The Pre-test was done by engaging experienced enumerators/ data collectors and supervisors whose were done pretest in the past. The GNSPU helped in the process. Moreover, senior members of the team were present in the initial days with the teams. For this purpose, the pre-experimental districts were selected in such a way that they could be coordinated between the survey headquarters and the survey teams by verifying daily experience and their work efficiency. Instruments/Tools were draft finalized for application through incorporating the necessary modifications identified from the pre-test. After consultation meeting with GNSPU and HEU the Instruments/Tools were finalized.

2.6.1 Recruitment of field staff:

Total numbers of twenty two field staffs were recruited for this study. All the field staffs were recruited from a list of qualified and experienced staffs whose were participated at least three studies of similar nature of S.N Associates and another agency. There are a large number of data collectors in associated with S.N Associates, whose are worked in different projects conducted by S.N Associates. Most of them have prior experience of such type of studies. They were given preference while selecting data collectors. The minimum qualification for data collectors were a graduation degree from a recognized university or institution. The qualified and experienced staffs were selected for smooth and quality data collection.

2.6 .2 Training for data collectors on the study instruments:

Five days (10.03.2020 to 14.03.2020) of extensive training including two days of field practice was conducted for the data collectors and supervisors. The timing of training was scheduled by 9 am to 5 pm with one hour launch break on each day of classroom training. Total numbers of twenty two persons were trained. The training was conducted S.N Associates training venue.

The training was imparted to the monitoring study team for clear understanding of the objectives of the monitoring, its importance for national program monitoring and also the extended use of the study data nationally and globally. The methodology of the training included lectures, group discussions, question-answer sessions, role play, demonstration and role play under the close supervision of resource person. During the classroom practice, each trainee was to fill questionnaire adopting mock interview technique where one would be a respondent and the other an interviewer and vice versa. Performance of each trainee was evaluated at the end of the training using appropriate checklist. Here mentioned that during the training period the Honorable Director General (DG) of HEU, Project Manager (PM), Deputy Project Manager (DPM) and Consultant of GNSPU visited the training program of data collectors and supervisors. They have input their valuable comments and suggestions of the study objectives.

2.6.3 Techniques of interviewing:

In each sample point the interviewer was identify health facilities, introduce him/herself to the respondents, explain the objectives of his/her visit, take inform consent, assure confidentiality and conduct the interview in a suitable environment. The interviewer was careful in asking each and every question for each and every respondent. Any difficulties encountered by the interviewer immediately communicated to the respective supervisors. After each interview

she/he carefully checked whether all questions were asked and responses to all applicable questions were properly recorded.

2.6.4 Techniques of supervision and quality control:

The supervision by the team supervisors were essential assignment distribution and task to the those members, ensure their safety and security, arrange for accommodation and transportation, assist in locating the sample of respondents of facilities, ensure random checking of some interviewed questionnaires, and resolve any problem arising during the course of the field work. The supervisors in the team were responsible for ensuring that the interviews have been done properly, non-responses are authentic. She/he was also assisted in dealing respondents whose were un will to participate in the study. in addition, he observed some interviews to assess their quality of work. She/he was compared the rate of non-responses among the interviewers, and also informed lack of integrity among team members. The supervisors and the data collectors were met with the team members in the evening to review their performances.

The Quality Control Officer (QCO) was deployed for quality control checking of the study data. The QCO was physically verified whether the interviewer completed the questioner by interviewing the right respondents in the exact health facilities by asking the question. The Quality control checking was undertaken in both presence and absence of the interviewing team. The QCO was directly observed the interviewer's work and immediately reviewed their data and discussed his/her observations with the interviewers. The QCO was also checked 5% of the reported non-response cases. He was compare re-interview data with the corresponding interviewed data. If any discrepancy found, the QCO was discussed them with the concerns interviewers and find out the reasons. For any problem identified during the time of interviewing, the QCO was act appropriately to stop the occurrence.

2.7 Data Processing and Computerization:

2.7.1 Collection and registration of completed questionnaires:

The completed questionnaires were collected from the field and brought to office in Dhaka on a weekly basis. After receiving the questionnaires from field, these were registered in the registration book.

2.7.2 Data Processing:

Data processing comprises documentation of schedules, editing, coding and computerization, generation of analytical tables, and matching of data. This is well accepted that editing of the collected raw data is a very important task for ensuring the data quality. During data processing editing of the instruments were ensured by the data management team. The completed questionnaire collected from the field and supplied to the data entry operator on a weekly basis for input the data in computer.

2.7.3 Data entry:

For efficient data entry process EPI data entry software were developed. After receiving the questionnaire completed during a phase, a tracking number was putted in the questionnaire and in the tracking register. Inconsistencies check was done between inter-related questions. In addition, single tables were generated for all variables for checking range, consistency and quality control of all variables of the data sets.

2.8 Data Analysis:

After accomplished of entry, editing and coding of the collected data were processed at S.N Associates office. Data analysis was done by applying SPSS in IBM/IBM compatible PC. The transcription of observation was also reviewed and managed at S.N. Associates Office. Finally tabulation was done according to the objectives of the study for preparation of report where, both the uni-variate and bi-variate tables were accomplished.

2.9 Coverage of sample:

Table 2.1 shows the results of Female Health Workforce's interviews. Interviews were successfully completed in one hundred sixty six through in-depth interview (IDI), or 95% of service providers. In the study fifty seven KII identified and 100% interviewed successfully.

Table 2.1 Number of in-depth interview and coverage rate

Target Interviews	Number of Target Samples	Sample Covered (%)
Service Providers	174	166 (95.4)
KII	57	57 (100.0)

Chapter 3

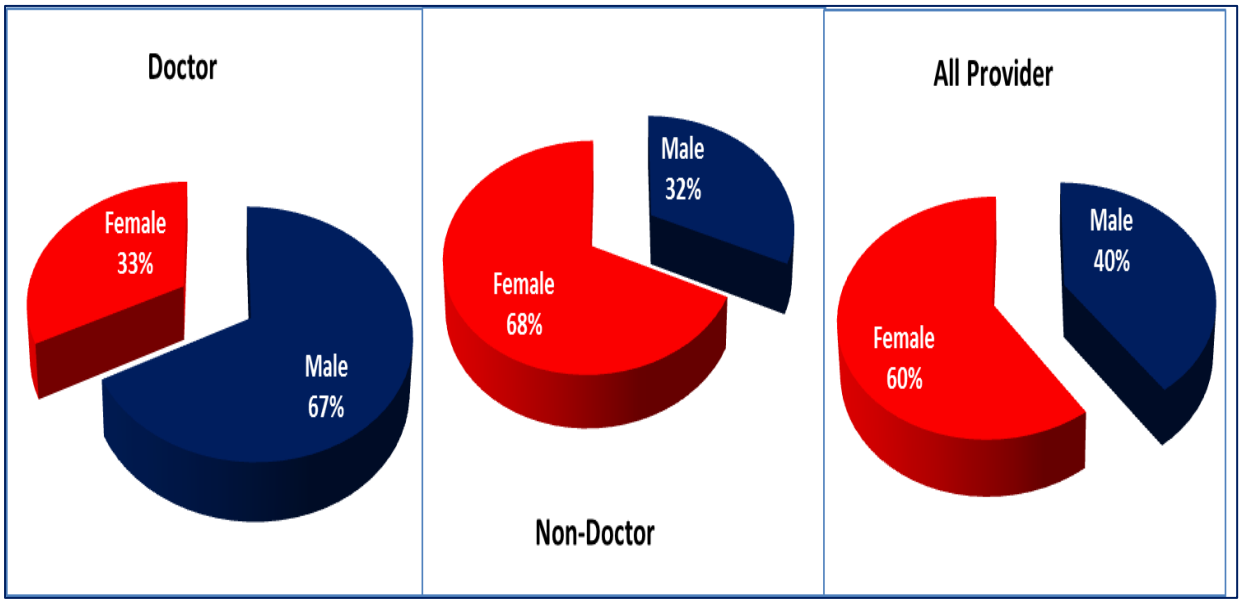
Pattern of female Health Work Forces Across the Health Facilities

In this chapter data were presented for gender segregated analysis. Information was collected from the survey respondents and from different sources of ministry of health and family welfare. The chapter also discussed the background characteristics of sampled female health workforces.

3.1 Female work force ratio in Health:

Figure 3.1 presents service providers by doctor and non-doctor and gender. It was seen from that at aggregate level, overall, male and female participation in health work forces were 40% and 60% respectively. The percentages of female health work force in non-doctors were 68% and doctors were 33%. According to DHIS 2, 47% of health work forces are female (Annex I, Table 3).

Figure 3.1 Percentage of men and women in the health workforce



3.2 Pattern of health workforce by job segregation:

The survey analysed the quantitative data to assess patterns of job segregation. There was unequal distribution by gender in various career tracks (i.e., doctor and non-doctor).Figure 3.2 shows the differences in the concentration of female and male doctors. It was observed that men are dominating in managerial position such as Superintendent, Director, Civil Surgeon (CS), Deputy Director Family Planning (DD-FP), Deputy Civil Surgeon (DCS), Upazila Health & Family Planning Officer (UH&FPO) and Residential Medical Officer (RMO), while more men were in consultant and junior consultant (68%) and Medical Officer (MO) (61%).

Figure 3.2: Percentage of male and female in doctor profession

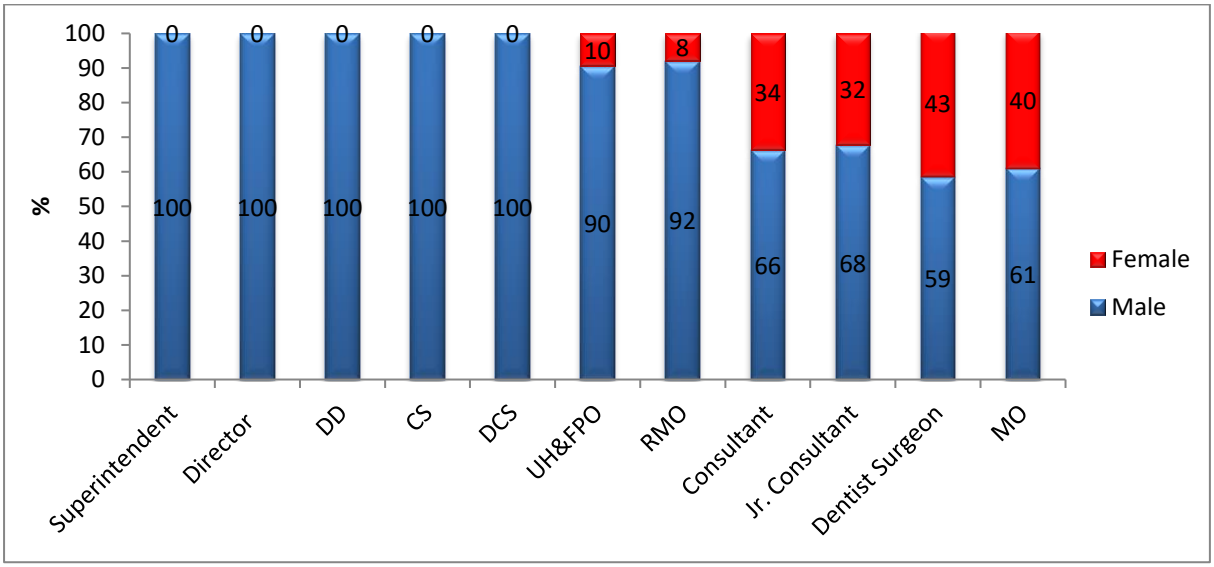
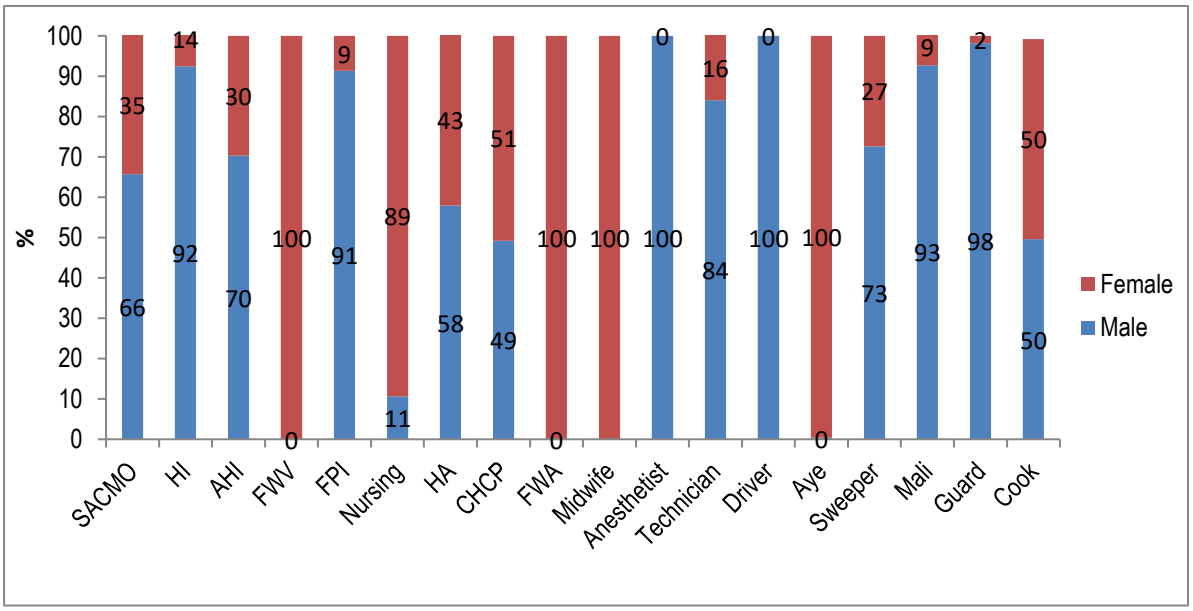


Figure 3.3 shows the differences in the concentration of female and male non-doctor position. There were almost all women were midwife, Family Welfare Assistant (FWA) and Family Welfare Visitor (FWV) (100%), and nursing[2] (89%) in CHCP (51%), while more men were employed in Health Inspector (HI) (92%), Assistant Health Inspector (AHI) (70%), Sub-Assistant Community Medical Officer (SACMO) (66%) and technician (84%). The data suggested that some professions were female profession with the most striking segregation appearing in the nursing, Family Welfare Visitor (FWV), Family Welfare Assistant (FWA) and midwifery occupations. Total number of 33062 workers are providing Clinical Services[3] of whose 2885 (9%) were male and 30,777[4] (91%) were female. The divisional variations in male-female ratio are given below (Figure 3.4).

Figure 3.3: Percentage of male and female in the Non-Doctor profession



[2] Staff Nurse and Brother
[3] Clinical Service refers to employees who are practicing nursing in the hospitals at different level.
[4]Human Resources Report 2018, Directorate General of Nursing and Midwifery (DGNM), MoHFW

Figure 3.4: Provider's distribution by division and sex

3.3 Percent distribution of sample Providers:

The study collected information from all level of service facilities. Table 3.1 shows that the number of respondent by division. Total numbers of one hundred sixty six female health workforces were selected for the study; among them 13% respondents were selected from Dhaka division. 19% percent were interviewed from Sylhet division. About 17% from Chattogram and Mymensingh division, 18% from Rajshahi division were selected. From Khulna 16% of respondents are selected.

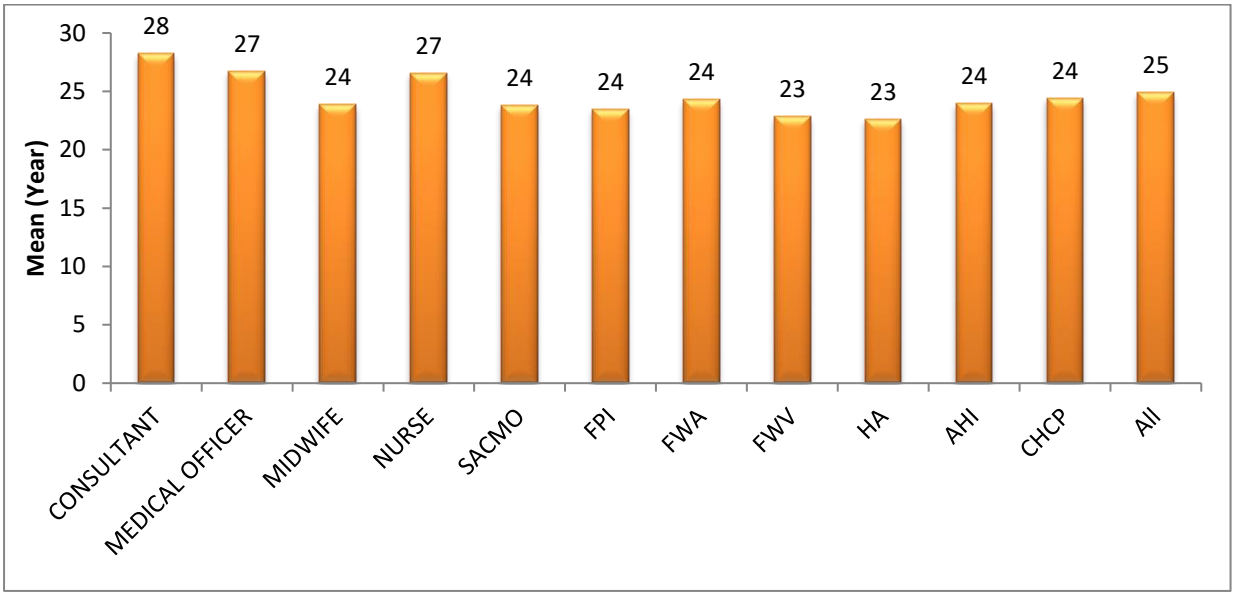
Table 3.1 Percent distribution of sample providers by division

Division	DH		UHC		UH&FWC		CC		Total	
	n	%	n	%	n	%	n	%	n	%
Dhaka	4	13.8	8	12.7	5	12.8	4	11.4	21	12.7
Chattogram	6	20.7	8	12.7	6	15.4	8	22.9	28	16.9
Mymensingh	3	10.3	13	20.6	7	17.9	5	14.3	28	16.9
Sylhet	5	17.2	10	15.9	10	25.6	7	20	32	19.3
Khulna	5	17.2	10	15.9	6	15.4	6	17.1	27	16.3
Rajshahi	6	20.7	14	22.2	5	12.8	5	14.3	30	18.1
Total	**29**	**100.0**	**63**	**100.0**	**39**	**100.0**	**35**	**100.0**	**166**	**100.0**

3.4 Characteristics of service providers:

The characteristics of the one hundred sixty six female health workforces were presented in Table 3.2 and Figure 3.5. About one-third of the female health workforces (34%) were above age 45 years. Every one in five respondents (22%) was below 30 years of age. The mean age of joining the job was 25 years.

Figure 3.5: The average (mean) age of joining the job



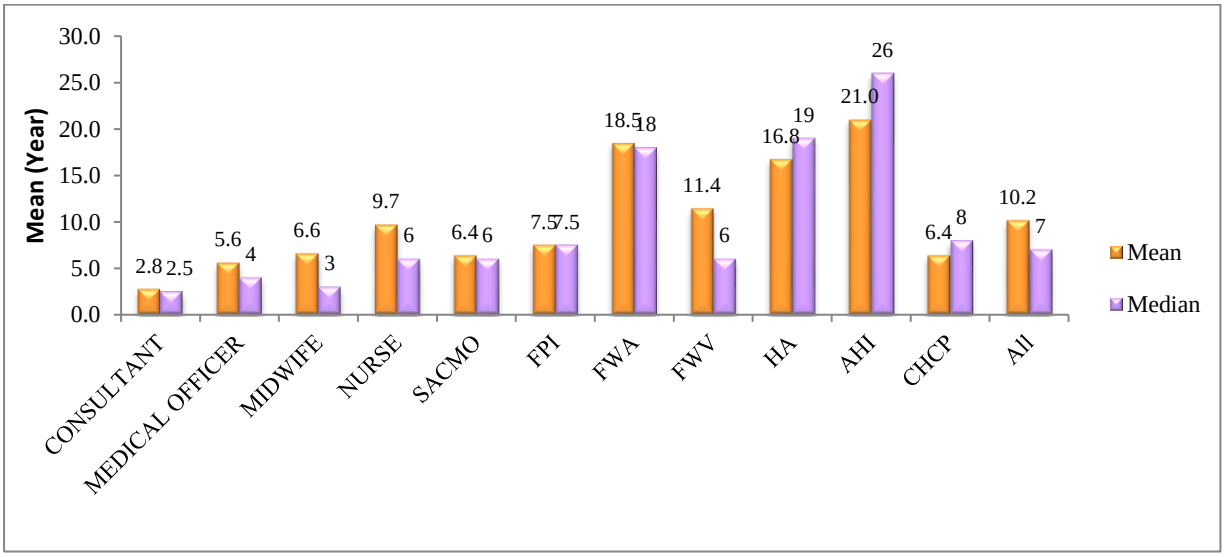
The mean and median age of the female health workforces were 39 and 38 respectively. Mean length of service in current position is about 12 years. The female health workforces were working at current place on an average 10 years. The result also shows that 27% female health workforces have been working same position for 20 years or more. About 20% of the respondents have been working current place more than 20 years.

Table 3.2 Characteristics of respondents

Characteristics of respondents	n=166	Percent
Age group (in year)		
<30	37	22.3
30-34	34	20.5
35-39	27	16.3
40-44	11	6.6
45-49	20	12.0
50-54	18	10.8
55-59	19	11.4
Mean±SD;39±10.5, median=38		
Duration of current position (in year)		
<10	93	58.1
10-19	24	15
20-29	25	15.6
>30	18	11.3
Mean±SD;12.5±10.4, Median=9		
Duration of service at current place (in year)		
<10	102	64.2
10-19	24	15.1
20-29	24	15.1
>30	9	5.7
Mean±SD; 10.2±9.3, median=7		
Total	**166**	**100.0**

The study collected data from female health workforces. For this sample of female health workforces, there was substantial variation in the reported average number of years worked within their current profession by job position. Figure 3.6 shows both the mean and median number of years worked in the current profession of health worker. Medical doctors, midwife, nurse, and Sub-Assistant Community Medical Officer (SACMO) have the shortest average (median) duration in health, three to six years. There are variations in the average number of years worked by non-doctors, the average number of years worked in their current health facility also varied by cadre for this sample of health workers. Assistant Health Inspector (AHI) and Health Assistant (HA) reported the highest average (median) time employed at their current health facility. Midwives, Nurses and Family Welfare Visitor (FWV) have been working, on average 7 years, 10 years and 11 years in their current facility, while the median time for these professions was about six and half years.

Figure 3.6: Average (Mean and median) Years Worked in Health (Current Profession) by Job position



Chapter 4

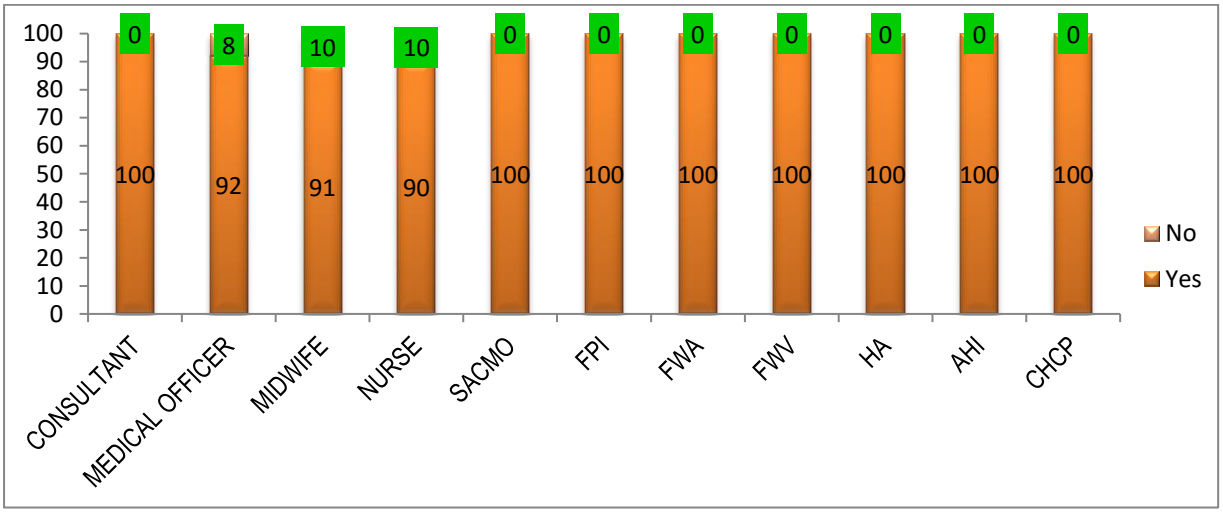
Factors Influencing Health Worker Performance

The study seeks to identify strengths and weaknesses in technical and overarching competencies of health workers across all targeted professionals involved with delivering the services at different levels of the health care system. The study identified some key research areas for achieving the objective such as the competency gaps of health workers at sample areas, health worker views of their performance and perceived barriers or challenges, key determinants of working environment, and perceived level of support that regulatory bodies provide to female health workforces.

4.1 Health Workers Competencies:

The health care providers need both general competencies as well as specific technical competencies in order to provide quality services. Health workforce technical competency is very important for capacity building. Training in service plays a vital role to inspire and energize workforce in their working sector. Training also helps in brainstorming and build-up confidence among the employees. Training was provided through operational plan performed by ministry of health and family welfare. There are two types of training organized for the health workforces in every year, one is in-service training arranged by locally and other is foreign training arranged by enlisted training consultant, national, international NGO's as planned. According to Directorate General of Health Services (DGHS) report 2018 various type of in service training offered to the workforce during 2017-18. But very few training held after 2018 in Directorate General of Nursing and Midwifery (DGNM). Respondents were asked whether received any training in last year. Figure 4.1reports attendance in a training course within the last year.

Figure 4.1: Percentage of health care provider received on job training



Overwhelming majority of respondents in all categories reported that having attended training. Medical officers were (92%), nurses and midwife were (90%) that were relatively less likely than other health workforces (100%) to report revealed attended training within the last year (Figure 4.1). The high rates of attendance in training courses indicate that many health workforces are receiving updates to their knowledge and skills. Table 4.1 reports the type of training attended, for those attending training within the last year. According to the respondents surveyed the most frequently attended areas are in breastfeeding (16%), midwifery (13%), Maternal and child health (12.7%), nutrition (12.7%) and infectious disease (12%).

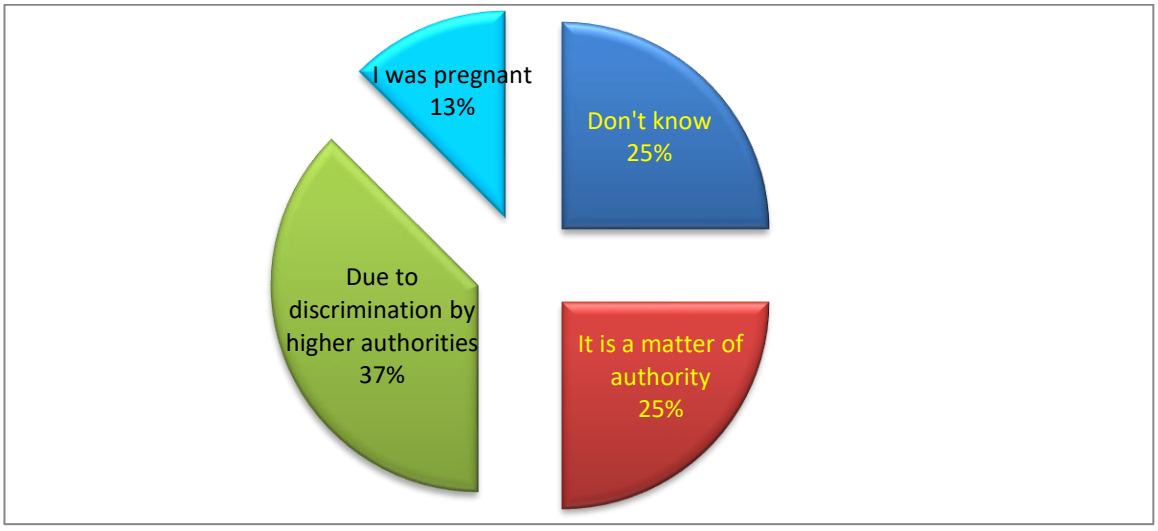
Table 4.1: Percentage of respondents received on job training

Types of training	Doctor		Non-Doctor		Total	
	n	%	n	%	n	%
ANC/PNC	2	11.8	9	6.0	11	6.6
MR related	1	5.9	18	12.1	19	11.4
Dengue	2	11.8	2	1.3	4	2.4
Malaria	2	11.8	17	11.4	19	11.4
Nutrition	3	17.6	18	12.1	21	12.7
Epidemiology and disease control	2	11.8	2	1.3	4	2.4
Infectious diseases	4	23.5	16	10.7	20	12.0
Medical Health	2	11.8	1	0.7	3	1.8
Maternal and child health	1	5.9	20	13.4	21	12.7
Breast feeding	1	5.9	25	16.8	26	15.7
Midwifery	-	-	22	14.8	22	13.3
IMCI	-	-	13	8.7	13	7.8
CNC/ ENC	-	-	13	8.7	13	7.8
EOC (Emergency Obstetric Care)	-	-	10	6.7	10	6.0
KMC	-	-	6	4.0	6	3.6
ESP (Essential Service Package)	-	-	4	2.7	4	2.4
HBBI	-	-	5	3.4	5	3.0
ARI	-	-	9	6.0	10	6.0
Diarrhoea	-	-	10	6.7	11	6.6
SRHR related	-	-	7	4.7	7	4.2
Others	1	5.9	3	2.0	3	1.8

Others: Hepatitis-B, Kala-azar, Rabies vaccine

The female health workforces whose did not attend the training courses they asked the reasons for not attending in the training. Almost 37% replied that they did not get the opportunity to go for training due to the discrimination of the higher authorities. About 25% of the female health workforces were pregnant when the training was started (Figure 4.2).

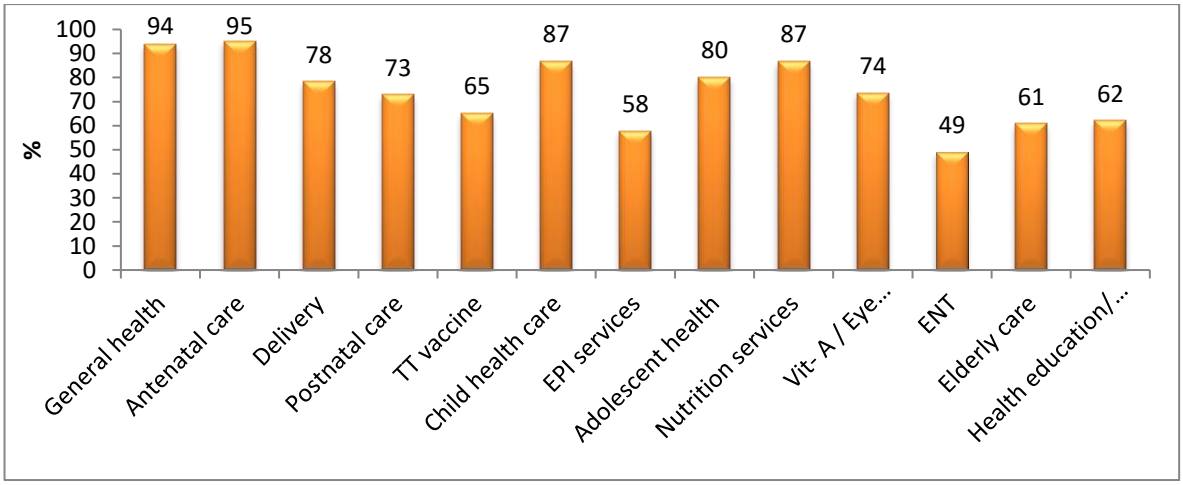
Figure 4.2: Reasons for not attending training courses



4.2 Self-reported performances and Satisfaction with current job:

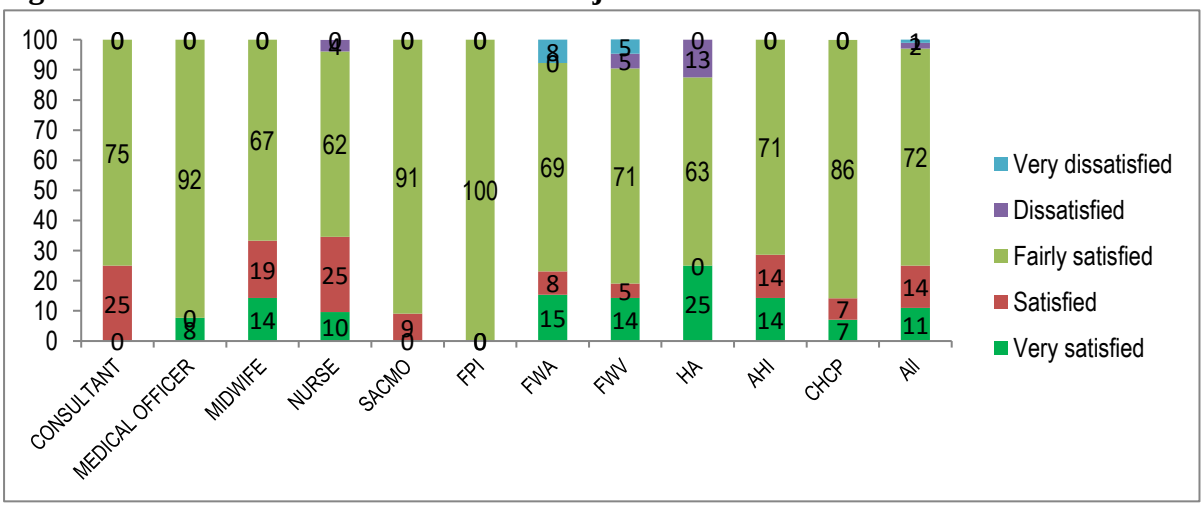
Respondents were also surveyed about the specific scope of work in their position. Each position was asked to determine the rate of their perceived efficiency in performing a series of specific tasks or responsibilities. With the extra work, health workers had a greater understanding of their skills in terms of specific task related to their position. The Figure 4.3 and Annex I, Table 5 show below, the percentage of all tasks performed by each provider. Observations of health services were divided among health workers, with the majority of workers, 95%, providing general health care and antenatal services, followed by nutrition and child health care (87%). Despite reporting being challenged, 25% of sampled female health workforces sampled reported being "Satisfied" or "very satisfied" in their jobs and 72% said they fairly satisfied (Figure 4.4).

Figure 4.3: Percentage of respondents performing different service



The job satisfaction was measured in 5 points scale (very dissatisfied to very satisfied). In the survey, respondents were asked how much she was satisfied with her current job position. Figure 4.4 shows the job satisfaction level of service providers. Overall satisfaction (fair or very satisfied) met the 75% threshold for all services providers (97%). In the category of Medical Officer, Midwife, Nurse, Sub Assistant Community Medical Officer (SACMO), Family Planning Inspector (FPI), Family Welfare Visitor (FWV), Assistant Health Inspector (AHI), Community Health Care Promoter (CHCP), Health Assistant (HA) and Family Welfare assistant (FWA) 7-25% were very satisfied with the job.

Figure 4.4: Satisfaction status with current job



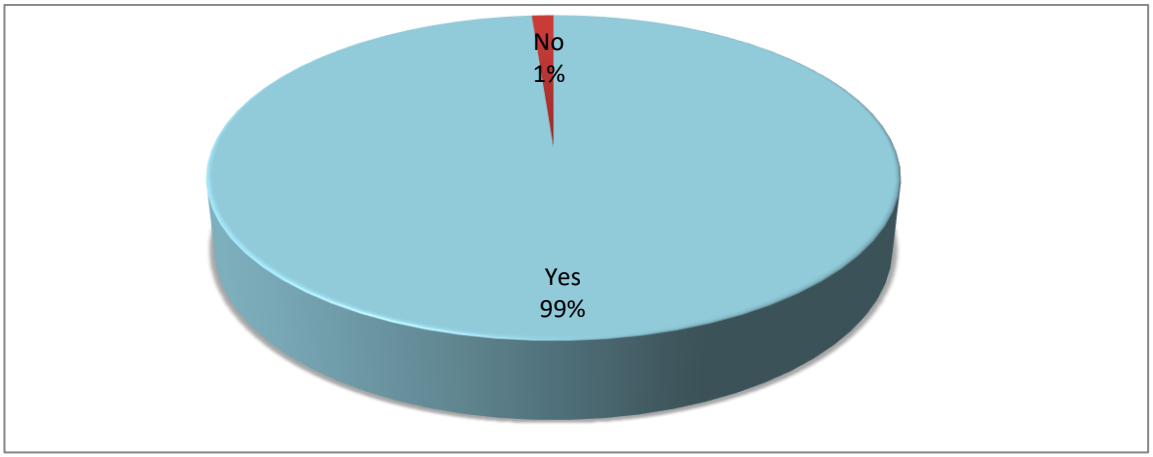
4.3 Factors that impede health worker performance:

In order to assess the factors perceived by female health workforces to impede their performance, both quantitative and qualitative data were collected. Health workers were surveyed regarding clarity around job description, overarching competencies that enable them to perform their functions, specific job within position that enable them to deliver the service, their frequency and quality, and their perceptions regarding performance outcomes.

4.3.1 Status of job description:

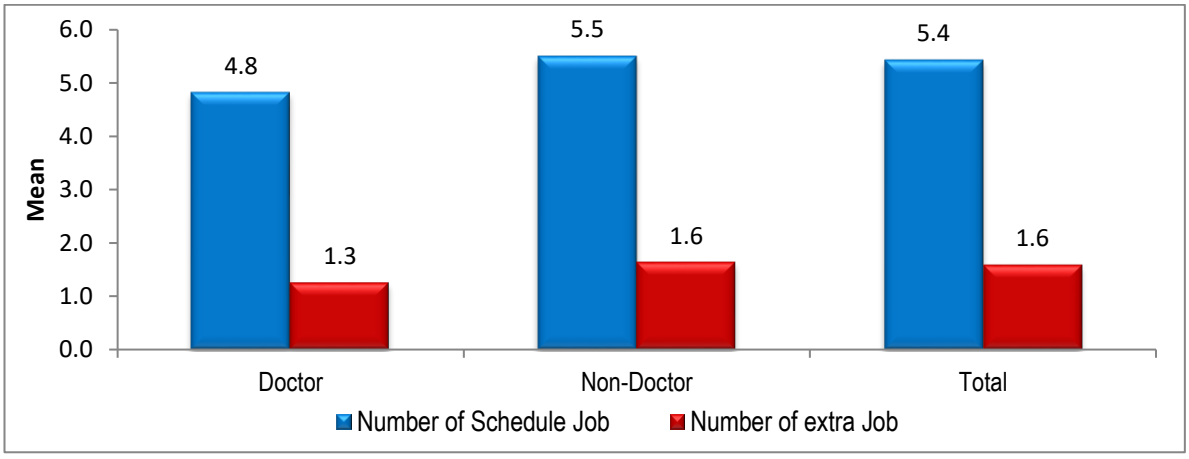
All categories of respondents felt they had clear idea about their job; the percentage of respondents replying in the positive 99%. However, substantially fewer respondents reported to that they have no written job description (Figure 4.5).

Figure: 4.5: Percentage of health workers having job description



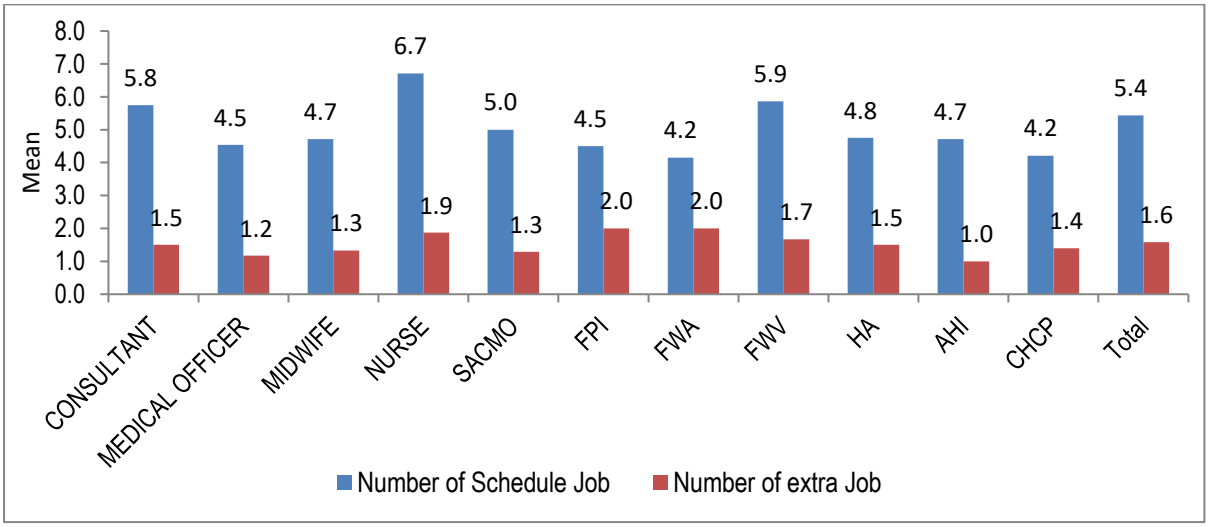
Medical doctors were the least likely to indicate they had on an average 4.8 assigned task, with only 1.3 extra work (like as-participation in the election, EPI program and all other GOB program etc.) (Figure 4.6).

Figure 4.6: Average (mean) number of job performing by health workers



On the other hand, non-doctors have to do an average of 5.5 jobs every day. There is an average of 1.6 more tasks to be done with their schedule task. Approximately 4 to 7 tasks had to done across most of the respondents, including consultant, medical officer, midwife and staff nurses, FWV and CHCP reported having a written job description. Nurses had highest number of task [mean±SD, 6.7±0.7], followed by FWV and consultant 5.9±0.6 and 5.8±0.5 respectively (Figure 4.7). (List of work/job description as an Annexure-1)

Figure 4.7: Figure 4.6: Average (mean) number of job performing by position



Female health workforces were asked to provide a list of scheduled tasks, in response to which they described their work in the Table 4.2.Analysis shows that two-thirds (63%) of health workers have been providing antenatal care and postnatal care service. In addition, half (51%) of the caregivers are providing general health care.

Table 4.2: Types of job performing by female health workforce (multiple responses)

Types of job performing	n	%
ANC, PNC service	104	62.7
Provide general health care	85	51.2
Adolescent services	53	31.9
Vitamin A + Campaign	50	30.1
Perform Delivery	43	25.9
Provide medicine to patients	42	25.3
Fill-up the Register book	41	24.7
Round patient's ward	40	24.1
Seeing the patient/ Patient checkup	38	22.9
Prepare Monthly report	38	22.9
Family planning services	36	21.7
Health and nutrition advice	33	19.9
All other orders given by the higher authorities	32	19.3
Providing patient care	30	18.1
Counselling health care after childbirth	30	18.1
Transfer medicine	25	15.1
Call a doctor if the patient's condition is worse	22	13.3
Outdoor service/duty	18	10.8
Solve various problems of the patient	12	7.2
Go to the ward and see the patient	11	6.6
Emergency duty	11	6.6
Save patient files	10	6
Others	26	15.3

Others: Prescribe medicine, Referral, Disinfect equipment

4.3.2 Perceived Inspiration / encouragement / recognition of good performance:

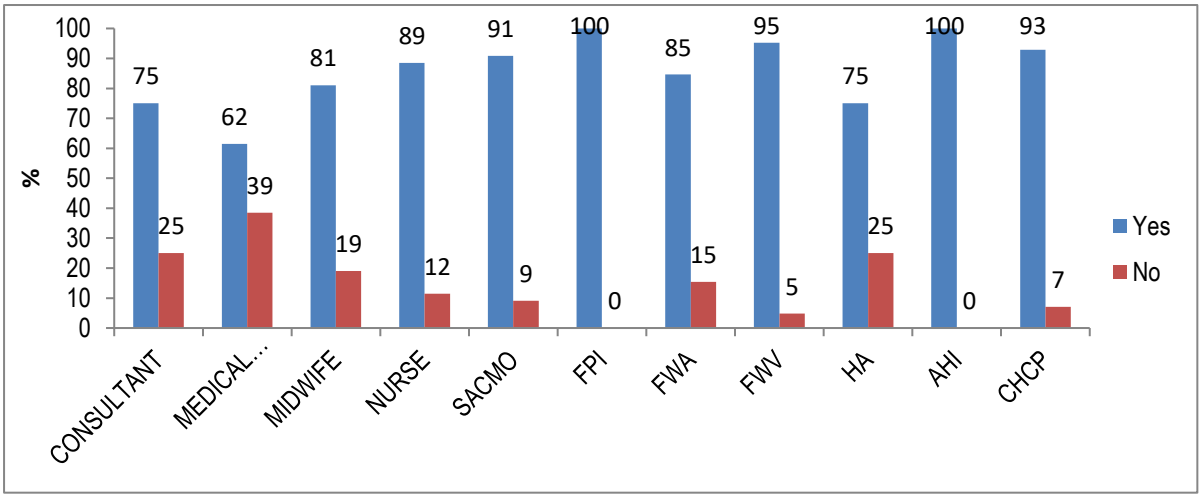
Health workforces were asked questions related to their perceptions regarding the outcome of their performance. These questions help provide some insight to the factors that may serve to motivate health workers. Specifically, participants were asked if there were recognition or inspiration if they performed well, as well as whether or not there were consequences for poor performance. Near about (14%) health workers responded "no" there were opportunities for reward if they performed well (Table 4.3).

Table 4.3: Percent of providers replying on opportunity for receive any inspiration/ encouragement from this hospital / service canter in recognition of good work.

Variables	n	%
Whether received any rewards for good works		
Yes	143	86.1
No	23	13.9
Types of rewards received		
Financial aid	10	6.1
Verbal recognition	134	81.2
Written acknowledgment	47	28.5
Dress	53	32.1
Rewards	45	27.3
Promotional opportunity	2	1.2

The position-based analysis of the figure shows that the chances of doctors getting a reward are much lower. In addition, non-doctors, health assistants and family welfare assistant (FWA) are deprived of this opportunity (Figure 4.8).Among the awards that are given the Verbal recognition (81%) and written acknowledgment (38%) are most frequent. But financial aid and promotion opportunities are much less 6% and 1% respectively.

Figure 4.8: Percent of respondents replied on whether they have opportunities of reward due better job performance, according to job position



According to the participants in FGDs and KIIs one of the main barriers discussed by health workers was physical or mental collapse caused by overwork or stress. Reasons include staffing shortages and lack of supervisory support, which has resulted in health workers taking on multiple roles or duties with many performing both administrative tasks and patient handling.

The participants also reported heavy workload and long working hours resulting from staff shortages. In order to cope with this, some indicated they used short-cuts, such as avoiding the use of certain recommended procedures that they perceived to be time consuming, and spent less time with patients. Finally, health worker attitude was cited as another major reason for poor performance. In discussion, issues including inadequate remuneration, lack of recognition, bureaucracy, lack of supervisorial support, and lack of opportunities for professional growth were among the explanations for negative attitudes.

4.4 Working environment for supporting good performance:

4.4.1 Discrimination at work place:

Health care providers were asked if they have ever been discriminated against or subjected to other harassment while providing services in the work place. If they gave positive answer further they inquired they type of discrimination they received. Almost every 1 in 3 (34%) female health workforces are either discriminated or subjected to harassment in their working environment. Most of them subjected to harass by verbal abuse (32%), followed by mental torture (29%). The health care provider also harasses by eve teasing, mental torture, sexual abuse and discriminated by financial aid.

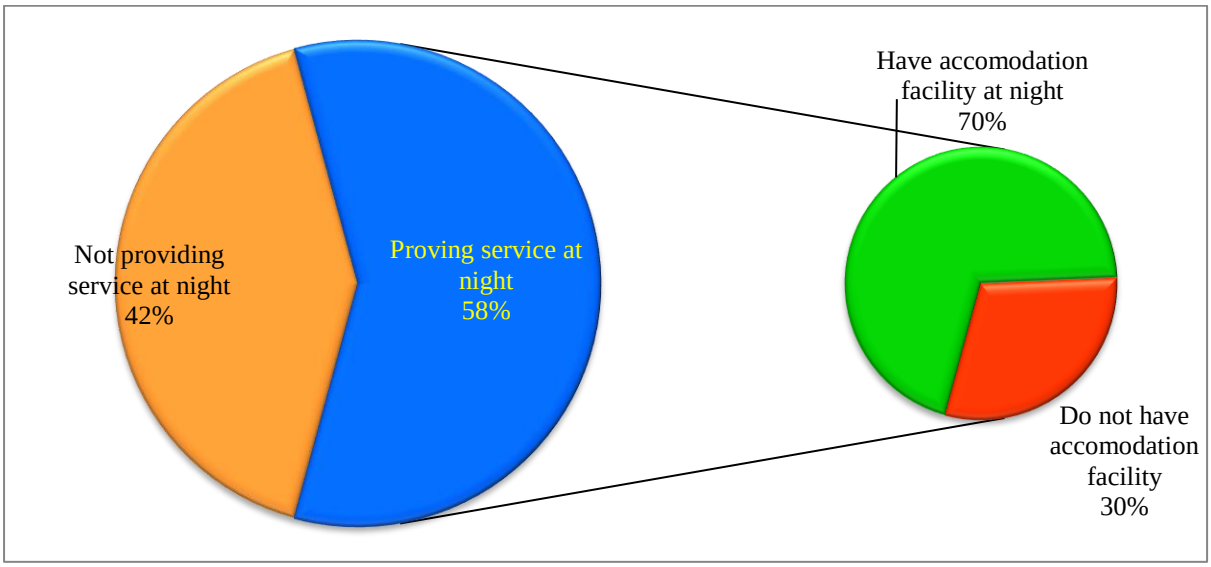
Table 4.4: Percent of respondents ever discriminated in working place

Variable	n	%
Ever been discriminated		
Yes	57	34.3
No	109	65.7
Type of discrimination		
Verbal abuse / abuse	53	32.1
Mental torture	48	29.1
Unusual Harassment	31	18.8
Eve teasing	17	10.3
Financial inequality	16	9.7
Habitat problems	11	6.7
Sexual abuse	8	4.8
Physically injured	3	1.8

4.4.2 Night duty and living arrangement at work place:

Figure 4.9 shows the percentage of female health workforces who has to provide night health service. According to the provider's opinion, 58 percent female health workforces have to provide service at night. The figure also represents 70 percent of service providers have accommodation facility during night stay and the rest of them do not have among those who has to do night duty.

Figure 4.9: Percentage of respondents provided services at night, provision of accommodations facility for female service providers



4.4.3 Female service provider's washroom facility at work place:

Overall, every 6 in 10 female health workforces have separate toilet arrangements (Table 4.5). The female health workforces who have the separate toilet facility, only 3% are very good condition and 23% mentioned their toilet conditions are good. About 11% are mentioned their toilet condition is either bad or very bad. Female health workforces who do not have separate toilets at work, they used to wash and defecate in different places such as: doctor's toilet, nurses' toilet, officer toilet, common toilet, Own residence (near to office), Going to someone else's / next door house or Going to the staff quarters.

Table 4.5: Percent of working female service providers have separate toilet arrangements

Variable	n	%
Whether have separate toilet arrangements		
Yes	95	57.2
No	71	42.8
Condition of toilet		
Very good	3	3.2
Good	22	23.2
Average	58	61.1
Bad	7	7.4
Very bad	4	4.2
Place of defecation and wash		
In the doctors' toilet	2	2.8
In the nurses' toilet	1	1.4
In the officers' toilet	2	2.8
In the common toilet	60	84.5
Own residence (near to office)	3	4.2
Going to someone else's / next door house	2	2.8
Going to the staff quarters	2	2.8

4.4.4 Prayer room facility at work place:

Table 4.6 shows whether female health workforces have separate prayer rooms. Only 5% providers have separate prayer rooms. Of them 25% of the rooms is good condition. Female health workforces who do not have prayer place at work, they used to pray mostly in office room (38%) and their own home (35%).

Table 4.6: Percent of female service providers have separate prayer room

Variables	n	%
Whether have separate prayer room		
Yes	8	4.8
No	158	95.2
Condition of prayer		
Very good	0	0.0
Good	2	25.0
Average	4	50.0
Bad	0	0.0
Very bad	1	12.5
Place of prayer		
In the office room	60	38.0
Own residence	56	35.4
Staff quarter	6	3.8
Corridor	10	6.3
Store room	4	2.5
Dressing room	7	4.4
OT room	3	1.9
Place where I get the opportunity	11	7.0

4.4.5 Breastfeeding corner at work place:

Table 4.7 presents whether female health workforces have separate breastfeeding corner. Only 13% providers have this facility. Of them 40% of the rooms is good and very good condition. Female health workforces who do not have breastfeeding place at work, they used to feed their baby mostly in office room or duty room (49%) with hanging a curtain and their own home (12%), nearest house in the catchment of the facility (9%).

Table 4.7: Percent of female service providers have separate breastfeeding corner

Variable	n	%
Whether providers have separate breastfeeding corner		
Yes	22	13.3
No	144	86.7
Condition of breastfeeding corner	144	100.0
Very good	2	9.1
Good	7	31.8
Average	11	50.0
Bad	2	9.1
Very bad	0	0.0
Place of breastfeed (if none in the workplace)		
In the doctor's room	3	2.1

With curtains in the office / duty room	70	48.6
Own home	18	12.5
Not required	4	2.8
In the nurses' room	7	4.9
Going to the staff quarters	15	10.4
In the store room	11	7.6
In the dining room	9	6.3
In the empty room of UH&FWC	13	9.0
Where I get the opportunity	20	13.9
The nearest house	13	9.0
In the delivery room	9	6.3
In the dress changing room	3	2.1

4.4.6 Dress changing room for female at work place:

Table 4.8 presents whether female health workforces have separate dressing room. Only 19% providers have this facility. Of them 16% of the rooms is good condition. Female health workforces who do not have dressing room at work, they used to change dress mostly in office room or duty room (42%) with hanging a curtain and going their staff quarter home (19%). About 21% respondents mentioned they do not need to change dress.

Table 4.8: Percent of female service providers have separate dress changing room

Variable	n	%
Whether have separate dress changing room		
Yes	31	18.7
No	135	81.3
Condition of changing room	136	94.4
Very good	0	0.0
Good	5	16.1
Average	22	71.0
Bad	2	6.5
Very bad	1	3.2
Place of dress changing (if none in the workplace)		
In the doctor's room	6	4.4
With curtains in the office / duty room	57	42.2
In the store room	13	9.6
Not able to change at work	5	3.7
Going to the staff quarters	26	19.3
With curtains in the dining room	3	2.2
In the empty room of UH&FWC	2	1.5
Not required	29	21.5

4.4.7 Status of uninterrupted electricity:

The respondents were asked whether their health facilities have 24 hours uninterrupted electricity supply. In response to this query only 38% gave positive answer. In addition, they also inquired they have alternative arrangements in case of electricity failure. Majority (78%) of the health facility have alternative arrangement for electricity (Table 4.9).

Table 4.9: Percent of female service providers have access to uninterrupted electricity

whether they have 24 hours uninterrupted electricity	n	%
Facility has 24 hours uninterrupted electricity		
Yes	61	36.7
No	105	63.3
Alternative arrangements for electricity		
Yes	82	78.1
No	23	21.9

4.5 Individual and Community factor impede the good performance:

4.5.1 Individual factors:

About 87% of the workers live with their families and 80% of them live with their husbands (Table 4.10).The husbands of 50 percent of the female workers work are in job. Service providers often have to fulfill financial and other responsibilities in addition to their job, such as: Taking care of father, mother, father-in-law, mother-in-law, brother-in-law and sister-in-law, Caring for children, to bear the household expenses, to bear the cost of education of children.

Table 4.10: Percent of female service providers according to living with family, doing responsibility of the family

Variable		n	%
Living with family member	Yes	144	86.7
	No	22	13.3
Member category	Father/Mother	26	15.7
	Husband	126	75.9
	Brother/sister	13	7.8
Husband currently working	Yes	84	50.6
	No	82	49.4
In addition to the job, you have to fulfil the financial or other responsibilities of your family	Yes	145	87.3
	No	21	12.7
Type of responsibility			
	Taking care of father, mother, father-in-law, mother-in-law, brother-in-law and sister-in-law	87	52.4
	Caring for children	119	71.7
	To bear the household expenses	115	69.3
	To bear the cost of education of children	30	18.1
Transportation arrangement	Yes	0	0.0
	No	166	100.0

No health facility makes any arrangements to travel from the health center to residence for their service providers (table 4.10).

4.5.2 Community and Co-worker:

The service providers were questioned whether they had been abused by their co-worker or by incoming patients or attendant of the patients. Only 4 percent of service workers were abused by their co-worker, and 11 percent were abused by incoming patients; the types of abused they

experienced are Eve teasing, sexually abuse, Unusual Harassment, Financial inequality, Provision on leave and Work distribution (Table 4.11). Evidence from this result suggests that sexual harassment by male co-worker is a problem for female worker and constitutes unequal and detrimental treatment of women and an obvious barrier to equal opportunity.

Table 4.11: Percent of female service providers ever abused by coworker or by patients

		n	%
Abused or discriminated by co-worker	Yes	7	4.2
	No	159	95.8
Type of abused or discrimination	Eve teasing	1	14.3
	Sexually abuse	1	14.3
	Unusual Harassment	4	57.1
	Financial inequality	2	28.6
	Provision on leave	3	42.9
	Work distribution	3	42.9
Abused or harassed by patient	Yes	19	11.4
	No	147	88.6
Type of harassment	Eve teasing	7	36.8
	Sexually abuse	3	15.8
	Unusual Harassment	14	73.7
	Financial inequality	2	10.5

FGD reveals that workers do not have a good relationship with the patient attendant because there are long queue for many people, it creates the disturbance, it hinders the delivery. In response to the question, “What do you think are the major challenges facing health care in health center?” As a focus group respondents noted “they feel very bad when the attendant who comes with the patient or the people in the community threaten if they do not get the medicine and even come to touch the body”. Many female health workforces do not report job discrimination or sexual harassment for fear of losing their jobs, being transferred, or being demoted. Regarding contribution of earnings they mentioned sometimes all earnings took their husband.

4.5.3 Supportive supervision from higher authority:

Supervision is a critical component to improving health worker performance and ensuring the effective delivery of the health service. The study examined supervision from the perspective of the health worker being supervised in order to better understand some of the factors that contribute to effective supervision.

The key informants were asked whether their staff being supervised by higher authorities. Two-thirds of respondents said their staff was regularly supervised. In FGD, the provider opinions were taken about the type of supervision they receive: internal supervision, external supervision, or both. Internal supervision was also the most frequently reported form of supervision by medical doctors, officers, registered nurses and midwives. Internal supervision accounted for one-third to one-half of supervision across the higher position. External only supervision was the least frequently reported type of supervision, although providers were cited this type of supervision they receive.

Chapter 5

Existing Process of Capacity Enhancement and Empowerment

Capacity enhancement focuses on furthering an organization's ability to do new things and improve what they currently do. Most simply, it improves the health worker's performance and enhances their ability to function and continue to stay relevant within a rapidly changing environment. It is the process by which worker obtain, improve, and retain the skills, knowledge, tools, equipment, and other resources needed to do their jobs competently.

5.1 Provision of training for Enhance capacity:

In this study KII and FGD were conducted to assess the existing process of enhancing capacity. The key actors were asked whether female health workers feel adequately trained to increase their capacity and empowerment and if not, further asked what steps have been taken to enhance their skills. In respond to the query, 72% of respondents agreed the service providers have trained to perform the duty smoothly (Table 5.1). However, about 80%of them mentioned they arrange any periodic training for enhancing skills.

Table 5.1: Percent of key respondents perceived on enhancing capacity

	n	%
Whether the workers adequately trained to perform the duty		
Yes	41	71.9
No	16	28.1
Arrange any periodic training for enhancing skills		
Yes	45	78.9
No	12	21.1
Equal participation of female workers is ensured		
Yes	50	87.7
No	5	8.8
Type of problems raise in organizing training program		
Training centre is far from residence	12	21.1
Due to family problem	12	21.1
Because of emergency duty	10	17.5
Child rearing problem	9	15.8
Lack of Accommodation facility in Training centre	9	15.8
Transportation problem	8	14.0
No problem in participation	8	14.0
Due to pregnancy	7	12.3
Lack of Security	6	10.5
Negligence of training	4	7.0

Every 9 in 10 respondents mentioned that they ensured the equal participation of female health workforces. The respondents also mentioned they faced many difficulties while organized training with female health workforces. Problem of exclusions, restrictions or distinctions are made on the basis of pregnancy, childbirth, or related conditions. It often includes unwillingness to promote, or retain female workers who may get pregnant and require maternity leave and benefits. Pregnancy may also be included in a larger category called "family responsibilities," in which occurs against workers who have family care giving responsibilities, such as mothers and fathers of disabled children and workers who care for family members. Indeed, it is difficult to separate the two forms of discrimination since exclusion from a job may be linked to the pregnancy as well as to the expectation of subsequent care giving responsibilities.

5.2 Barrier to provide quality service:

The study identified some important barriers that hinder the quality service delivery is given below:

- There are shortage of doctors and nurses in the hospital
- Lack of midwife
- Lack of refresher training
- There is no separate toilet for female service providers
- Only one night guard for the whole hospital
- There is no security guard
- Lack of medicine and logistics
- There are no specialist doctors in all the centres, no anaesthetist and no obstetrics and gynaecology consultants,
- There is no breastfeeding corner /room
- There is no separate room for changing dress
- The delivery of services is disrupted due to the abuse and harassment of the companions who come with the patient
- There is no Aya
- the influence of local leader
- Influence of agent or middle-man

5.2 Steps need to take for quality service delivery:

Type of Steps need to take	n	%
Creating a conducive environment	156	94
Taking up motivational programs	145	87.3
Provide advanced training	150	90.4
Collaboration in the workplace	123	74.1
Family cooperation	137	82.5
Appropriate supervision and monitoring by higher authorities	138	83.1
Stakeholder cooperation	95	57.2
Receive accurate information from stakeholders	118	71.1
Provide regular increments	127	76.5
Give Recognition of work	145	87.3
Recruitment of skilled staff	139	83.7
Provide social security	113	68.1
Provide personal security	92	55.4
Provide improved and secure accommodation	79	47.6
Ensuring transportation	71	42.8

Participants from FGDs following steps need to consideration to improve the service delivery in the facility.

- Refresher training is required
- Cleaning staff, midwife and ayah are required
- Rest room and changing room is required
- Work routine needs to be maintained

- Strengthen security
- Oxygen cylinder and digital X-ray machine is needed
- To ensure the presence of the doctor
- Increase the supply of medicine and logistics
- To improve the sewerage system
- To improve the patient's bed and furniture
- Every ward, duty room, delivery room bathrooms have to be good.
- It is necessary to provide modern equipment.
- It is very important to mention the name of the roster duty of doctors
- Political influence must be stopped

Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Directorate General of Nursing and Midwifery (DGNM) and Ministry of Health and Family Welfare (MoHFW) are both producers, for example through the training centre, as well as major employers of health and family planning workers, among others. Coordination among these actors is critical to a well-functioning system. It is envisaged that enhanced and better coordinated training systems will go a long way toward improving the performance of health workers.

5.3 Barrier in providing services in hard to reach area:

To assess the barriers of providing quality health services in hard to reach areas qualitative investigation was conducted to gather information from Habiganj district. Two facilities of two upazilas (Lakhai and Azmiriganj) of this district were visited. Since, these two places are remote area that is why there are many problems such as: the number of doctors and nurses in the hospital is less, no ayah, no midwife.

When new doctors arrive they are under threat (like as-political presser, pressurised by local leaders and terrorist etc). They wonder when they will leave this place. In reality, many people are given postings but not everyone stays at the station and does not do their duty. Health workers do not have separate bathrooms. There is only one night guard for the whole hospital. Shortage of medicine and supplies for cleaning such as: soap, hand wash, toilet tissue not available.

Service recipients get upset and talk nonsense when they don't get medicine. Most of doctors and staff do not stay at the station. They come to work from Habiganj sadar upazila. The distance from Habiganj to Ajmiriganj is about 40km.Many of the people who came with the service recipients and the people of the community threatened if they did not get the medicine.
If an official goes to a higher authority for any work, he has to wait for a long time. Due to bureaucratic complexities, it is always too late to get the cooperation of the party. In many cases the higher authorities do not care. Providers have to clean the bathroom and office room outside of their work as there are no cleaners. Most of the time they have to work more than 8 hours. There is no standard canteen, rest room, official vehicles and ambulance. The haor area is therefore very difficult to navigate during the rainy season. Problems of walking at night. The women threatened to walk at night. Sometimes local representatives made threats in front of everyone.

During the FGD, some health workers said that they were vague about their assigned work in the health center, although they had a general idea about what they were asked to do about the service delivery of the service center. Lack of staff was cited as a barrier that prevented health workers from complying with their formal roles. In general, health workers realized that there

was less agreement between their expected roles and the actual responsibilities they performed. Qualitative data explains that what is expected from health worker does not at least officially reflect their actual duties.

Findings from Local level Data validation workshop:

Validation Workshop was conducted in two districts (Hobiganj and Chapai Nowabganj). The workshop was held on 19 September 2020 at Hobiganj District Hospital conference room. Other one was virtual meeting held on 22 September 2020 at the conference room of Health Economics Unit, Health Services Division, Ministry of Health and Family Welfare.

Points discussed at local level workshop:

- Most of the time the female health workforces can't face any social constrains during providing services in health facility.
- Residential/accommodation facility is available for female health workforces in Lakhai upazila health complex.
- The toilet arrangement should be separate for men and women and it would be in good condition in every health facility
- Two types of toilet should be ensuring in every health facility. One with high commode and other is normal.
- For good working environment for female health workforces the posting of aya must be ensure in every health facility.
- Most of the doctor stays in Lakhai upazila health complex.
- The female health workforces can't stay in the place of posting because there is no accommodation facility for them in some health facility.
- Limited residential facilities for female health workforces in some health facility.
- Most of the doctor and nurse stay in their working place.
- Monitoring and supervision should be ensuring in every health facility by the higher authority.
- Vacant post should be filled-up urgently.
- Personal Protection Equipment (PPE) should be ensuring for all types of health workers.
- Separate Breastfeeding corner should be needed for female health workforces.
- The data of the report which was collected from Lakhai and Ajmeriganj upazila under Hobiganj district is consistent with the survey results.
- The facility for recreation, canteen, and latrine and prayer room should be established.
- The facility of residential quarter should be developed especially female health workforces.
- There are no promotion to female health workforces especially FWA, HA, HI.
- Some participants expressed in the workshop that female health workforces have limitation in the family life.
- Husbands take the salary from their wife in most cases. Sometimes female health workforces are bound to give their full amount of salary to their husband. Even female health workforces face difficulties to meet their daily expenses for want of money.
- Most of the female health workforces depend on their husband's opinion.
- The participation of local public representatives should be ensuring.
- The health worker should be stay in nearby 30 kilo Meters of their working place.
- Baby Care Room (Corner) should be needed in health facility.

- Female doctor do not want to go in the condemn cell.
- Urgently 10 (ten) extra doctor should be posted in the corona unit of district hospital.
- Third and fourth class employees should be posted.

Civil surgeon Chapai Nawabganj:

- During the structural design of all the health facility should be included separate toilet facility for male and female, dress changing room, breastfeeding corner, prayer room for female health workforces.
- Arrange/establishment of the good school in the upazila health complex.
- During the night duty transport facility and rest room should be ensure for female health workforces.
- A committee should be form for the prevention of violence against women.
- Incentive system should be introduce for field female workforces like-HA, FWA.

Director General, HEU:

Why female doctors are less?

- The husbands of female doctors are service holder. They want to stay with their husband place of posting. Moreover, none of the female provider wants to be transferred in the upazila as there is no good school for their children.
- Provide incentive of those female workers doing better performance

Is there innovative idea to overcome the difficulty?

- If resource if available the health manager will be able to implement

Why there is shortage of equipment?

- The equipment is usually supplied from the directorate. Due to which we do not have any warranty or guarantee of equipment at the local level. In the hospital it becomes unmaintainable after few months.

Chapter 6
Conclusions and Policy Implication

6.1 Conclusions:

The study was conducted to identify the factors influencing quality service delivery, and to ascertain existing process of capacity enhancement and empowerment for female health work forces and developed the distribution of female health work forces. This chapter presents a brief discussion of the key findings of the study. And, it is followed a list of recommendation to improve the evidence base for policy advocacy on future plans to encourage and retain female health work forces in hard to reach areas. The findings of the study revealed that almost 27% of female health work forces were working in same position for 20 or more years. And 1 in 5 (20%) of the female health work forces are same place for more than 20 years. The average (mean) length of their service is about 40 years.

Result indicates that 60% of the health workforces are females and males are dominating in managerial position. Almost all of female health work forces were reported they had received at least one training within 1 year previous the survey. Those who are not attended the training either discriminated by authority or due to pregnancy. The study assessed the self-reported performance of the providers in both quantitative and qualitative investigation. The observed performance of health care workers is not consistent with the expectations. The factors identified for good performance as job description; working environments such as absence of discrimination and harassment, living arrangement at night, room facility (dress changing, wash, prayer, and breastfeeding); support from community and coworker; and supportive supervision.

6.2 Discussions and Policy Implications:

The findings confirm there are several important observations that can be made based upon the data collected as of this study. First, the health workers observed satisfaction were not at levels desired, though the health workers generally regard themselves as competent both technically and in overarching areas to provide services. Second, health workers reported having clear job expectations; however, fewer health workers reported not having a written job description, and some indicated that they struggle with being overworked, which can result in taking shortcuts in service delivery. And finally, health workers are receiving supervision, yet the quality of the supervision received somewhat need to reviews, with some health workers participating in focus groups portraying the situation less favorably than was reported through quantitative data collection.

These observations reveal that health workers seek to deliver services amidst a variety of constraints. There are shortage of worker generates long queues, lack of medicine and equipment also make angry to the clients this context, supervisors also have a critical role to play to in ensuring that health workers are making the appropriate trade-off decisions, providing as much quantity of services as possible without compromising quality beyond a certain limit.

Doctors and nurse play key roles in ensuring that clients what is needed to provide high quality health care. Data indicates that doctors and nurse both need more support to be effective in their jobs. Several areas of concern emerged under the facility standard. These included shortages of health workers, inadequate support for training, insufficient supervision for female

health work forces, lack of written job descriptions, and a lack of infrastructure related facility for female health workers in health care system.

Gender issues raised in health workforce focus groups included the following perceptions: health training is not flexible with respect to family constraints; female clients do not want to be treated by male provider; some female provider left in male wards alone, especially at night, fear that male patients will attack them.

Female providers participating in FGDs reported incidents of sexual harassment in facility institutions. Providers were asked to describe gender-related challenges in the service environment, including sexual harassment. Some female providers reported harassment by senior provider and community people. Discrimination based on pregnancy and family responsibilities against workers who have family care giving responsibilities, such as mothers and fathers of disabled children and workers who care for family members are came to light. For example, since maternity leave poses long-term facility challenges. A senior provider notes that, "Female goes for long maternity leaves and this provides some sort of shortages of providers". In addition, female providers stated that they had to manage family responsibilities, such as household duties and childcare, while also studying, implying that they could not pursue educational opportunities under the same conditions as their male counterparts. Results add further evidence that equal opportunity for employment are constrained by gender in health system, including forms of discrimination based on pregnancy and family responsibilities, sexual harassment, and working position.

Findings suggest the need to take policy, program, and community action to decrease professional segregation and sexual harassment, and empower female health workforces. Balancing all responsibilities and work appear to pose challenges to provide service for female providers. Evidence of gender constraints shows the need to actively promote equal opportunity in health facility with respect to specific barriers to entry, performance, and retain female provider in health system. Along with the findings, a set of recommendations is given to improve the quality of service for health care providers are as follows. In addition, a policy matrix is given in Annex II.

Objective	Recommendations	Way Forward
To identify the distribution pattern of female health work forces across the Health Facilities	• Ensure equality and equity in recruitment and distribution of female health work forces across the all facilities. • Ensure 30% of female doctors • Ensure at least 30% female participation in decision making process	• Revise and implement the recruitment policies in health system for equal opportunity in recruitment in health system • Develop guideline for deployment of female health work forces
To define factors influencing quality service delivery by female health workforces	• Ensure appropriate physical facilities for each and every health facilities (district hospital to community clinic) for female health workforces • Reduce family barriers and ensure quality of life (like-quality education for children of female health work forces, accompany with husband/ guardian of female health work forces,	• Renovation and extension of existing health facilities to align with more women friendly provisions • Enforcement of existing law of emphasizing education facilities for children of female health workforces

Objective	Recommendations	Way Forward
	secured residence arrangement for female health work forces etc.) specially at Upazila level • Strengthen supportive supervision and monitoring to doctors and non-doctors • Ensure prevention of sexual harassment • During the night duty transport facility and rest room should be ensure for female health workforces. • Ensure safe road communication	• Enforcement and update of the supervision policy • Establish women friendly environment • A committee should be form for the prevention of violence against women. • Allocation more vehicles in each hospital specially upazilla level
To ascertain existing process of capacity enhancement and empowerment for female Health Wok force	• Increase training opportunities for 10% of female health workforce • Ensure advance or refresher training for all female providers. • Ensure female participation in all capacity development program • Ensure regular promotion and recognition of work.	• Develop and update training plan for 10% of female health workforces. • Ensure develop relation between stakeholders and management committee.
Future plan for retain female health work force in hard to reach areas	• Proper transportation and road communication need to be develop in hard-to reach areas. • Provide incentive of those female workers doing better performance in the hard to reach areas. • Ensure housing and opportunity of education.	• Develop need based policy for transportation and road communication in hard to reach areas. • Increase housing and education facility • Develop special incentive for hard to reach areas for female health workforces. • System should be develop for promotion and recognition of work

Policy Matrix

Specific Objectives:	Relevant Recommendations
1. To identify the distribution pattern of female health work forces across the health facilities	1, 2
2. To define factors influencing quality service delivery by female health work force	3, 4, 5
3. To ascertain existing process of capacity enhancement and empowerment for female health work force	2, 6, 7
4. To prepare an evidence base for policy advocacy on future plans to encourage and retain female health work force in hard to reach areas	1, 4, 8

Recommendations	Key/Major Activities (What to do)	Strategies (How to Do)	Responsibilities		Timeline			Resource Intervention		Objectively Verifiable Indicators (OVIs)				Means of verifications (MOV)	Remarks
			Lead	Support	Short (<2yr)	Medium (2-3 yr)	Long (3yr+)	HR	Finance	Process	Output	Outcome	Impact		
1. Ensure equality and equity in recruitment and distribution of FHW across the all facilities[5] 30% of women doctor.	Revising existing recruitment policy to ensure equitable distribution of female health workforce among 30% of women doctor in each and every health facility	Identify the relevant personnel from appropriate departments/wings, directorates of MoHFW and other relevant ministries Form a working committee with the identified personnel Gap analysis workshop to review the existing policy and identify and area(s) of intervention Policy revised	MoHFW HEU MoP	GNSPU DGNM DGHS DGFP DGME NIPORT	3 months 3 months 6 months	2 yrs.		Man power need	Finan cial support need	√	√ √	√		A list of personnel available, and duly endorsed A committee is formed, duly endorsed Minutes/reports of meetings, workshops available Revised policy available	
2. Promote at least 30% female participation in decision making process[6]	Develop a deployment guideline for FHWF	Engage the above committee Gap analysis and Consul-tative workshops to identify area(s) of intervention	MoHFW HEU MoP	GNSPU DGHS DGFP NIPORT	3 months 3 months 4-8			Man power need	Finan cial support need	√	√			A committee is formed, duly endorsed Minutes/reports of meetings, workshops available	

[5]Link to objective 1 and objective 4

[6]Link to objective 1 and objective 3

Recommendations	Key/Major Activities (What to do)	Strategies (How to Do)	Responsibilities		Timeline			Resource Intervention		Objectively Verifiable Indicators (OVIs)				Means of verifications (MOV)	Remarks
			Lead	Support	Short (<2yr)	Medium (2-3 yr)	Long (3yr+)	HR	Finance	Process	Output	Outcome	Impact		
		Develop draft guideline Finalizing the guideline through national dissemination			months 8-18 months					√	 √			Draft guideline Guideline available duly validated and disseminated	
3. Ensure appropriate physical facilities for each health facility (DH to CC) for female health workforce (FHWF)[7]	Renovation and extension of existing health facilities to align with more women friendly provisions	Engage the above committee Mapping of health facilities to prioritize area(s) of infrastructural renovation focus on toilet arrangement; sitting arrangement; Separate breastfeeding corner ; Baby Care Room, dress changing room; prayer room; facility for recreation, canteen. Consultative meetings to prepare a costed work plan and pursue accordingly for approval from appropriate authority Infrastructural renovation done in selected HFs	MoHF WHEU MoP	DGHS, DGFP, HED DGNM DGME	3 month 6 months to 1 yr 12-18 months		3-5 yrs	Man power need	Finan cial support need	√ √ √	√ √ √	√		A list of personnel available, duly endorsed List of facilities prepared, duly endorsed Minutes and approved work plan available Renovated works are available for physical inventory/inspection	

[7]Link to objective 2

Recommendations	Key/Major Activities (What to do)	Strategies (How to Do)	Responsibilities		Timeline			Resource Intervention		Objectively Verifiable Indicators (OVIs)				Means of verifications (MOV)	Remarks
			Lead	Support	Short (<2yr)	Medium (2-3 yr)	Long (3yr+)	HR	Finance	Process	Output	Outcome	Impact		
4. Reduce family barriers to ensure quality education for children of female HWF specially at Upazila level[8]	Enforcement of existing law of emphasizing education facilities for children of FHWFs	Engage/designate the previous committee Consultative meetings to identify bottlenecks for enhanced adherence with the law Workshop with relevant stakeholders to prepare a directives for increased adherence with the law Validate the directives through workshop	MoHF WHEU MoP	DGHS DGFP DGNM DGME	6 months 6 month-1 yr. 12 -18 months 18 months-2 years	.		Man power need	Finan cial support need	√	√ √	√		Committee available, duly endorsed Minutes of meetings/ Workshop reports are available Workshop reports available Directives available	
5. Strengthen supportive supervision and monitoring[9]	Enforcement and update of the supervision policy	Engage/designate the previous committee Review existing policies/ strategies through gap analysis workshop with stakeholder Finalize the revised policies/ strategies through stakeholder dissemination Arrange orientation meeting on job description based on the revised policies/ strategies	MoHF WHEU MoP	DGHS DGFP DGNM DGME	6 months 6months-1 yr. 12months-18 months	2-3 years		Man power need	Finan cial support need	√ √	√ √		√	Committee available, duly endorsed Workshop reports available Revised document available Training reports available	

[8]Link to objective 2 and objective 4

[9]Link to objective 2 and objective 3

Recommendations	Key/Major Activities (What to do)	Strategies (How to Do)	Responsibilities		Timeline			Resource Intervention		Objectively Verifiable Indicators (OVIs)				Means of verifications (MOV)	Remarks
			Lead	Support	Short (<2yr)	Medium (2-3 yr)	Long (3yr+)	HR	Finance	Process	Output	Outcome	Impact		
6. Ensure prevention of sexual harassment	Establish women friendly environment	Functioning/ revitalizing Sexual Harassment Committee Review and reset the frequency of meeting with the committee members	MOHFW	HEU, DGHS, DGFP	6 months 6 months-1 year			Man power need	Finan cial support need			√ √		Relevant documen-tation available Minutes of the meetings are available, duly endorsed	
7. Increase training opportunities for 10% of female health workforce [10]	Develop and update training plan for 10% of female health workforce.	Review existing plan and undertake a need assessment Validate the proposed areas of changes in the training plan through consultative workshops with stakeholders Prepare and disseminate the updated training plan	MoHFW HEU MoP	DGHS DGFP NIPORT DGNM DGME	1 year 12- 18 months 18 months to 2 years			Man power need	Finan cial support need		√	√		Need assessment report available Workshop reports available Revised/updated training plan available	
8. Proper transportation and communication need to be develop in hard-to reach areas	Develop need based policy for transportation and communication in hard to reach areas.	Identify the appropriate person and form committee with the identified personnel Arrange stakeholder workshop Draft policy Finalize policy Construction of Submers-ible road, introduce water ambulance, speed boat, improve water vehicle	Mo-LGRDC MoS MoRT&B	MoHFW	6 months 3 months 1 yr. 6 months		3 yr.	Man power need	Finan cial support need		√ √	√ √ √		Inter-ministerial meeting with MoLGRD Number of meeting Policy formed Implementation Plan Number of road constructed	

[10] Link to objective 3

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Annex I

Job Description (Doctor)

ওয়ার্ডে গিয়ে রোগি দেখা
ঔষধ লিখে দেয়া
রোগির বিভিন্ন সমস্যা সমাধান করা
আউটডোর ডিউটি করা
ইমারজেন্সি ডিউটি করা
রোগির সেবা প্রদান করা
ডেলিভারী করা

Job Description (Nurse)

ডেলিভারী করা
রোগির ঔষধ দেয়া
সন্তান জন্মদানের পর স্বাস্থ্য সেবা বিষয়ে পরামর্শ দেয়া
ডাক্তারের সাথে রাউন্ড দেয়া
স্বাস্থ্য সেবা প্রদান করা
রোগির সেবা প্রদান করা
ANC, PNC সেবা প্রদান করা
আউটডোর ডিউটি করা
উর্ধ্বতন কর্তৃপক্ষের দেয়া সকল বৈধ আদেশ পালন করা
গর্ভবতী রোগির চেকআপ করা
রোগির অবস্থা খারাপ হলে ডাক্তার ডাকা
রোগির ফাইল সংরক্ষণ করা
রোগির বিছানা প্রদান করা
নার্সদের মাঝে কাজ ভাগ করে দেয়া
Pts হস্তান্তর করা
ঔষধ হস্তান্তর করা
রেজিষ্টার খাতা সংরক্ষণ করা

Job Description (SACMO)

সাধারন স্বাস্থ্য সেবা প্রদান করা
ANC, PNC সেবা প্রদান করা
মা ও শিশু স্বাস্থ্য সেবা প্রদান করা
রোগি দেখা
স্বাস্থ্য সেবা প্রদান করা
ডেলিভারী করা

Job Description (HI/AHI)

সাধারন স্বাস্থ্য সেবা প্রদান করা
পুষ্টি বিষয়ক পরামর্শ/সেবা প্রদান করা
জাতীয় টিকাদান কর্মসূচী পালন করা
মাসিক প্রতিবেদন তৈরি করা
ভিটামিন এ+ ক্যাম্পেইন-এর আয়োজন করা
মনিটরিং ও সুপারভিশন করা

Job Description (Midwife)

ANC, PNC সেবা প্রদান করা
ডেলিভারী করা
মা ও শিশু স্বাস্থ্য সেবা প্রদান করা
পরিবার পরিকল্পনা সেবা প্রদান করা
স্বাস্থ্য ও পুষ্টি বিষয়ক পরামর্শ প্রদান করা
সাধারন স্বাস্থ্য সেবা প্রদান করা
উর্ধ্বতন কর্তৃপক্ষের দেয়া সকল কাজ সম্পাদন করা
যন্ত্রপাতি জীবানুমুক্ত করা

Job Description (FWV)

সাধারন স্বাস্থ্য সেবা প্রদান করা
ANC, PNC সেবা প্রদান করা
মা ও শিশু স্বাস্থ্য সেবা প্রদান করা
স্বাস্থ্য ও পুষ্টি বিষয়ক পরামর্শ প্রদান করা
পরিবার পরিকল্পনা সেবা প্রদান করা
প্রসবকালীন সেবা প্রদান করা
কিশোর কিশোরীদের সেবা করা

Job Description (CHCP)

সাধারন স্বাস্থ্য সেবা প্রদান করা
ANC, PNC সেবা প্রদান করা
কিশোর কিশোরীদের সেবা প্রদান করা
রেজিষ্টার সংরক্ষণ করা
স্বাস্থ্য ও পুষ্টি বিষয়ক পরামর্শ প্রদান করা
রোগি রেফার করা
পরিবার পরিকল্পনা সেবা প্রদান করা

Job Description (FWA)

সাধারন স্বাস্থ্য সেবা প্রদান করা
পরিবার পরিকল্পনা পদ্ধতি বিতরন/সেবা প্রদান করা
রেজিষ্টার সংরক্ষণ করা
মাসিক প্রতিবেদন তৈরি করা
ANC, PNC সেবা প্রদান করা
স্বাস্থ্য ও পুষ্টি বিষয়ক পরামর্শ প্রদান করা

Job Description (HA)

মা ও শিশু স্বাস্থ্য সেবা প্রদান করা
ইপিআই সেবা প্রদান করা
মাসিক প্রতিবেদন তৈরি করা
রোগি দেখা
স্বাস্থ্য ও পুষ্টি বিষয়ক পরামর্শ/সেবা প্রদান করা
ভিটামিন এ+ ক্যাম্পেইন-এ সেবা প্রদান করা

Tables

Table 1: Number of sample service providers for the Survey

Type of service provider	Frequency	Percent
NURSE	52	31.3
FWV	21	12.7
MIDWIFE	21	12.7
CHCP	14	8.4
FWA	13	7.8
MEDICAL OFFICER	13	7.8
SACMO	11	6.6
HA	8	4.8
AHI	7	4.2
CONSULTANT	4	2.4
FPI	2	1.2
Total	**166**	**100.0**

Table 2: Number of sample KII for the Survey

Type of respondents	Frequency	Percent
CIVIL SURGEON	4	7.0
DCS (DEPUTY CIVIL SURGEON)	2	3.5
DDFP	5	8.8
FEMALE UNION PARISHED MEMBER	5	8.8
UFPO	11	19.3
UH&FPO	13	22.8
UNION PARISHED CHAIRMAN	5	8.8
UPAZILA PARISHED CHAIRMAN	4	7.0
UPAZILA PARISHED VICE CHAIRMAN	8	14.0
Total	**57**	**100.0**

Table 2a: Distribution of sample health facility

Facility	n	Percent
DH	6	16.6
UHC	12	38.8
UH&FWC	9	23.9
CC	7	20.6
Total	34	100

Table 3: Distribution of work force in DGHS by position

Grade (Pay-scale)	Male	Female	Total	Male (%)	Female (%)
Grade-2	4	1	5	80.0	20.0
Grade-3	399	107	506	78.9	21.1
Grade-4	939	236	1175	79.9	20.1
Grade-5	708	190	898	78.8	21.2
Grade-6	3122	1087	4209	74.2	25.8
Grade-7	301	113	414	72.7	27.3
Grade-8	160	64	224	71.4	28.6
Grade-9	8292	5397	13689	60.6	39.4
Grade-10	2338	23094	25432	9.2	90.8
Grade-11	6481	2121	8602	75.3	24.7
Grade-12	25	6	31	80.6	19.4
Grade-13	326	47	373	87.4	12.6
Grade-14	9159	6869	16028	57.1	42.9
Grade-15	3661	1513	5174	70.8	29.2
Grade-16	11969	7433	19402	61.7	38.3
Grade-17	138	27	165	83.6	16.4
Grade-18	177	16	193	91.7	8.3
Grade-19	512	57	569	90.0	10.0
Grade-20	11637	4263	15900	73.2	26.8
Grand Total	**60348**	**52641**	**112989**	**53.4**	**46.6**

Sources: DHIS2 (date of access 20-06-2020)

Table 3a: Distribution of work force in district hospital (DH) by position

Position	Male		Female		Total	
	n	%	n	%	n	%
Superintendent	1	100.0	0	0.0	1	100.0
Director	1	100.0	0	0.0	1	100.0
Deputy Director of Family Planning (DD-FP)	1	100.0	0	0.0	1	100.0
Civil Surgeon (CS)	6	100.0	0	0.0	6	100.0
Deputy Civil Surgeon (DCS)	4	100.0	0	0.0	4	100.0
UH&FPO	17	94.4	1	5.6	18	100.0
RMO	17	94.4	1	5.6	18	100.0
Consultant	34	68.0	16	32.0	50	100.0
Junior consultant	27	69.2	12	30.8	39	100.0
Dental Surgeon	11	55.0	9	45.0	20	100.0
MO	89	59.7	60	40.3	149	100.0
SACMO	37	66.1	19	33.9	56	100.0
HI	16	88.9	2	11.1	18	100.0
AHI	9	69.2	4	30.8	13	100.0

Position	Male		Female		Total	
	n	%	n	%	n	%
FWV	0	0.0	71	100.0	71	100.0
FPI	5	100.0	0	0.0	5	100.0
Nurse/Sister		0.0	396	100.0	396	100.0
Brother	49	100.0	0	0.0	49	100.0
HA	26	57.8	19	42.2	45	100.0
CHCP	14	46.7	16	53.3	30	100.0
FWA	0	0.0	28	100.0	28	100.0
Midwife		0.0	47	100.0	47	100.0
Anaesthetist	2	100.0	0	0.0	2	100.0
Technician	55	84.6	10	15.4	65	100.0
Driver	34	100.0	0	0.0	34	100.0
Aye	0	0.0	57	100.0	57	100.0
Sweeper	23	71.9	9	28.1	32	100.0
Mali	11	91.7	1	8.3	12	100.0
Guard	36	97.3	1	2.7	37	100.0
Cook	13	50.0	13	50.0	26	100.0
Total	535	40.3	794	59.7	1329	100.0

Table 3b: Distribution of work force by facility

Position	Male		Female		Total	
	n	%	n	%	n	%
DH	169	36.7	292	63.3	461	100.0
UHC	319	43.7	411	56.3	730	100.0
UH&FWC	41	36.3	72	63.7	113	100.0
CC	6	24.0	19	76.0	25	100.0
Total	535	40.3	794	59.7	1329	100.0

Table 3b: Distribution of work force by type of providers

Position	Male		Female		Total	
	n	%	n	%	n	%
Physician	205	67.0	101	33.0	306	100.0
Non-physician	330	32.3	693	67.7	1023	100.0
Total	535	40.3	794	59.7	1329	100.0

Table 3b: Distribution of work force in district hospital (DH) by position (KII findings)

Position	Male	Female	Total
Superintendent	100.0	0.0	100.0
Deputy Director of Family Planning (DD-FP)	100.0	100.0	100.0
Civil Surgeon (CS)	100.0	0.0	100.0
Deputy Civil Surgeon (DCS)	100.0	0.0	100.0
UH&FPO	100.0	0.0	100.0
RMO	75.0	25.0	100.0
Consultant	77.8	33.3	100.0
Junior Consultant	71.4	42.9	100.0
Dental Surgeon	66.7	33.3	100.0
MO	66.7	33.3	100.0
SACMO	60.0	40.0	100.0
FWV		100.0	100.0
FPI	82.5	17.5	100.0
Nurse		100.0	100.0
Brother	100.0	25.0	100.0
FWA		100.0	100.0
Midwife		100.0	100.0
Anaesthetist	100.0	0.0	100.0
Technician	75.0	25.0	100.0
Driver	100.0	0.0	100.0
Aya	20.0	100.0	100.0
Cleaner/Sweeper	50.0	0.0	100.0
Mali	50.0	50.0	100.0
Guard	100.0	0.0	100.0
Cook	50.0	100.0	100.0

Table 4: Distribution of work force in Upazila Health Complex (UHC) by position

Position	Male	Female	Total
UH&FPO	100.0	0.0	100.0
RMO	100.0	0.0	100.0
Consultant	66.7	33.3	100.0
Junior Consultant	75.0	25.0	100.0
Dental Surgeon	100.0	0.0	100.0
MO	66.7	33.3	100.0
SACMO	75.0	25.0	100.0
HI	100.0	33.3	100.0
AHI	66.7	16.7	100.0
FWV	0.0	100.0	100.0
Nurse		100.0	100.0
Brother	100.0	0.0	100.0
HA	88.9	22.2	100.0
Midwife		100.0	100.0
Anaesthetist	100.0	0.0	100.0
Technician	66.7	33.3	100.0
Driver	100.0	0.0	100.0
Aya	100.0	100.0	100.0
Cleaner/Sweeper	50.0	50.0	100.0
Mali	100.0	0.0	100.0
Guard	100.0	0.0	100.0
Cook	100.0	100.0	100.0

able 5: Self-reported performance of service provider by position

Position	General health	Antenatal care	Deli very	Post natal care	TT vaccine	Child health care	EPI services	Adolescent health	Nutrition services	Vit- A/ Eye Treatment	ENT	Elderly care	Health education/ BCC
CONSULTANT	100	75	75	75	50	75	75	100	75	50	75	25	75
MEDICAL OFFICER	100	100	92	85	54	100	54	85	77	62	69	54	54
MIDWIFE	86	100	95	86	52	86	76	81	86	100	33	57	95
NURSE	100	94	96	83	65	77	48	83	79	83	58	56	67
SACMO	100	100	55	82	55	91	55	82	82	64	46	55	64
FPI	100	0	0	0	0	100	0	100	100	0	0	0	50
FWA	77	100	15	15	85	100	54	46	100	23	0	77	92
FWV	86	100	95	86	48	91	38	95	91	81	62	76	43
HA	88	100	63	88	100	88	88	75	100	63	50	88	38
AHI	100	86	14	0	71	100	86	29	100	57	14	43	43
CHCP	100	86	79	71	100	86	79	93	100	86	64	71	21
Total	94	95	78	73	65	87	58	80	87	74	49	61	62

Table 6: Number of male-female by division

Position	Dhaka			Chottagram			Mymensingh			Sylhet			Khulna			Rajshahi			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Civil Surgeon (CS)	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	6	0	6
Deputy Civil Surgeon (DCS)				1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	4	0	4
UH&FPO	2	0	2	2	0	2	5	0	5	3	0	3	3	0	3	2	1	3	17	1	18
RMO	2	0	2	2	0	2	5	0	5	3	0	3	2	1	3	3	0	3	17	1	19
Consultant	5	3	8	4	3	8	9	2	12	7	1	8	4	4	8	4	3	7	34	16	50
Junior consultant	4	0	4	2	1	2	1	0	1	10	4	14	2	3	5	9	5	13	27	12	39
Dentist Surgeon	2	2	3	0	3	3	1	4	5	3	0	3	3	0	3	3	1	3	11	9	20
MO	9	5	14	11	8	19	26	23	49	13	6	19	16	10	25	15	9	24	89	60	150
SACMO	8	4	12	4	2	6	4	2	6	6	2	9	7	4	11	8	6	13	37	19	57
HI	5	2	7	2	0	2	9	0	9				1	0	1	1	0	1	16	2	18
AHI	1	1	2	0	1	1	1	1	1	4	0	4	0	0	1	3	1	4	9	4	13
FWV		11	11		9	9		20	20	0	11	11		11	11		10	10	0	71	71
FPI	1	0	1	1	0	1	1	0	1	1	0	1	0	0	0	1	0	1	5	0	5
Nurse/Sister		40	40		54	54		112	112		60	60		62	62		69	69		396	396
Brother	5	0	5	5	1	5	18	0	18	7	0	7	7	0	7	8	0	8	49	1	50
HA	3	2	5	3	3	6	6	5	11	4	3	7	3	2	4	7	5	12	26	19	45
CHCP	2	3	5	2	1	4	3	6	9	4	3	7	3	2	5	0	1	2	14	16	30
FWA		6	6		3	3		8	8	0	5	5		3	3	0	3	3	0	28	28
Midwife		3	3		5	5		13	13		7	7		10	10		8	8		47	47
Anaesthetist	1	0	1	0	0	0		0	0	0	0	0							2	0	2
Technician	8	1	9	5	2	7	19	2	21	6	1	7	5	2	7	12	2	14	55	10	65
Driver	6	0	6	4	0	4	10	0	10	5	0	5	4	0	4	5	0	5	34	0	34
Aye	0	9	9	0	8	8		14	14		10	10	0	8	8	0	8	8	0	57	57
Sweeper	2	2	4	4	2	6	5	1	6	3	1	4	5	0	5	5	2	8	23	9	32
Mali	4	0	4	1	1	2	2	0	2	2	0	2	1	0	1	2	0	2	11	1	12
Guard	7	0	7	5	0	5	9	0	9	5	1	5	5	0	5	5	0	5	36	1	36
Cook	3	1	4	2	1	3	3	3	6	2	2	3	1	3	4	2	2	5	13	13	25
Total	**78**	**93**	**172**	**61**	**107**	**167**	**138**	**217**	**355**	**89**	**115**	**204**	**74**	**125**	**199**	**96**	**136**	**232**	**535**	**794**	**1329**

List of Research Team

Sl. #	Name	Designation
01	Mr. Fashiur Rahman	Quality Control Officer
02	Mr. Babul Akhter	Supervisor
03	Mr. Mofakhkharul Islam	Supervisor
04	Mr. Md. Jahangir Alam	Supervisor
05	Ms. Shanaz Pervin	FGD Organizer
06	Mr. Anisuzzaman	FGD Organizer
07	Mr. Mofazzal Hossain	Enumerator/Data Collector
08	Ms. Shahida Lashkar	Enumerator/Data Collector
09	Mr. Giash Uddin	Enumerator/Data Collector
10	Mr. Mohshin	Enumerator/Data Collector
11	Mr. Abdul Hannan	Enumerator/Data Collector
12	Mr. Siddikur Rahman	Enumerator/Data Collector
13	Ms. Kakuli Akter	Enumerator/Data Collector
14	Ms. Sharmin Akter	Enumerator/Data Collector
15	Mr. Kazi Sorrowar Hossain	Enumerator/Data Collector
16	Ms. Riya Akter	Enumerator/Data Collector
17	Mr. Sharif Miah	Enumerator/Data Collector
18	Mr. Mukhlesur Rahman	Enumerator/Data Collector
19	Mr. Sayed Abdullah	Data Entry Operator