**PARTNERSHIPS FOR EQUITY AND INCLUSION**

**of**

Equity in Health and Education Services during COVID 19 Pandemic in Bangladesh: Challenges and Way-forward

**PILOT PROJECT REPORT**

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**FOREWORD**

This report was produced as part of the activities of the [Partnership for Equity and Inclusion](https://medicinehealth.leeds.ac.uk/dir-record/research-projects/1366/partnerships-for-equity-and-inclusion), a collaboration of international research networks aiming to support equitable practice in public service institutions. Findings aim to inform policymakers and practitioners in public services as well as advocacy groups that seek to improve public service access, outcomes and representation for socially excluded populations.

This pilot study was implemented by Centre for Injury Prevention and Research Bangladesh (CIPRB) in collaboration with ARK Foundation. The study involved national key stakeholders of health and education sector in Bangladesh as Advisory Board members.

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# Executive Summary

**Background:** The onset of the pandemic has made the lives of millions of people living in disadvantage more difficult than before by extending the existing disparities. Reduced income and uncertainty has made essential services like healthcare and education burdensome for disadvantaged families. According to the Bangladesh Bureau of Statistics in its August 2020 report, the national poverty rate has risen from 20.5 percent to 29.5 percent from July 2019 and June 2020 owing to the COVID-19 pandemic. Lower socio-economic groups were already living at a disadvantage in Bangladesh before the pandemic took its toll. For instance, people living in rural regions need to travel a long distance to avail proper healthcare services from a public hospital. Ethnic indigenous groups are even more deprived in terms of income and this affects the different facets of their lives including education, healthcare, food consumption, etc. Inequality is also rampant within the urban sphere where around 19 percent of urban dwellers live in poverty (Household Income and Expenditure Survey, 2016). The urban slums are wrought with poor sanitation, lack of proper housing, poor access to education and healthcare services. Furthermore, at least 44 percent of households in Bangladesh were affected by natural disasters in 2014 (Bangladesh Bureau of Statistics, 2014). In contrast, the affluent urban dwellers have significantly higher income and are able to afford high quality education and healthcare services. These disparities prove that in order to address the existing inequalities, different disadvantaged groups require different interventions in order to receive the same accessibility and quality of healthcare and education services. In other words, there is a need to establish equity in the delivery of these essential services.

**Study Purpose:** This study aims to explore the varying experiences of different disadvantaged groups in accessing healthcare and education services during the pandemic in Bangladesh. The primary objective was to identify the gaps and challenges in current practices, and to recommend mitigation strategies to address them.

**Research Design and Methods:** The study deployed qualitative approach. Both the service providers’ (teachers and healthcare staff) and receivers’ perspective (parents of school going children and patients) have been explored in the study. Once the disparities in the different social groups surfaced from the study, the barriers and challenges in accessing and providing health and education services during the pandemic were identified. Based on the findings, mitigation strategies were recommended through the participation of different stakeholder groups in a workshop that aimed to come up with strategies to establish more equity in services.

The study was done in three main parts. In the first phase of the study, in-depth interviews and focus group discussion were carried out on healthcare and education service providers and receivers. The healthcare and education service receiver group respondents were purposively selected from five different communities- indigenous community, rural community, disaster-stricken hard-to-reach community, urban slum dwellers, and community with middle/upper middle income in capital city. The service receivers were interviewed at an in-depth level with the help of a semi-structured questionnaire. The questions focused on health seeking information of the patients, experience at healthcare centres, opinion on services during pandemic, opinion on improving healthcare services, experience of education of children during pandemic and economic impact of the pandemic. Clustered samples of healthcare and education providers were interviewed in a similar way. Healthcare and education providers were selected from all levels—primary, secondary, and tertiary—as well as from both public and private institutions. In the final phase, the identification of the key disparities in healthcare and education facilities were presented at a workshop to a group of stakeholders. Participants at the workshop included representatives from all key interest groups, including policymakers, planners, NGO workers serving marginalized communities, and key professional stakeholders. The interviews were transcribed, translated to English, and analysed using a thematic approach.

**Findings:** Findings from the initial explorative study highlighted the glaring inequality present among the different socio-economic groups in terms of accessing health and education services during the pandemic.

***COVID-19 Preventive Practices and Economic Burden***

It was found that preventive measures like wearing masks, washing hands and maintaining social distancing rules were very low among the indigenous respondents, rural respondents, and respondents from the geographically hard-to-reach region. Although urban dwellers were well aware of the pandemic, it appeared that only the higher socio-economic background individuals followed the COVID-19 health protocols. The urban slum dwellers could not take preventive measures due to their overcrowded living arrangements, inadequate sanitation facilities (lack of clean water and soap), and a lack of affordability for masks and hand sanitizers. Surprisingly enough, Indigenous ethnic groups were unaffected economically during the pandemic. Their economic burden which is historically high, did not increase or decrease during the pandemic. A key reason for this may be that their economic activities are separated from the rest of the economy of Bangladesh. Other disadvantaged groups like the rural inhabitants and the coastal regions were hit hard by the pandemic. However, as expected the affluent urban dwellers were not much affected economically during the pandemic.

***Accessibility to Health and Education***

It was found from the study that people from higher socio-economic groups said they availed healthcare services from private hospitals or clinics where the quality of service is higher than that of the public hospitals. The urban affluent respondents also informed that during the pandemic, health services were also sought through telemedicine options. However, due to the digital divide and lack of education among the lower socio-economic groups, telemedicine services was not an option for them. On receiving education services for school going children, respondents from rural and coastal areas reported that their children were able to study at home by themselves or with the help of a tutor. Self-teaching was not possible in indigenous regions or for slum dwellers, and their children's education was completely halted. Except for the urban affluent class, accessing mental health check-up or psychological counselling was not an option for the children experiencing distress as a result of the covid-19 pandemic consequences. Although both English and Bangla medium urban schools have a digital learning process in action, English medium schools are a few steps ahead as they have a dedicated app for classes. Additionally, as the number of students are low in private schools the teachers are able to check attendance and progress of each student. However, while English medium schools offer planned extracurricular activities, Bangla medium schools do not. None of the schools offer psychosocial counselling for the students, teachers or parents.

***Experience of Health and Education Service Providers***

Questions directed towards the health and education service providers also explored existing inequalities in the system. Government healthcare providers reported that they perceive the patients in the government hospitals are not satisfied with their health treatments while the patients in the private hospitals and NGOs are perceived to be satisfied by the healthcare providers. The major cause of patient dissatisfaction with public services, according to healthcare providers, is a lack of resources, both in terms of human resources and logistics, to accommodate a large influx of patients. While government healthcare providers were satisfied with their pay and professional development opportunities, they were concerned about the lack of safety in their workplace. In contrast, healthcare providers at private facilities reported to have adequate and modern resources to serve their patients, but the high price of services allowed them only to cater to patients in the middle to upper wealth quantiles. Similarly, in the education sector, teachers from government institutes reported struggling with insufficient internet connections and devices, which hampered their ability to provide proper online education. Teachers in public schools had not received any training on the digital learning process, and those in rural areas reported that a considerable number of students had dropped out of their institution. Conversely, teachers from private educational institutions, mostly in urban areas, were satisfied with their facilities, and their only concern was the students' level of concentration during the digital process.

***Recommendations for Mitigation Strategies***

The compiled findings of initial phases were presented to a group of stakeholders in an online workshop in order to devise mitigation strategies. Workshop participants proposed three inter-connected key strategies for mitigating the overreaching inequity present among the different disadvantaged groups in Bangladesh. The first recommendation was to generate more evidence on inequities in services, which is currently scarce in a low-income country like Bangladesh. More research is needed to uncover the disparities in the current service delivery system so that evidence-based approaches can be developed. The following recommendation was to advocate for evidence-based findings and approaches to be reflected in policies and national operational plans. When developing research or policy level strategies, the inclusion of beneficiary groups or representatives from the disadvantaged was especially emphasized. Additionally, the workshop participants recommend that the heightened gap in receiving essential services among socioeconomic groups, as suggested by this study's findings, necessitates a customized and targeted approach, as well as the allocation of additional resources in relevant regions.

**Conclusion:** This report highlighted the disparities among the different communities in Bangladesh. Based on the findings from the open-ended interviews, it proposes strategies for minimizing these disparities through a number of actionable tools. Thus, policymakers can use the report to develop evidence-based policies, and advocacy groups can voice the disparities highlighted in the report to achieve better essential services for the marginalized communities.

# Introduction

Coronavirus (COVID-19) pandemic in Bangladesh has spread to around 1.2 million individuals and claimed 20,916 lives as of August 2nd, 2021 (Worldometer, 2021). The pandemic not only claimed lives in Bangladesh, but extended the existing disparities in society even more. Gini coefficient in Bangladesh before the pandemic was 32.4% (World Bank, 2016) but increased in recent times as the poverty rate rose sharply after the pandemic took its toll in early 2020. Substantial income inequality, as well as unequal distribution of opportunities, have historically existed in Bangladesh. Existing disparities, combined with the pandemic's consequences, have put a fresh burden on marginalised communities, making the lives of millions of people living in disadvantage more difficult than before.

People living in poverty suffer from lack of quality public services in Bangladesh. The country’s current expenditure in healthcare is only 2.34 percent of GDP (World Bank, 2018), and government expenditure in education is only 1.326 percent of GDP (World Bank, 2019). This low expenditure in essential services does not bode well for reducing disparity among the different socio-economic groups of Bangladesh and improving the quality of their lives. The pandemic has further decreased the access to these fundamental services. Consequently, the declining quality of lives of the disadvantaged people and the subsequent rise in inequality between the affluent and the lower socio-economic people has become a matter of grave concern.

Healthcare is known to be one of the most affected sectors during a humanitarian crisis. The Ebola outbreak between 2014-2015 in Liberia caused a severe halt in healthcare where maternal health especially suffered from lack of proper health services (Shannon *et al.*, 2017). Obtaining healthcare services has similarly become more difficult for the general population of Bangladesh as a result of the current pandemic. The already burdened healthcare sector where there are 1800 ICU beds for a population of 160 million (Abdullah, 2021) and only one registered doctor for every 1,581 person (Khatun and Saadat, 2021), during the pandemic has been unable to cater to the healthcare needs of millions of people. Due to the scarcity of critical care resources, the most vulnerable patients are frequently facing huge challenges in getting appropriate treatment. Apart from struggling to treat coronavirus patients due to lack of ICU beds and oxygen supply, the hospitals have been unable to fully cater to the non-coronavirus patients especially in the maternal, child care, and non-communicable diseases departments. The District Health Information System (DHIS2) data from healthcare institutions also revealed that there has been some sharp drop in acquisition of essential health services with the onset of the pandemic from April to May 2020 (Wangmo *et al.*, 2021). Furthermore, the nationwide immunization campaign for children had to be postponed for the risk of transmission of COVID-19 pandemic, and came out from study that child mortality has also increased during the pandemic (Ahmmed, Babu and Ferdosy, 2021) as well. Since June 2020, some initiatives by the government was undertaken including recruitment of more 2500 doctors and 5000 nurses, and introduction of alternate health services via telemedicine and tele-pharmacy to mitigate the effect of pandemic on healthcare (WHO, 2020). However, ensuring widespread availability and accessibility of these services, particularly to vulnerable populations, continues to be a major concern.

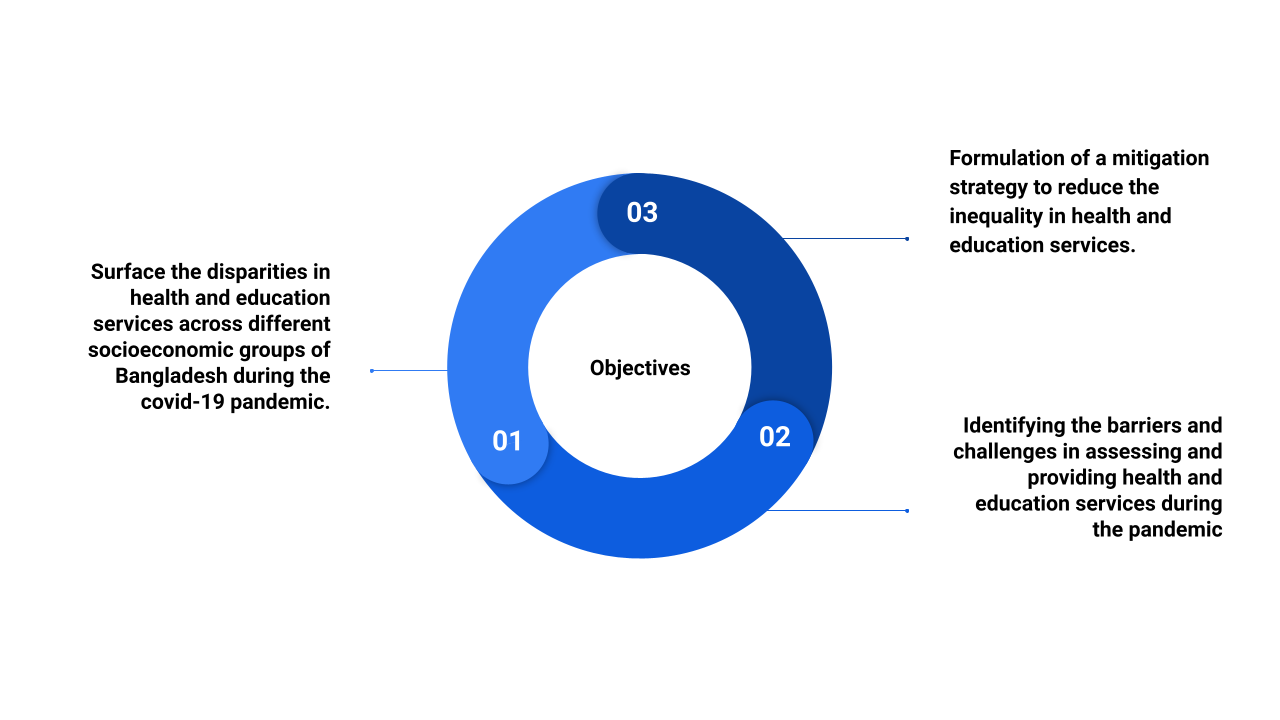
The outlook is similarly grim in the education sector as all educational institutions are closed in Bangladesh since March 2020. The dropout rate in secondary schools of the country is the highest at 37.6% according to Bangladesh Bureau of Educational Information and Statistics (BANBIES) and experts believe this figure is expected to rise due to the pandemic (Yususf and Rabi, 2020). School lessons aired in the national television has been implemented by the government but the services comes with a catch, as the digital divide arising from poverty prevents a large part of the population from availing these services (Ahmed, 2020). Despite the best efforts of the government, the initiative to cast lessons through the national broadcasting channel is not being received well by school going children. A BRAC survey on 5000 students from urban slums and rural regions show that time spent studying has been reduced by 80% while only 16% of students attended the classes shown in the national television (BRAC Institute of Governance and Development, 2020). The closure of in-person education for more than a year has ushered in digital learning in Bangladesh, but the benefit is not equally distributed across different socioeconomic groups.

The existing inequality in Bangladesh means that a one-size-fits-all strategy for delivering essential healthcare and education services cannot be applied for all the people of Bangladesh as there are various socio-economic groups suffering from different disadvantages in multiple ways. For instance, people living in rural regions need to travel a long distance to avail proper healthcare services from a public hospital. Ethnic indigenous groups are even more deprived in terms of income and this affects the different facets of their lives including education, healthcare, food consumption, etc. (Rahman *et al.*, 2021). Inequality is also rampant within the urban sphere where around 19 percent of urban dwellers live in poverty (Household Income and Expenditure Survey, 2019). The urban slums are wrought with poor sanitation, lack of proper housing, poor access to education and healthcare services. Furthermore, cyclone Amphan and the monsoon flood on top of COVID-19 have made life extremely difficult for coastal communities. (Ober, 2020). On the flip side, the affluent urban dwellers have significantly higher income and are able to afford high quality education and healthcare services. These disparities prove that in order to address the existing inequalities, different disadvantaged groups require different interventions in order to receive the same accessibility and quality of healthcare and education services. In other words, there is a need to establish equity in the delivery of these essential services. To establish equity in essential services, it is imperative to explore the experiences of different socioeconomic groups and identify the gaps in existing practices.

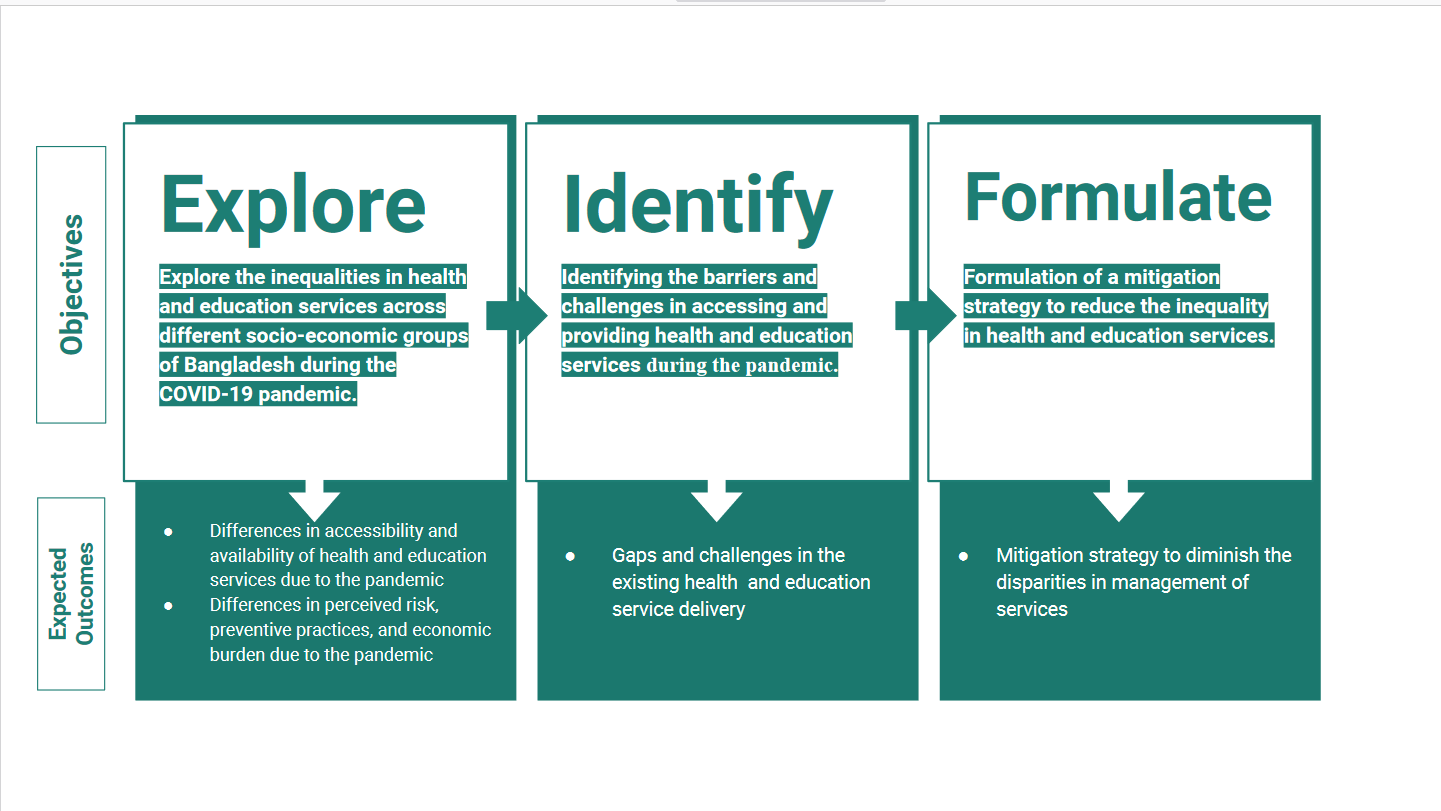
## Objectives of the Research

The various socio-economic groups of Bangladesh suffering from different levels of deprivation and disadvantages may not equally access quality education and healthcare services, particularly during a pandemic crisis. This study aimed to explore the varying experiences by different sociodemographic groups in accessing healthcare and education services during the pandemic. Both the service providers’ (teachers and healthcare staff) and receivers’ perspective (parents of school going children and patients) have been explored in the study. Once the disparities in the different social groups surfaced from the study, the barriers and challenges in accessing and providing health and education services during the pandemic were identified. Based on the findings, some mitigation strategies were recommended through the participation of different stakeholder groups in a workshop that aimed to come up with strategies to establish equity in services.

## 



*Figure 1: Objectives of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*



*Figure 2: Objectives in relation to the expected outcomes of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic**.*

## Research Questions

This study aims to generate robust evidence on the existing and increase in disparity in receiving education and healthcare services during the pandemic by answering the following research questions.

### COVID-19 and Health Service:

* Are there any differences in accessing health services by patients from different socioeconomic groups during COVID 19 pandemic?
* What are the barriers and challenges faced by patients and their attendants while seeking healthcare services during COVID-19 pandemic?
* What are the experiences and challenges of healthcare workers of different sectors and different levels (e.g. doctors, nurses, health assistants and other healthcare workers and volunteers) while serving patients during COVID-19 pandemic?

### COVID-19 and Education Service:

* What are the barriers and challenges faced by children across different socio-economic groups regarding education/schooling during COVID-19 pandemic?
* What are the experiences and challenges of education providers of different sectors (government & private) and different levels (primary, secondary, university level) while delivering education during COVID-19 pandemic?

### COVID-19 and Behavioural Practice:

* How patients from different socioeconomic groups perceive risk behaviours and practice preventive measures for COVID 19 pandemic?

### COVID-19 and Economic Burden:

* How is economic burden distributed among patients (parents) and their attendants of different social groups during COVID-19 pandemic?

### Mitigation Strategies:

* What are the suggestions and perception of key stakeholders and what can be learned from this pandemic regarding equitable health and education service delivery for future crisis?

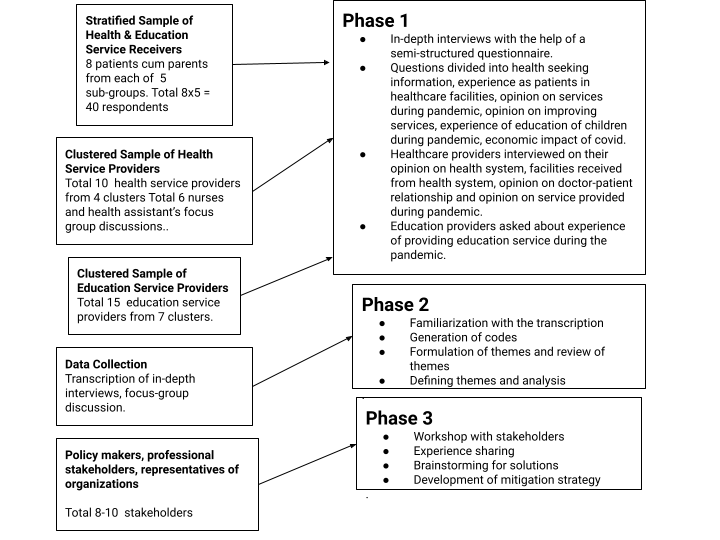
# Methods and Materials

A qualitative method was deployed to achieve all the objectives of the study. An elaborate thematic approach was undertaken to explore and analyse the disparities among the various socioeconomic groups of Bangladesh in an inductive manner.

## Study Design

In order to identify the inequalities across different socioeconomic groups of Bangladesh in terms of access to services, delivery of services and economic burdens during the pandemic, a process of triangulation was used.

The study was done in three main phases. In the first phase of the study, In-depth interviews (IDI) and Focus Group Discussion (FGD) were carried out among purposively selected healthcare and education service receivers and providers. In the second phase of the study, the raw data was condensed with the help of thematic approach. In the final phase, the identification of the key disparities in healthcare and education facilities were presented in a workshop to a group of stakeholders and some mitigation strategies were recommended. Figure 3 presents the phases of the study.



*Figure 3: Methodological phases of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

## Study Setting and Participants

The objective of this study was to explore the differences in healthcare and education services during the pandemic both from service receivers and providers point of view. Based on this objective, the following study participants were included:

* Patients who have sought healthcare services during the COVID-19 pandemic and are parents of school or college going children.
* Healthcare workers (doctors, nurses and healthcare assistants) who have been providing service during the pandemic.
* Education providers (teachers) of different government and private schools and colleges.

### Healthcare and Education Service Receivers

A total of 40 health and education service receivers (patients cum parents of school/college going children) were selected from five different regions. From each region, eight participants were purposively selected. The regions represent groups of people from different socio-economies undergoing different criteria of disadvantages. The characteristics of the regions are described in brief below:

* **Raiganj**: The Raiganj sub-district under Sirajganj district of Bangladesh is a rural area of agriculture based economy. The selected respondents from here represent the middle to low socio-economic rural population of Bangladesh.
* **Barisal**: Barisal district is a coastal region. People living here are frequently hit by flooding and live in poverty (World Bank, 2015). Selected respondents from this region represent the experience of a low socio-economic group of geographically hard to reach areas.
* **Sylhet**: Sylhet district is situated in the north-eastern side of the country and one of the places in Bangladesh where indigenous or ethnic minority population predominantly resides. Respondents were selected from the Moulvibazar sub-district under Sylhet where most of the ethnic population are involved in the production and harvest of tea in the tea gardens. They are a culturally marginalized and exploited community living in abject poverty (Rahman *et al.*, 2021). Respondents from this region will represent the experience of the poorest indigenous group.
* **Dhaka (Urban Slum):** To explore the experience of urban poorest, data was collected from urban slum respondents in the Dhaka region. People in urban slums live in severely congested, unhygienic conditions (Hossain, 2020). The adults and many of the children are usually involved in informal works. The children from the slums often dropout of school as they cannot afford to go to school when they can add to the household income. For this study, respondents were selected from Mirpur Beribadh slum.
* **Dhaka (Upper-middle to high income)**: Dhaka is the capital city of Bangladesh. Although the place for a large number of slum dwellers, Dhaka is made up of middle to high income people who have either migrated from rural areas or are born there. Eight respondents from upper middle to high income groups of Dhaka was selected to represent the experiences of affluent group.

Table 1 summarizes the characteristics of the service receivers.

*Table 1: Characteristics of the participants representing service receivers in the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SL** | **No. of Patients** | **Socio-Economic Group** | **Vulnerability Characteristics** | **Area** |
| 1 | 8 | Middle to Low Socioeconomic | Geographical-Rural area | Raiganj sub-district |
| 2 | 8 | Low-Socioeconomic | Slum Dwellers | Mirpur Beribadh Slum, Dhaka |
| 3 | 8 | Low-Socioeconomic | Ethnicity-Indigenous community | Moulvibazar Tea Garden |
| 4 | 8 | Middle to Low Socioeconomic | Geographical-hard to reach coastal area | Patuakhali, Barisal |
| 5 | 8 | Upper Middle to high Income Group | N/A | Dhaka City |
|  | **Total = 40** |  |  |  |

### Healthcare Service Providers

The healthcare system of Bangladesh is dependent on three different categories of service delivery, namely government, private, and NGO/INGO. The government and private facilities are further divided into primary, secondary, and tertiary healthcare facilities. While the government and NGO facilities provide healthcare for free or at a subsidized rate, the private health facilities charge a high fee (Siddiqui and Khandaker, 2007). Table 2 presents the number and facility type of the healthcare providers.

*Table 2: Type of healthcare facilities and corresponding number of health service provider respondents of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

|  |  |
| --- | --- |
| **Type of Health Facility** | **Number of Respondents (Doctors, nurses & health assistants)** |
| Government Primary Health Care Facility | 6 |
| Government Tertiary Health Facility | 4 |
| Private tertiary/ Specialized Health Care Facility | 3 |
| Private NGO/ INGO | 3 |
| **Total** | **16** |

### Education Service Providers

Bangladesh has three major education stream- Bengali medium, English medium, and the Madrasah (religion based education). People from the lower tier of the socio-economy mostly go to the government schools and colleges, including Madrasahs. On the other hand, the private schools and colleges of Bengali and English medium curriculum are usually attended by the affluent portion of the population. Table 3 presents the different sub-groups of education service providers.

*Table 3: Type of educational institution and corresponding number of teachers in the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

|  |  |
| --- | --- |
| **Type of Educational Institute** | **Number of Respondents** |
| Government Primary School (Rural) | 2 |
| Government College (Rural) | 2 |
| Government Primary School (Urban) | 2 |
| Government College (Urban) | 2 |
| Private School and College (English Medium) (Urban) | 3 |
| Private School and College (Bangla Medium) (Urban) | 3 |
| Madrasah | 1 |
| **Total** | **15** |

### Workshop Participants

The findings of the study were presented at a workshop attended by key professional and policy level stakeholders from Bangladesh's health and education sectors. Ten people including the research investigators attended the workshop to identify mitigation strategies. Table 4 presents the particulars of workshop participants.

*Table 4: Particulars of the workshop participants of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

|  |  |  |
| --- | --- | --- |
| **SL** | **Sector/Area** | **Designation** |
| 1 | Policy & Planning | Director General,  Directorate General of Medical Education |
| 2 | Policy & Planning | Senior Secretary,  Ministry of Primary and Mass Education |
| 3 | Policy & Planning | Ex-Additional Secretary,  Ministry of Health and Family Welfare |
| 4 | Policy & Planning | Ex-Director, Primary Health care,  Directorate General of Health Services |
| 5 | Policy & Planning | Senior Epidemiologist and Divisional Coordinator,  National Public Health Committee for COVID-19 Management |
| 6 | Policy & Planning | Member of Public Service Commission |
| 7 | Media | Senior Journalist, Head of News,  ATN News Limited |
| 8 | NGO representative | Executive Director, ARK Foundation |
| 9 | Professional | Public Health Specialist & Executive Member, Early Childhood Development (ECD) network |
| 10 | Professional | Public Health Specialist & Equity Researcher |

## Instruments

Literature guided instruments were used for IDIs and FGDs. Recent literatures on the COVID-19 pandemic was reviewed and references from past epidemics like Ebola and SARS, were also drawn. The questions for service receivers were focused on health seeking information of the patients, experience at healthcare centres, opinion on services during the pandemic, opinions on improving healthcare services, experience of education of children during pandemic and economic impact of the pandemic. Questions in the section examining healthcare and education providers' experiences during the pandemic focused on the various levels of challenges faced by providers working at different tiers of the facility. Participants in the workshop were asked to elaborate on what they thought would be the most effective way to address existing inequities in services.

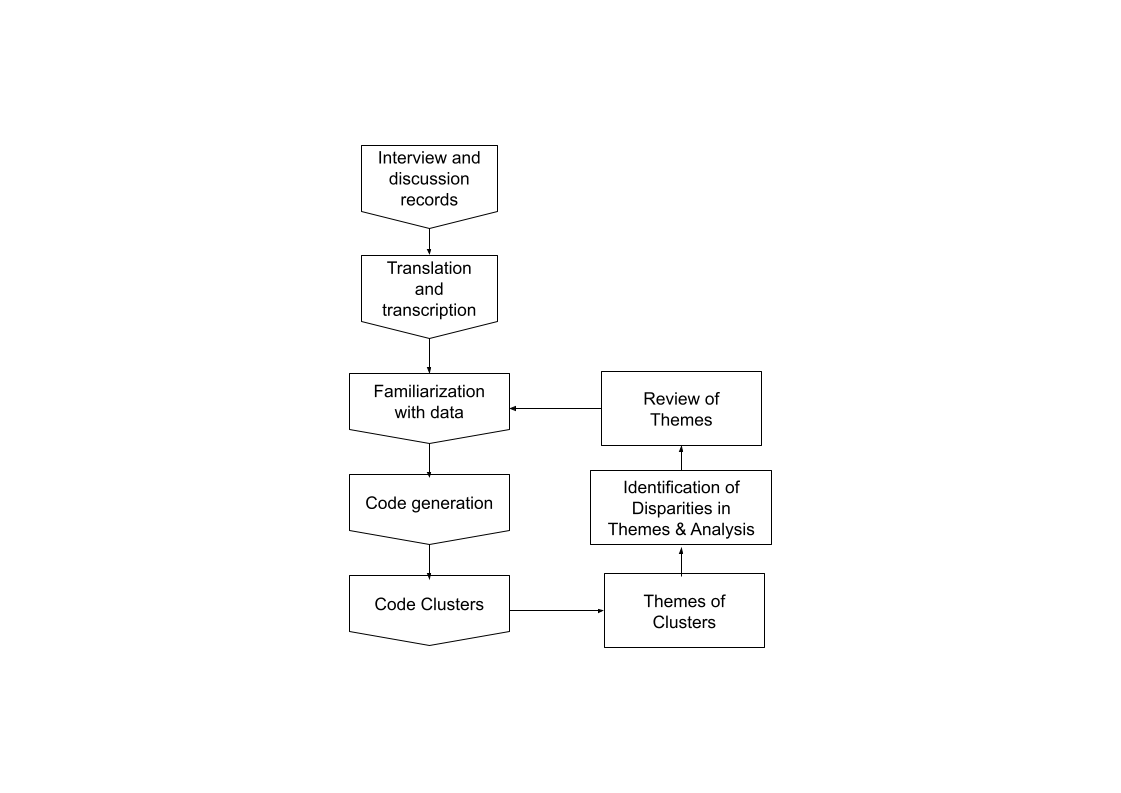
## Data Collection

The in-depth interviews were conducted face-to-face with the respondents from urban slums and indigenous communities. Due to limitations posed by the risk of COVID-19 infection, other groups comprising rural inhabitants, coastal people and affluent urban dwellers, were all reached through phone interviews. The healthcare professionals as well as the education providers were reached by phone as well.

The workshop, comprising stakeholders of the healthcare and education services sector, was conducted online. The discussions were akin to focus group discussions and guided by an experienced moderator. The discussions from the workshop were documented to help in identification of the mitigation strategies.

## Data Analysis

The process of analysis started with elaborate data collected from the in-depth interviews and focus group discussions. The recordings were played and transcribed in Bengali. Consequently, the transcripts were translated to English. For the purpose of extracting valuable insights from the interview transcripts, consisting of numerous perspectives of healthcare and education service providers plus receivers, a thematic approach was employed. Through finding recurring perspectives, codes were generated through an open-coding method at first. Later the codes were condensed and categorized into broader themes. A “constant comparative method” was deployed to compare the themes and refine them as the study progressed.

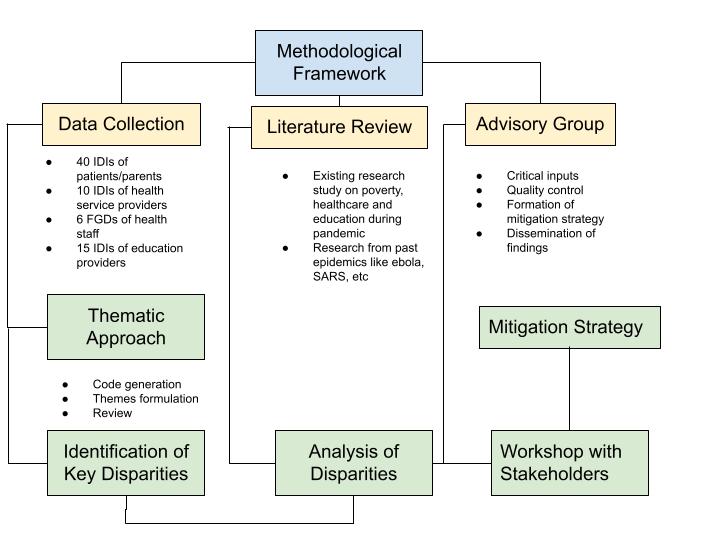


*Figure 4: Thematic analysis flowchart of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

The first set of codes emerged in an open manner, where any relevant codes that repeated or did not repeat were recorded. Once the first phase of the coding of the transcripts were completed, the transcripts were again reviewed for overlapping codes of similar nature. In this manner of “constant comparison”, a shortlist of repeating thoughts or patterns were identified for each of the sub-groups and healthcare and education service providers. Once the coding list seemed condensed and comprehensive enough, the codes were grouped together based on similarities. The code clusters thus formed were then combined in a diagrammatic form to visualize the possible themes for the cluster. Once themes emerged and all the codes were covered under the themes, there surfaced the disparities present among the various socio-economic groups. Furthermore, there emerged clear patterns among government or non-government owned healthcare and education facilities and private healthcare and education facilities. The former facilities are usually attended by the lower socio-economic groups while the latter are more frequented by the affluent population of Bangladesh. Each participant was given a pseudo-name and it was used while presenting findings.

## Ethical Issues and Quality Control

Informed recorded verbal consent was taken from all the respondents. For face-to-face interviews, preventive measures like maintaining social distancing, wearing masks, washing hands, etc. were maintained and the Directorate General of Health Services’ guideline for research during COVID-19 were comprehensively followed. Anonymity and confidentiality of the respondents along with secure storage of data was strictly maintained throughout the study process. Pseudo-names were used while presenting findings. Contact details of the patients were available in sampling frames of previous research studies. Of those, the respondents who gave consent to be contacted again were purposely selected according to the inclusion criteria of the study and were contacted over phone. Following their informed verbal consent, interviews were scheduled. An advisory group was also formed to ensure the quality of the research activities and to advocate for the findings at the policy level.



*Figure 5: Methodological framework of the study addressing the disparities in health and education services in Bangladesh during the COVID-19 pandemic.*

# 

# Findings

The study findings have surfaced the disparities in accessibility and availability of health and education services among the different socioeconomic groups during the COVID-19 pandemic. Consequently, the variance in the perceived risk, preventive practices, and economic consequences of COVID-19namong the groups were exposed. It also revealed the differences in service providers' experiences and challenges at different levels of facility. The findings of the study are discussed in detail below.

## Covid-19: Perception, Practice and Economic Burden among service users

Respondents (patients and parents of school-going children) were asked about their views on the covid-19 pandemic. In response, the different socio-economic groups gave varying responses. The geographical disadvantaged groups living in rural areas, indigenous tea garden regions, and coastal regions had low awareness about the pandemic. However, urban dwellers regardless of their socio-economic background, were well aware of the pandemic. Preventive measures like wearing masks, washing hands and maintaining social distancing rules were similarly very low in the rural, coastal, and indigenous groups. Although urban dwellers were well aware of the pandemic, it appeared that only the higher socio-economic background individuals followed the covid-19 health protocols. Congested living conditions and a lack of sanitation facilities prevent urban slum dwellers from practicing social distance and hand washing. Inability to purchase and scarcity of masks were also cited as reasons for not wearing masks.

***‘How can we maintain distance here? It’s not possible, you can see. I used to wear the mask supplied to us. Now we don’t have money for mask or hand wash.’’*** *–* (‘Salma’, 23yrs, slum dweller)

Risk perception of the covid-19 infection was mostly low in the lower socio-economic tiers. The perceived risk was lowest among the indigenous respondents, who considered COVID-19 as a disease of mainlanders or urban people. Only the affluent urban dwellers considered the infection a serious threat to their lives.

***‘It’s (the pandemic) God will. If it’s in my fate to die due to corona, the there’s nothing I can do about it. I don’t worry about it much.’’*** *–* (‘Rahim’, 36yrs, coastal region)

Indigenous regions were left out of electronic media’s health messages. Many respondents reported that they were unable to understand the awareness messages that were circulated in national media due to a language barrier. Socio-economic groups including the rural inhabitants, urban slum dwellers, coastal people were well-versed on the health protocols of covid-19, owing to the digital coverage through mobile phones and televisions. Urban affluent individuals were further informed of the covid-19 pandemic nitty gritties through personal communications from their workplaces.

Urban slum dwellers, who are mostly involved in the garments industry, tertiary service industry, domestic help services, and other daily wage income works, were economically the most affected by the pandemic. Many individuals faced downsizing in their employment organization or temporary halt in their income during the lockdown period. Other disadvantaged groups like the rural inhabitants and the coastal regions also suffered economically, particularly those who were involved in small business and enterprises.

***‘‘I used to work in an NGO. As the project was closed due to the pandemic, I lost my job. I am now maintaining my expenses on loan.’’***

– (‘Sufia’, 32yrs, coastal region)

***‘‘I run a small shoe shop. Due to the restrictions on travel and gathering, I faced significant loss, particularly during EID time. I had to sell a land to cover the loss.’’*** – (‘Joynal’, 52yrs, rural region)

Indigenous ethnic groups continue to work in the teagardens. Their economic burden which is historically high, did not increase or decrease during the pandemic. However, despite some economic loss, urban affluent dwellers did not experience a significant change in their lifestyle during the pandemic. Table 5 summarizes the perception, practice, and economic consequences regarding COVID-19 among the five different socioeconomic groups.

*Table 5: Variance in COVID-19 perception, practice, and economic consequences among the five different socioeconomic groups.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Theme** | **Rural** | **Costal** | **Indigenous** | **Urban Slum** | **Urban Affluent** |
| **Awareness/ knowledge** | Low | Low | Poor | Aware | Aware |
| **Preventive Practice** | Low | Low | Poor | Poor | Good |
| **Risk Perception** | Low | Low | Poor | Poor | High |
| **Health communication** | Through Electronic and print media | Through Electronic and print media | No health communication | Through Electronic and print media | Media & workplace communication |
| **Economic Burden** | Affected | Affected | Not Affected | Highly Affected | Not/less Affected |

This disparity in perceiving the risk associated with infection and its contagiousness, and preventive practices is partly due to the digital divide and the lack of education among the disadvantaged populations. This study additionally found that urban slum dwellers lack the scope and affordability to practice preventive behaviours for COVID-19. In another cross-sectional study conducted on 406 slum habitants, it was found that most slum habitants in Bangladesh did not undertake necessary preventive measures due to lack of facility (Islam *et al.*, 2021). Due to the varying nature of job and security, the economic impact varied as well. The urban slum dwellers, who are mostly engaged in informal works with lack of job security, have mostly lost their jobs during the pandemic. According to a survey conducted by Participation Research Centre (PPRC) and BRAC Institute of Governance and Development, the urban slum dwellers experienced around 80 percent drop in daily income during the lockdown period(Basher, 2020).

## Accessibility to Healthcare Services

For the population living in rural areas, coastal regions, ethnic locations, the healthcare coverage has been traditionally low. According to the in-depth interviews, the majority of people living outside of cities rely on local government facilities. which are often far away and difficult to reach. The situation is even more dire for urban slum dwellers who although living in urban areas, face difficulty in availing the public healthcare facilities. Respondents from urban slum mentioned that they didn’t get the desired attention and importance from the healthcare staff while seeking healthcare from the tertiary public health facilities in Dhaka city. They informed that most of the time they seek healthcare from the NGO health services which actively work in the slum areas and pay attention to their concerns, despite the fact that these facilities lack capacity to address critical medical conditions and medical emergencies. High out-of-pocket expenses were also mentioned as a barrier to receiving proper and affordable healthcare services in public healthcare facilities by respondents from rural, coastal, and urban slum areas. On the other hand, respondents from higher socio-economic groups informed that they usually avail healthcare services from private hospitals or clinics where the quality of service is higher than that of the public hospitals.

The urban affluent respondents also informed that during the pandemic, health services were also sought through telemedicine options. The other socioeconomic groups, however, couldn’t access this opportunity. During the pandemic, affordability (inability to purchase smart devices and internet packages) was reported as a barrier to accessing alternate treatment facilities by the indigenous community and slum dwellers. Respondents from rural and coastal areas cited poor internet coverage and speed as reasons for not using telemedicine. They also stated that they were not aware of any physician, both public and private, who provided such a service.

***‘‘We generally use mobile data, which is quite expensive for video calls. Also, because it rains a lot here, the network is frequently disrupted’’***

– (‘Abdul’, 45yrs, coastal region)

This study further found that access to primary and essential healthcare (maternal and child care services, immunization services) were also restricted for these disadvantaged communities during the pandemic. Respondents from rural and coastal areas who are heavily dependent on the district hospitals or community clinics faced challenges in availing required health promotion and management services. As health services were focused to dealing with COVID-19, basic and routine are for people got disrupted. For the limited services available, the distance between healthcare staff and patients, as well as the healthcare staff's reluctance to perform clinical examinations, was a barrier to receiving satisfactory services.

***‘‘I was scheduled to attend my antenatal visit, but the health center was not providing antenatal check-ups at that time. I later visited a private clinic and had my check-up’’***

– (‘Selina’, 22yrs, rural region)

The situation for indigenous peoples in terms of healthcare access differs from that of other groups. Respondents stated that they seek care primarily from tea-garden health facilities. These facilities, however, have limited services and frequently refer patients to district hospitals. Furthermore, respondents identified high out-of-pocket expenses as a major constraint for their healthcare. Despite the fact that the tea-garden health facilities were completely closed for one month during the lockdown, respondents stated that the impact is not new to them because they have long been exposed to systematic disparities in healthcare.

***‘‘Getting treatment is always tough for us. We need to buy our own medicine due to lack of supply in the health centres. It is a burden for us. The situation is same for both before and during corona.’’***

– (‘Karim’, 40yrs, indigenous respondent)

Table-6 summarizes the discrepancies in accessing healthcare services among different socioeconomic groups during the pandemic.

*Table 6: Discrepancies in Accessing Healthcare Services Among Different Socioeconomic Groups during the COVID-19 Pandemic.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Theme | Rural | Costal | Indigenous | Urban Slum | Urban Affluent |
| Health facility | **Nearby government facility** | **Nearby government facility** | **Tea-garden health facility** | **NGO Health Services** | **Private Clinic** |
| Alternative healthcare facility | **None** | **None** | **None** | **None** | **Telemedicine** |
| Access to healthcare | **Restricted** | **Restricted** | **No access** | **Restricted** | **Accessible** |
| Challenges in accessing healthcare | **Limited interaction & high cost** | **Limited interaction & out of pocket expenditure** | **Restricted Accessibility** | **Lack of importance & high cost** | **Lack of safety measures for Pandemic** |

Several other studies are in line with these findings. A study by UNICEF Bangladesh supports that conclusion as the study found that only 33 out of the 63 primary level district hospitals were attending to obstetric department patients during the pandemic in Bangladesh as most of hospital resources were concentrated to save lives in the COVID-19 units (UNICEF Bangladesh, 2020). Furthermore, the Directorate General of Health Services data has found a staggering decrease in the number of patients in different healthcare facilities (UNICEF Bangladesh, 2020). However, this consequences of the pandemic disproportionately affected the rural inhabitants, indigenous groups, people living in coastal regions, and slum dwellers as they rely on public and NGO health facilities and unable to afford private healthcare.

## Accessibility to Education Services

Closure of schools since the pandemic set in has affected millions of school-going children. Bangladesh already has a high drop-out rate of 37.6% from secondary schools. The lower socio-economic groups of Bangladesh bore the brunt of the school closures disproportionately. Access to education was limited in rural and coastal areas, while the indigenous people and the urban slum dwellers had no access to education. However, urban affluent group’s children had access to education.

Rural and coastal regions had restricted access to digital learning or alternative learning. However, the indigenous people and slum inhabitants could not have any access to alternate education for their children. A large part of this is due to the digital divide in accessing education. Operating digital devices to access education was a limitation. Furthermore, public schools did not hold live group classes but cast lessons through the national television in a program called “Ghore Boshe Shikhi”. Lack of internet, smartphone limited the live interactive class opportunity for majority of children of Bangladesh. The indigenous community and urban slum dwellers expressed that they are not bothered by the halt in education. Parents from both communities shared that their children usually continue their studies on their own. Following the closure, no alternative methods of learning were introduced to the children of these communities.

**‘‘*I don’t follow their (two school going daughters) education much. They used to go to school by themselves. Now that school is closed they are helping in works*’’- (‘**Monira’, 26yrs, indigenous respondent)

Despite the well-meaning efforts to help education reach the mass, a survey by BRAC Institute of Governance and Development on 5000 students from urban slums and rural areas found that students time spent studying has reduced by 80 percent after the schools shut down and only 16 percent of school going children watched the national TV programs casting school lessons of different grades. In contrast, the higher socio-economic group’s children could access regular classes with the help of the internet and necessary devices. However, parents reported that children had trouble paying attention to the online class sessions.

One upside throughout the socio-economic classes was that the rural and coastal area children were able to study at home by themselves or with the help of a tutor/ Self-teaching was not possible in indigenous regions or for the slum dwellers. Except for the urban affluent class, accessing mental health check-up or psychological counselling was not an option for the children suffering from the covid-19 pandemic.

*Table 7: Discrepancies in Accessing Education Service Among Different Socioeconomic Groups during the COVID-19 Pandemic.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Theme** | **Rural** | **Costal** | **Indigenous** | **Urban Slum** | **Urban Affluent** |
| **Access to education** | Limited | Limited | No Access | No Access | Accessible |
| **Digital Learning/alternative learning** | Restricted | Restricted | **None** | **None** | Good |
| **Challenges in accessing education during pandemic** | Lack of internet & Smartphone, improper use | Lack of internet & Smartphone | **No access** | **No access** | Lack of attention from children |
| **Self-taught opportunity** | Yes | Yes | NO | No | Yes |
| **Mental Health & Psychosocial Counselling** | **No** | **No** | **No** | **No** | Yes |

## Education Providers Experiences

Bangladesh ceased on-campus activities for all educational institutions in April 2020 and transitioned to a digital learning process. The education providers interviewed for this study discussed the difficulties they encountered in providing education through this alternative process.

Teachers from public institutions informed that regular schooling was replaced by lessons broadcasted in the national television. The lessons of different classes were aired at different times, and home-works was given for the next class. Teachers in rural areas reported that, despite television being a popular digital media, many households do not have one, making it difficult for their students to follow classes. Furthermore, the television classes did not allow the interactive setting present in regular classrooms. Although the government advised them to take online classes and assignments, it was not possible because both teachers and students in rural schools face limitations such as poor internet connection and a lack of a smartphone or laptop. They teachers further reported that the lack of regularity of students, lack of interaction in the lessons, and the digital divide in learning, all contributed to a high dropout rate at the high school level in the year 2020. One teacher from Madrasha informed that the Madrasha curriculum faced a complete halt during the pandemic. As the teaching style requires a living-in setting, it was difficult to administer lessons through online methods. Furthermore, due to a lack of devices and internet access, it was difficult for both students and teachers to navigate the new digital methods of lessons, as most of the Madrasha is run on a charitable basis and is attended by students from low socioeconomic backgrounds.

Education providers in urban schools, including both English and Bangla medium schools, were using a digital learning process. English medium schools, on the other hand, were found to be a few steps ahead as they had a dedicated app for classes. Furthermore, the teachers stated that since the number of students in private schools is relatively small, they were able to monitor each student's attendance and progress. However, unlike English medium schools, Bangla medium schools did not provide planned extracurricular activities. According to the respondents, none of the schools provided psychosocial counselling to students, teachers, or parents.

The experiences of education providers echo those of service users, strengthening the case for a digital divide. According to the providers' experiences, students from low-socioeconomic backgrounds and rural areas suffered more as a result of the pandemic's consequences than other students. A significant number of these students were forced to drop out of school, putting them at risk of child marriage (Sakib, 2021).

## Healthcare Providers Experiences

With the onset of the pandemic, Bangladesh's healthcare sector has been under severe challenge., Healthcare providers from various government and private institutions shared their experiences and challenges of providing services during the pandemic.

Healthcare workers from government primary and tertiary level hospitals reported a lack of availability of Covid-19 protective equipment. They also stated that public hospitals have historically faced challenges due to a lack of human resources. Public hospitals are dealing with a large influx of patients and a limited number of doctors and other healthcare personnel to treat them. This problem was reported to have worsened during Covid-19, when several healthcare providers became infected and had to be isolated. The crisis was exacerbated by a lack of adequate supply of Personal Protective Equipment (PPE). They also complained about insufficient logistical supplies, such as a lack of oxygen and testing equipment. A lack of adequate logistics has also been reported to be a long-standing issue in government healthcare facilities. While they expressed satisfaction with their pay and career advancement opportunities, they reported a lack of security in their workplaces. Healthcare workers from private institutions, on the other hand, reported having adequate resources and a secure environment. The majority of private facilities also began offering telemedicine services and home-sample collection during the pandemic. While providers are satisfied with the services they provide, they informed that patients had to spend a lot of money to receive quality care in these institutions, which frequently cost a fortune to patients from low socioeconomic backgrounds. Due to the disruption of essential services in public facilities, many patients sought care in private institutions, predisposing them to financial burden, according to private healthcare providers.

The experience of the healthcare providers reiterated the historical disparities in healthcare in Bangladesh. According to the most recent health bulletin published by the Ministry of Health and Family Welfare, there is a huge disparity in the ratio between patients and their doctors and nurses in the country, with only 5.26 doctors for every 10,000 populations, making the ratio the second lowest in South Asia (Kumar and Pinky, 2021). During the pandemic, this uneven ratio put additional strain on the health-care system, disproportionately affecting the low-socioeconomic group who relied on public facilities.

## Equitable Mitigation Strategies: Workshop Recommendations

Two workshops have been conducted as part of this study following data collection from service users and providers. One stakeholders workshop was arranged with policymakers and key professional stakeholders related to health and education sector in Bangladesh, where the findings, including challenges in accessing and providing services, were presented. The aim of the stakeholders’ workshop was to recommend mitigation strategies. Following the stakeholders' workshop, a community workshop was held with community members from various socioeconomic groups (excluding study participants) to explore whether the findings and recommendations reflect community views, and to determine the focus of future research areas.

**Stakeholders Workshop**

The workshop participants consisting of 10 stakeholders (policymakers/planners, professionals, NGO representatives) of the education and health sector, proposed three key strategies for mitigating the overreaching inequity present among the different disadvantaged groups in Bangladesh. Fig 6 below presents the strategies proposed by the workshop participants.

**■ Evidence Generation on Existing Inequity**

The workshop participants recommended for conduction of more equity-focused research, along with integration of equity as outcome evaluation criteria for programs and interventions, to surface the unequal distribution of services among disadvantaged communities. Evidence of existing inequity will help identify gaps in current policies, allowing for subsequent policy formulation and reform with a focus on equitable services.

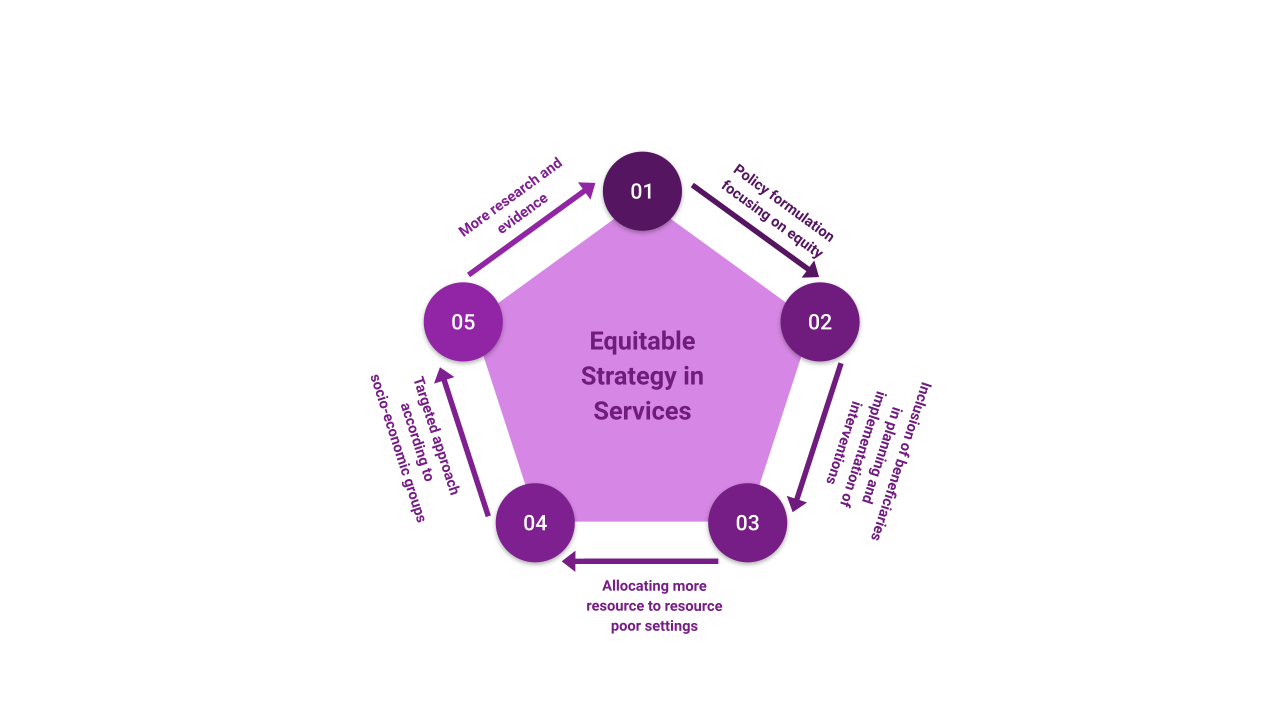
**■ Representation of Disadvantaged Communities during Policy and Planning**

Inclusion of representatives from disadvantaged communities was also recognized as a priority area. It was recommended that while developing national policies and programs, including interventions from international and non-governmental organizations, involvement of representative from marginalized communities should be emphasized. It will ensure that these strategies are more aligned with the priorities and needs of vulnerable communities and that equitable participation is established.

**■ Targeted Approach with Multi-Sectoral Involvement**

Workshop participants also advocate for designing targeted approach to disadvantaged involving multiple government sectors. To ensure adoption and equitable distribution of benefit, it was advised that solution strategies should take into account the social and environmental circumstances of different communities, and alternate strategies for disadvantaged communities should be developed if necessary.

Integration of multiple government sectors is also imperative for building targeted approaches, as basic services are interlinked with each other and promotion of all aspects is necessary for a sustainable development.

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*Figure 6: Equitable mitigation strategy in services proposed by workshop participants.*

In addition to the key strategies, some specific directions for health and education sector, particularly during a crisis situation emerged from the workshop discussion. Sector wise specific strategies that were recommended are discussed below.

## Workshop Recommendations (Health and Pandemic)

The World Health Organization opines that other sectors should work to support the health sector in addressing health inequity. The workshop conducted as part of this study, concluded that health-financing with expansion of financial protection for disadvantaged communities would be an integral step towards a more universal healthcare keeping the disadvantaged communities in mind. In order to achieve this feat, the experts recommended pooling of funds to create a national health insurance scheme. Furthermore, the cohort of experts recommended a stronger Primary Health Care (PHC), especially in rural areas with capacity building of PHC staff to increase access to essential services at community level. The strategies for equitable interventions during the pandemic crisis were 1) Expansion of digital coverage, particularly to disadvantaged and remote areas, 2) Targeted risk communication strategies for vulnerable communities during epidemics and humanitarian crisis, 3) Development of context-specific preventive strategies for disadvantaged communities.

## Workshop Recommendations (Education & Economic)

The workshop conducted as part of this study came up with recommendations for policy makers to improve education and economic condition of the marginalized communities, thereby reducing the disparity that has become more pronounced during the COVID-19 pandemic. Firstly, the experts suggested that the infrastructure along with the logistical supply needs to improve at government education institutions. Experts further pointed out that there is an urgent need for human resource capacity building of government school teachers for the teachers to become more accustomed with digital classes. Integration of inclusive preschool education and psychosocial counselling at all tiers of educational facilities was also imperative to address the mental health of school going children, parents and teachers, the experts opined. Lastly, to cushion the economic blow the communities faced, the group of experts emphasized the need to introduce targeted social safety net programs especially in rural areas to protect vulnerable communities during crisis situations like the ongoing pandemic.

## Community Workshop

The study findings were also presented to community respondents to gain insight and direction for future research. A community and public involvement workshop was conducted with health service users of different socioeconomic group purposively selected from different health facilities in Dhaka.

The workshop was conducted in person and the participants expressed their opinion regarding the generalizability of the findings and recommendations for wider community and potential areas for future research. The detail of the workshop participants with key findings are described below.

**Information on the attendees at the workshop is presented below:**

Total Participants: 12

Male: 08

Female: 04

Patients: 05

Family members: 04

NGO/other community representative: 03

*Table 8: Characteristics of Participants Attending Workshop on Findings Sharing and Insights on Community Mental Health.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ID | Gender | Age | Education | Occupation | Type of participant | Type of Disease | Treatment Centre |
| 101 | Female | 45 | Bachelor | Housewife | Patient | Diabetics | BIRDEM, Mirpur-10 |
| 102 | Male | 52 | Bachelor | Retired | Attendant | n/a | n/a |
| 103 | Male | 40 | HSC | NGO staff | Patient | High Blood Pressure | Town Health Center |
| 104 | Male | 22 | Honors | Business | Attendant | n/a | n/a |
| 105 | Male | 46 | BSS | Business | Patient | Diabetics | BIRDEM, Mirpur-10 |
| 106 | Female | 45 | Class-10 | Housewife | Patient | Diabetics | BIRDEM, Mirpur-10 |
| 107 | Male | 55 | Bachelor | Retired | Attendant | n/a | n/a |
| 108 | Male | 32 | MBA | Private Job | Patient | Diabetics | Private Hospital |
| 109 | Female | 54 | HSC | Housewife | Attendant | n/a | n/a |
| 110 | Male | 36 | Masters | Teacher | n/a | n/a | Bangladesh Adarsha Shikkha Niketon High School |
| 111 | Female | 36 | Masters | NGO worker | n/a | n/a | KMSS |

**Key workshop findings are:**

* Respondents expressed their belief that the study findings comprehensively presented community challenges in health and education services, particularly among disadvantaged groups.
* Participants reaffirmed the documented challenges posed by the pandemic and agreed that the pandemic's consequences are borne disproportionately by disadvantaged groups.
* The participants in the community workshop agreed with the suggested equity strategies and expressed their support for designing and implementing the strategies.
* Participants stated that, among health issues, mental health is one of the major areas where services are scarce and unevenly distributed at the community level.

# Direction for Future Research

**Direction from Stakeholders’ Workshop:**

* Future research should look into the intersectionality of disadvantaged groups in Bangladesh, as well as their process of structural exclusion.
* Equity should be considered in the evaluation of research and programs, and research design, sample recruitment, geographical coverage, and service coverage should all be evaluated through the lens of equity.
* Since the importance of including representatives from disadvantaged groups in research design and implementation has been highlighted, participatory action research has emerged as a recommended method for conducting research with disadvantaged communities.
* This study has brought to light the disparities in healthcare delivery in general. Future research could focus on health problems or issues that disproportionately affect disadvantaged groups.

**Direction from Community Workshop:**

* The community workshop emphasized the importance of involving community members in the research process.
* Respondents suggested that inequity in mental healthcare be investigated and addressed as a potential future research area.

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