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JAMES P GRANT

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BANGLADESH HEALTH WATCH

RAPID MINI-RESEARCH REPORT

" We, the nurses always remain on duty, what we will do with the money if we die"

- Nurse (female)

"I am always scared now a days… scared for my family and relatives."

- FWV (female)

"…I am always terrified. Thinking about physical hazard is a mental health hazard, too."

- Physician (female)

Front Line health Workers' (FLWs) perceptions and opinions on their personal safety while attending suspected or confirmed COVID-19 patients in Bangladesh

"If I die, what good would this reward do to me or my family? Rather government should spend this money to keep us safe… We don't need a reward. Just a little praise, encouragement is what we need. …."

- Physician (male)

"Life is much important than money so I've nothing to say about the announcement; All I know is I have to work by protecting myself;

- SACMO (male)

HIGHLIGHTS:

- 60 FLWs of various categories and levels from 14 districts and 43 institutions participated in the telephone survey;
- The FLWs were unequivocal about the necessity of using PPEs for suspected/confirmed COVID-19 patients since the country is in community transmission phase with asymptomatic cases, and patients are hiding facts;
- The FLWs want proper protection (PPE and others) for handling patients (suspected or confirmed) in preference to monetary incentives as declared by the Prime Minister; they also appeared sceptical about its justified distribution
- Concerns for spreading the infection to family members is precipitating mental health problems for the FLWs which needs to be addressed urgently
- Majority of the respondents were not happy about the role played by the different professionalassociations;
- The respondents had the consensus that this current chaotic situation could have been avoided if coordinated and focused actions would have been taken in the lead time since WHO 's declaration of global health emergency
- The respondents suggested to implement a 7/14 model (7 days of dut followed by 14 days of quarantine and rest to re-energize following the Wuhan experience) of roster and rotation of FLWs
- All types and levels of FLWs did not get the needed standard training on COVID-19 management and prevention which is largely lacking
- Country intensive and focused country wide IEC campaign on basics of the disease and preventive measures to allay anxiety, fear and stigma; us of legal measures if and when necessary

[1] *FLWs include doctors, nurses and other healthcare workers*

China first identified the novel corona virus (later named COVID-19) on 8 Jan. 2020 and declared its first death from COVID-19 on 11 Jan. 2020. Subsequently, on 30 Jan. 2020, WHO declared it as a Global Public Health Emergency. The first COVID-19 case in Bangladesh was confirmed on 8 Mar. 2020. Thus, Bangladesh got a valuable lead time of around 5 to 7 weeks to prepare the people and the health systems for the outbreak and the impending surge of patients. However, neither the MoHFW nor the political establishment was found to rise to the occasion and provide the necessary stewardship for coordinated response. There were fragmented, half-hearted, and ad-hoc approaches which created more problems than solutions. Uncertainty about the roles and responsibilities of the different agencies of the MoHFW and the government at large, lack of intraministerial (MoHFW) and inter-ministerial (Finance, labour, social security, law and order etc.) coordination, unwillingness to heed to the advices of the public health scientists and practitioners in the country, non-inclusion of the non-state sectors and poor service readiness of the public health facilities baffle any description. This chaotic and disoriented situation continued until 17 Mar. 2020 when things slowly started to move.

From the identification of the first COVID-19 case in 8 Mar. 2020, the issue that came up at the top of agenda is the lack of supplies and logistics for containment of the COVID-19 situation. These included, but not limited to, dearth of test kits and small number of testing, monopolizing the tests to a single govt. institution, earmarking facilities to screen and quarantine suspected COVID-19 patients, service readiness of the testing laboratories and the hospitals including resourcing the hospitals with adequate number of ICUs and ventilators etc. However, the most important issue under media scrutiny became the availability of, and the quality of, Personal Protective Equipment (PPE) for the frontline health workers such as the doctors, nurses, technicians and supporting staff. The FLWs (mainly doctors) were rebuked and threatened by the government for not attending/refusing to treat patients unprotected. This has demoralized large sections of the FLWs and the healthcare professionals and demotivated them to attend to the call of humanity.

At the time of writing this report, the country is passing through the stage of community transmission and is in the climbing leg of the epidemic in terms of new cases and deaths. It is presumed to touch the spike within weeks soon according to public health scientists and practitioners in the country. With this scenario, it has become imperative to safeguard the FLWs with necessary amenities so that they can attend the suspected/confirmed COVID-19 patients without any hesitation and stress. Already quite a number of them got infected in the process of attending suspected/confirmed COVID-19 patients and according to a news report today, around 100 of the FLWs including doctors and nurses are currently under quarantine.[3]

[2] *Pseudo-screening of in-coming passengers at the airports (with non-functioning scanners) and forced quarantine, unplanned declaration of holidays keeping the transport open resulting in mass exodus from Dhaka, opening garments factories in lockdown situation resulting in mass return of the workers---all creating a nightmare case for spreading the virus.*

1. Justification

o alleviate this situation and boost up the morale of the FLWs it is imperative that we hear their side of the story and elicit their perspectives about the situation and what they think should be done so that the authorities can adjust the COVID-19 response appropriately. This information will also help in evidence-based advocacy to the MoHFW and relevant stakeholders on behalf of the FLWs for the personal protection of the FLWS before they are sent to fight the disease on the ground.

2. Objectives

This quick telephone survey is done to elicit the perceptions of the FLWs regarding personal safety against contracting the infection when attending suspected/confirmed COVID-19 patients. Besides their opinions on the problem of shortage and recommendations on how to resolve it so that the misunderstanding before the media/policy makers/people is mitigated and their morale is boosted to serve the humanity.

3. Methods

This time-bond survey adopted a cross-sectional design to elicit relevant information from the FLWs, beginning 8 Apr. 2020. Data were collected during the six days from 9 to 14 Apr. 2020. Due to constraints in time and resources and also, under lock-down condition, a telephone interview method was found to be most appropriate. This method is increasingly used in healthcare service research as it allows data to be collected from diverse geographical localities, is time and cost-effective compared to face-to-face interview, better response rate than postal surveys, and better completion of information.[4]

A simple two-page tool with 22 topics in the form of a semi-structured questionnaire was developed to address the objectives which was used as talking points for the telephone interview. Most of the topics were pre-coded for possible responses including an “Other” category to accommodate responses beyond the codes.

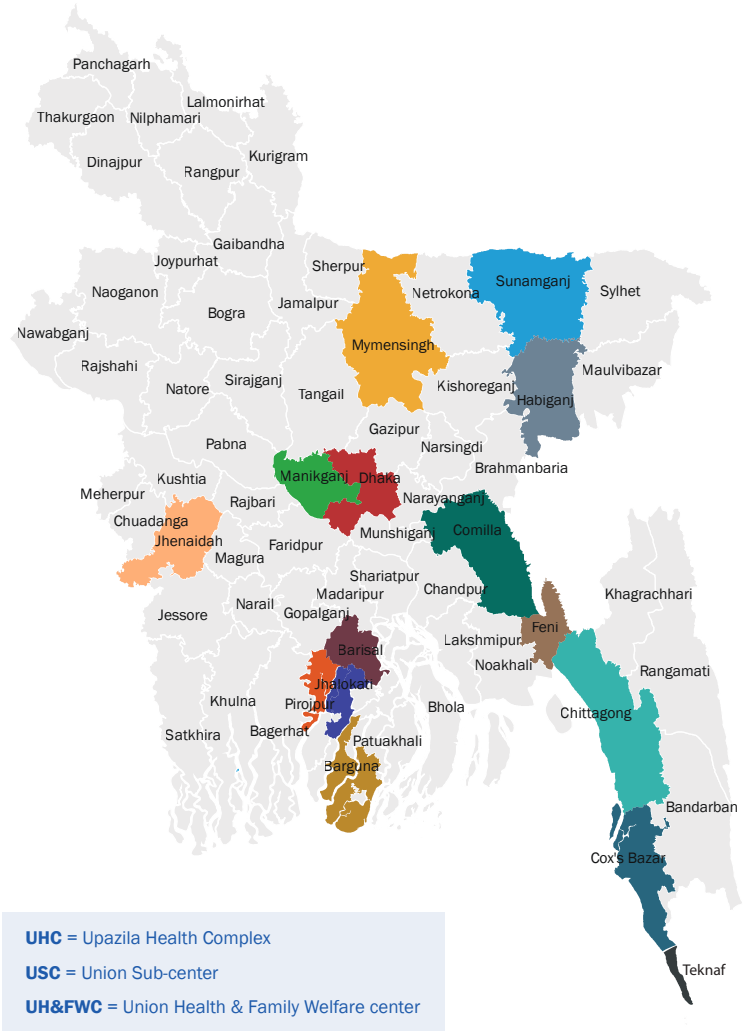
A number of open-ended questions were also included in the interview tool. The interview was meant to be conducted in a conversation mode.

A purposive sample of doctors, nurses and other FLWS was taken leveraging our past engagement with them in relation to some earlier studies done. Respondents from the initial list was also used for seeking further respondents of a particular category by ‘snowball’ sampling. Ultimately, 60 respondents could be interviewed for eliciting necessary information through telephone interview. For the location of the respondents, please see Fig.1.

[3] *It may be mentioned here that after quite a hue and cry in the media and also, pressure from public health experts and scientists, the PPE situation has started to improve in recent week (week of 5 Apr. 2020), though the service readiness of the designated hospitals is yet to be materialized.*

[4] *Smith EM. (2005). Telephone interviewing in healthcare research: a summary of the evidence. Nurse Researcher 12(3): 32 – 41.*

FIG.1: MAP SHOWING LOCATIONS OF THE RESPONDENTS INTERVIEWED



UHC = Upazila Health Complex

USC = Union Sub-center

UH&FWC = Union Health & Family Welfare center

LIST OF HEALTH FACILITIES AND LOCATIONS

COLOR	DISTRICT	HOSPITAL/ FACILITY
	Dhaka	Kurmitola General Hospital (KGH), Dhaka Sir Salimullah Medical College and Hospital (SSMCH), Dhaka Dhalka Medica College and Hospital (DMCH), Dhaka Shaheed Suhrawardy Medical College & Hospital (ShSMCH), Dhaka Kuwait-moitri hospital, Dhaka icddr, b, Dhaka Marie Stopes Clinic, Dhaka Hazrat Sahjalal Intl. airport, Dhaka
	Jhenaidah	Sadar Upazila Health Complex (UHC), Jhenaidah
	Chittagong	Chittagong General Hospital, Chittagong Chittagong Medical College Hospital, Chittagong Private hospital, Chittagong
	Comilla	Comilla Medical College & Hospital (CoMCH), Comilla
	Mymensingh	Gouripur UHC, Mymensingh
	Maikganj	Shibalay UHC, Maikganj
	Barisal	Gournadi Upazilla Health Complex (UHC) Barisal Sher-e-Bangla Barishal Medical College Hospital UHC, Bakerganj, Barishal UHC,Gournadi/Barishal Chorbaria FWC, Barishal
	Habiganj	Upazila Health complex,Azmeriganj, Habiganj
	Cox's bazar	Relief International, Ukhia, Cox's bazar Medicines Sans Frontiers (MSF), Cox's Bazar HOPE Foundation, Cox's Bazar IOM, Cox's Bazar Poly clinic, Cox's Bazar DanChurchAid (DCA), Cox's Bazar
	Teknaf	Save the Children, Teknaf
	Feni	UH&FWC, Pashuram, Feni | USC Gopal, Chagalnaiya, Feni
	Pirojpur	UHC, Mothbaria | UHC,Necharabad | UHC, Sarupkhathi, Pirojpur
	Barguna	USC,Fuljhori, Barguna Sadar, Barguna UH&FWC,Burirchar, Barguna Sadar, Barguna UH&FWC, Fuljhuri Union, Barguna Union Health & Family Welfare center, Gourichonna Union, Barguna Union Health & Family Welfare center, Burirchor Union, Barguna
	Jhalokhathi	USC, Krritipasha/Jhalokhathi Sadar, Jhalokhathi USC Baroiya | UHC Rajapur | UHFWC, Jhalokathi
	Sunamganj	UHC, Chhatak, Sunamganj

The four researchers from the study team (two doctors, one qualitative expert and one social science graduate, all experienced in research methodologies) used this list to call on the respondents, briefly described the context and purpose of the study, the contents of the interview and the probable duration (30 minutes on average) and sought their verbal consent. Following this either an appointment was made for the interview to take place later, or if agreed, the interview was done at the same time. Data were collected anonymously, confidentiality of data maintained and data was only used for research purpose.

Quantitative data were entered in a pre-designed google form, curated and made ready for analysis by the statistician in the team. This method of data management was necessary to accommodate the researchers working from home at different locations in Dhaka city. An analysis plan was made to extract the tables for the report. Responses to the open-ended questions were coded thematically and analysed. A draft report on main findings was prepared by 15 Apr. 2020, for dissemination on 16 Apr. 2020 for evidence-based advocacy.

RESULTS

In all, 60 respondents could be reached for the telephone interview comprising doctors (MBBS and post-graduates), nurses and midwives, and para-medics (SACMOs, lab technicians, FWVs). We tried to interview a few supporting staff (e.g., Cleaner, Ward boy and Aya) but they appeared to be too afraid to divulge any information even after all assurance. The findings are presented below.

Characteristics of the respondents

Majority of the respondents were from public sector health facilities in rural areas (40%) followed by those in the Dhaka city (37%) (Table 1). The para-medics of various categories comprised the major proportion of the respondents (32%) followed by MBBS doctors (30%). Most of them (68%) are in service for more than 5 years and were in duty in the in-patient wards. About 12% were servicing the emergency room. Twelve per cent respondents knows about a colleague in their close circle of relatives and friends who became infected while handling a COVID-19 patient while only 48% received any training/instructions/guideline on how to manage such patients

Table 1: Characteristics of the respondents (N= 60)

	Characteristics	% (n)
1	**Facility type**	
	Public facility in Dhaka city (Hospitals, International airport)	36.7 (22)
	Public facility in Rural area (Upazila Health Complex, Union sub centre, UHFWC)	40.0 (24)
	For-profit private facility	10.0 (6)
	Not-for-profit private facility (NGO)	13.3 (8)
2	**Type of respondents**	
	Doctors (MBBS)	30.0 (18)
	Doctors (post-graduate)	16.7 (10)
	Nurses (All types) and Midwives	21.7 (13)
	Para-medics (SACMOs, FWV, Lab technician etc.)	31.7 (19)
3	**Years of service**	
	<1 year	3.3 (2)
	1 – 5 year	28.3 (17)
	>5 year	68.3 (41)
4	**Place of duty**	
	In-patient wards	33.3 (20)
	Out-patient department (OPD)	31.6 (19)
	Emergency	11.7 (7)
	Both outpatient and in-patient	23.3 (14)
5	**Knows about a colleague/friend's colleague who became infected while managing a COVID-19 patient**	11.7 (7)
6	**Received training/instructions/guidelines regarding management of suspected or confirmed COVID-19 patients**	48.3 (29)

Personal protective equipment (PPE)

The respondents mostly agreed about the necessity of using PPE in current situation when the epidemic has entered the stage of community transmission (Table 2). The nurses and midwives were more in favour of this (85%) opinion compared to others. Compared to doctors (80-100%), lesser proportion of nurse/midwives (46%) and para medics (21%) were found to be aware about the WHO guideline for use of PPE. Interestingly, 43% of the respondents did not receive any training/instructions or guidelines on the use of PPE. Around only 54% of nurse/midwives and 37% of the para-medics received any training/instructions/guidelines on the use of PPE.

Seventy-five per cent of the doctors and nurses received PPE following COVID-19 outbreak while only around 40% of the support staff got it (Table 3). The PPE were mostly supplied by respective hospital authorities. When no PPE was available, they just used mask, gloves and ordinary gowns (15%) (Table 2). On further probing, the respondents expressed doubt about the quality of the PPE supplied by the hospital authority/ MoHFW administration; they opined that the PPEs supplied appeared to be akin to an ordinary raincoat rain coat, which they used to carry home to wash or wash at the facility and reuse, which they perceived as risky for both themselves and the patients. Except the COVID-19 dedicated hospitals, FLWs in no other facility, including the flu corner and isolation ward, received a complete set of PPE with all components as per WHO Interim Guideline of 20 March 2020.

Opinion on current situation regarding shortage of PPE

When respondents were asked about how the current situation evolved when FLWs do not have adequate number of PPEs but have to attend suspected or confirmed patients, 50% identified slow and delayed preparation for managing the epidemic to be responsible (Table 4). Others mentioned that the situation evolved from lack of awareness among the policy makers about the epidemic potential of the disease (38%), or failure to respond to the warnings by public health experts (15%). Still others were of the opinion sarcastically that the authorities didn't value the lives of the FLWs (32%).

Table 2: Personal Protective equipment (PPE)

	Types of health care professional %(n)				
	Doctors (MBBS)	Doctors (post-grad)	Nurses (All types)/ Midwives	Para-medics (SACMOs, FWV, Lab technician etc.)	All
No. of respondents	**18**	**10**	**13**	**19**	**60**
A health care professional need personal protective equipment (PPE)*					
Physical examination of patient with respiratory symptoms	61.1 (11)	80.0 (8)	53.9 (7)	42.1 (8)	56.7 (34)
While handling any patient in OPD	22.2 (4)	20.0 (2)	-	-	10.0 (6)
Any patient in current situation of community transmission	61.1 (11)	50.0 (5)	84.6 (11)	73.7 (14)	68.3 (41)
Aware of WHO guideline for use of PPE	100.0 (18)	80.0 (8)	46.2 (6)	21.1 (4)	60.0 (36)
Received training /instructions/guidance on use of PPE*	66.7 (12)	80.0 (8)	53.9 (7)	36.8 (7)	56.7 (34)
Source of training					
Health Facility	33.3 (6)	50.0 (5)	38.5 (5)	15.8 (3)	31.6 (19)
Self-study	27.8 (5)	30.0 (3)	15.4 (2)	26.3 (5)	25.0 (15)
National guideline	5.6 (1)	10.0 (1)	-	-	3.3 (2)
WHO guideline	11.1 (2)	30.0 (3)	-	-	8.3 (5)
Did not get any training	33.3 (6)	20.0 (2)	46.2 (6)	63.2 (12)	43.3 (26)
Measures taken when no PPE was available*					
Using mask and gloves and ordinary gowns	5.6 (1)	10.0 (1)	15.4 (2)	26.3 (5)	15.0 (9)
Use mask and gloves only	5.6 (1)	-	15.4 (2)	21.1 (4)	11.7 (7)
Managed own PPE	5.6 (1)	10.0 (1)	-	5.3 (1)	5.0 (3)
Not applicable/ Received PPE	88.9 (16)	90.0 (9)	69.2 (9)	57.9 (11)	75.0 (45)

Table 3: Availability and use of PPE following COVID-19 outbreak

	%(n)
Doctors and nurses Got PPE following outbreak	75.0 (45)
Other staff at frontlines who got PPE	
Cleaner	46.7 (28)
Ward boy	45.0 (27)
Aya	40.0 (24)
Others (guards, pathologist, CHCP, SACMO)	26.7 (16)
No other staff got PPE	16.7 (10)
Source of PPE	
Hospital authority/MoHFW administration	66.7 (40)
Donation	18.3 (11)
Personal	18.3 (11)
Did not get any PPE	25.0 (15)

When asked, the great majority (>80%) were of the opinion that this situation could have been averted (Table 5). According to respondents this could be done if the lead time that Bangladesh got could be properly utilized for preparation (40%), resources could be mobilized (43%) or timely activation of the already existing strategies on 'One Health' or 'Health Security' could be initiated (38%).

Table 4: Evolution of the current situation related to COVID-19

Perceived reasons underlying the situation where HCP do not have PPEs but have to attend suspected or confirmed patients	%(n)
From lack of awareness about the disease and its epidemic potential by policy makers and practitioners	38.3 (23)
Slow/delayed preparation for managing the epidemic;	50.0 (30)
Not valuing the necessity of safety of HCPs by the MoHFW authorities;	31.7 (19)
Not paying attention in time to the warnings by the public health specialists	15.0 (9)
No idea/don't know	21.7 (13)
Think that this situation could have been averted	83.3 (50)
How could have been the situation averted	
Adequate preparation for combating the epidemic in the lead time (about 6-to-8 weeks) that we got since Wuhan);	40.0 (24)
Mobilization of resources for procuring priority supplies (e.g., test kits, Oxygen, ventilators etc. including PPEs)	43.3 (26)
Operationalization of government's strategies on 'health security' and 'one health' that were in place	38.3 (23)
Don't know	1.7 (1)

Doctors vs non-doctors

Next, we grouped the respondents into doctors (n=28) and non-doctors (n=32) and wanted to investigate their differences in experiences and opinions, if any (Table 5). We found greater proportion of doctors (39%) working in both OPD and in-patient wards compared to others (9%), and therefore, exposed to more risk. A very small proportion of the non-doctor FLWS (19% vs Table 5: Characteristics by groups of respondents 82% for the doctors) received training/instruction/guideline on management and prevention of COVID- 19 and only 31% of them were aware about the HO guideline for the use of PPE compared to 93% of doctors. More doctors got donation of PPE (32%) than non-doctors displaying their relative importance before the eyes of the concerned.

When asked to express their opinions on the evolution of current situation, greater proportion of doctors blamed lack of awareness of the authorities (71%) about the disease and its epidemic potential shown in China. On the other hand, the non-doctors (37.5%) placed the blame squarely on to be due to slow/delayed preparation for the outbreak (Table 6). Doctors (89%) more than non-doctors (78%) thought that this situation could have been averted, by adequate preparation (61%) and mobilization of resources (64%). Interestingly, half of the non-doctors perceived that it could be avoided if the already existing strategies on health security and one health could be called into action.

Responses to open-ended questions

We had some open-ended questions in our list of talking points and we encouraged the respondents to state freely their opinions on some relevant issues and noted their responses. These are summarized below focusing on the key thematic responses.

PM announcement on monetary incentives for FLWs dealing with COVID-19 patients

A mixed response was observed. Some of the respondents praised this declaration as encouraging, while others preferred proper PPEs and pragmatic management of the Covid-19 crisis to monetary reward. Some of them mentioned about instant 'risk allowance' rather than reward/insurance in future. Some illustrative quotes:

"If I die, what good would this reward do to me or my family? Rather government should spend this money to keep us safe."

- (Male_33_Physician)

"We don't need reward. Just a little praise, encouragement is what we need. What honourable PM said is a result of fabricated statement was reached to her by the bureaucrats. Our demand was for PPE, N95, face shield; but the bureaucrats made it like if our demands are not met, we would not attend patient. Even at a video conference today, an assistant professor told health minister that we don't need incentive, we need protective equipment."

- (male_34_physician)

Table 5: Characteristics by groups of respondents

	Characteristics	Types of health care professional %(n)		
		Doctors	Other stuffs (Nurse, Paramedics etc.)	All
	No. of respondents	**28**	**32**	**60**
1	**Facility type**			
	Public facility in Urban area (Hospital, International airport)	67.9 (19)	9.4 (3)	36.7 (22)
	Public facility in Rural area (Upazila health complex, Union sub centre)	14.3 (4)	62.5 (20)	40.0 (24)
	Private facility	17.9 (5)	3.1 (1)	10.0 (6)
	NGO	---	25 (8)	13.3 (8)
2	**Years of service**			
	<1 year	7.1 (2)	---	3.3 (2)
	1 – 5 year	21.4 (6)	34.4 (11)	28.3 (17)
	>5 year	71.4 (20)	65.6 (21)	68.3 (41)
3	**Place of duty**			
	Both outpatient and in-door	39.3 (11)	9.4 (3)	23.3 (14)
	In-patient	39.3 (11)	28.1 (9)	33.3 (20)
	Out-patient department (OPD)	14.3 (4)	46.9 (15)	31.6 (19)
	Emergency	7.1 (2)	15.6 (5)	11.7 (7)
4	**Knows about a colleague/friend's colleague who became infected while managing a COVID-19 patient**	25 (7)	0 (0)	11.7 (7)
5	**Received training/instructions/guidelines regarding management of suspected or confirmed COVID-19 patients**	82.1 (23)	18.8 (6)	48.3 (29)
6	**Aware about WHO guideline on use of PPE**	92.9 (26)	31.3 (10)	60.0 (36)
7	**Received training on how to use PPE**	71.4 (20)	43.8 (14)	56.7 (34)
8	**Source of PPE***			
	Hospital authority/MoHFW administration	71.4 (20)	62.5 (20)	66.7 (40)
	Donation	32.1 (9)	6.3 (2)	18.3 (11)
	Personal	39.3 (11)	---	18.3 (11)
	Did not get any PPE	10.7 (3)	37.5 (12)	25 (15)

"I have no interest in the announcement. We, the nurses always remain on duty, What we will do with the money if we die"

- (Female_52_Nurse)

"I appreciate this announcement. However, apart from PPE, risk allowance would be motivational and helpful for the healthcare providers in this corona pandemic."

- (female_24_midwife)

Table 6: Opinions by groups of respondents

		Types of health care professional %(n)		
	Characteristics	**Doctors**	**Other stuffs (Nurse, Paramedics etc.)**	**All**
	No. of respondents	**28**	**32**	**60**
1	**Reasons underlying the situation where HCP do not have PPEs but have to attend suspected or confirmed patients***	**% (n)**	**% (n)**	**% (n)**
	From lack of awareness about the disease and its epidemic potential	71.4 (20)	9.4 (3)	38.3 (23)
	Slow/delayed preparation for managing the epidemic;	64.3 (18)	37.5 (12)	50.0 (30)
	Not valuing the necessity of safety of HCPs by the MoHFW authorities;	42.9 (12)	21.9 (7)	31.7 (19)
	Not paying attention in time to the warnings by the public health specialists	28.6 (8)	3.1 (1)	15.0 (9)
	No idea/don't know	3.6 (1)	37.5 (12)	21.7 (13)
2	**Think that this situation could have been averted**	89.3 (25)	78.1 (25)	83.3 (50)
3	**How could have been the situation averted***			
	Adequate preparation for combating the epidemic in the lead time	60.7 (17)	21.9 (7)	40.0 (24)
	Mobilization of resources for procuring priority supplies	64.3 (18)	25 (8)	43.3 (26)
	Operationalization of government's strategies on 'health security' and 'one health' that were in place	25 (7)	50 (16)	38.3 (23)
	Don't know	3.6 (1)		1.7 (1)

They expressed concern about how this will be distributed as no details were laid out. Also, the amount of this kind of allowance should be more than declared, they thought.

"Also, the amount is less, it should be increased. I am doubtful about the list as speaking from my previous experience there might be political issue."

- (male_34_physician)

"The doctors in periphery are fighting as first line health care worker. We are also working but ours is a corona dedicated centre. So, who is working as first line health care worker is not clear... we have seen in the past that many people have collected the freedom fighter certificate without even fighting? In case of this insurance that may happen also. The doctors of private hospitals are also front-line health care worker. Who will get the insurance & how this should be clear?"

- (Female_36_physician)

Moreover, FLWs of the private sector were baffled about this announcement as the reward was announced for government health workforce only. However, some SACMOs were found to be content about it while others felt the same as other FLWs.

"In this war, we are the soldier. We have to protect us and serve people with what we have, it doesn't matter whether the government provides something or not."

- (Female_28_SACMO)

Role of Health Professional Associations

The respondents were largely dissatisfied about the role played by the different professional associations in this crisis. From statement of the different cadres of FLWs it was evident that these association are playing an almost 'non-existent' role. The role of the largest physician association was described as :

"As usual frustrating. All of the members of this association are in COVID steering committee, but they are doing nothing at all."

- (Male_34_physician)

"They failed to be the communication tether between us and the policy makers"

- (Male_33_Physician)

According to the physician respondents, alternative social media-based professional association for physicians like 'Bangladesh Doctors Foundation (BDF), and Foundation for Doctors Security and Rights (FDSR) are working as their voice instead:

"Recently a new association known as the BDF has taken some initiatives to make doctors' life comfortable. They manage ambulances for doctors to reach them to hospitals, they help doctors' family members in case of emergency. Moreover, they are neutral and provide equal services to all"

- (Male_33_physician)

Other professional cadres e.g. SACMO, nurse and midwives, Medical technologists, FWV etc. have more or less same idea about their respective professional associations. But according to some of them, some are still playing a praiseworthy role in small scale:

"We have an association like 'FWV association'. We 19 members in our area, visit different areas and provided awareness campaign among people. We did some BCC sessions with them. We trained them about handwashing, social distancing and aware them of staying at home."

- (Female_58_FWV)

Mental health of the FLWs

Almost all respondents mentioned about panic, anxiety, irritability, frustration and other psychological symptoms they are experiencing since the COVID-19 crisis began. These symptoms are happening mostly because they feel unsafe and unsecure due to poor availability of PPE and other supplies while handling suspected or confirmed COVID-19 cases. Probability of asymptomatic cases during community transmission and patients' tendency to hide true history due to stigma and fear was the major underlying reason triggering these symptoms. As the sole reason of anxiety, fear for family members' safety also came up. The thought of children and elderly of the family getting infected from them makes them terrified as a result of which a number of FLWs mentioned about insomnia. Some are staying away from their families. But other than this, they appeared to be fearless to deal with, and treat any, suspected and/or confirmed COVID-19 patients with proper protection:

"I came home and took my baby, later I felt like I infected him. Then my wife said that if we die, we all die together. The day I attend admission, I cannot sleep at night, feels like COVID is everywhere around me. It's a panic. If I am given accommodation from hospital, I will not come home, I need to keep my family safe."

- (Male_34_Physician)

"While I used to listen the authority, felt toxic, felt like tearing up my certificate. While I go back home, I feel guilt, that probably one day I am going to infect my mother and brother, who are staying home. I am always terrified. Thinking about physical hazard is a mental health hazard, too."

- (Female_32_physician)

"As a human being I am also terrified like everyone. I am on my duty regularly. Since I am going to hospital regularly from home so I am worried about my family members if they become infected by me."

- (Male_SACMO_32)

"Main fear is of being a corona bomb. I fear that my family members might be affected from me. Other than that, I have no fear."

- (Male_33_Physician)

"I am always scared nowadays. Scared of my family and relatives. We handle different types of patients, so we can be infected and ultimately the whole family will suffer."

- (Female_54_FWV)

Recommendations for safe, secure, and productive professional life

In order to make recommendation or appeal to the authorities to make their professional life more safe, secure and productive, the FLW's came with a number of recommendations which are summarized below.

First, IEDCR has to maintain transparency about number of total positive cases and total number of deaths from COVID-19 including testing for corona virus among patients reported dying from similar respiratory symptoms so that the FLWs can assess the situation. For this, the number of tests have to be increased.

Second, procurement of sufficient number of PPEs of appropriate quality[5]; accommodations for the FLWs on duty so that they can stay away from family for the time being and ensure family's safety. This is necessary even for the field level FLWs, too, as community transmission is happening.

> *"Besides, we need safety and security. Ensuring PPE, hand sanitizer and essential products are needed. Without safety, we are not comfortable providing services."*
>
> ***- (Female_58_FWV)***

Thirdly, Management of roaster and rotation of FLWs to limit exposure and keep health workforce reserved. Like Wuhan, 3 or 4 teams of FLWs can be made. Each team would deal patients for 7 days, then for 14-21 days they would be quarantined, while the other teams would serve by rotation. By this 7/14 model, FLWs would have a chance to stay physically and mentally healthy.

> *"I have recommendations: 1. Need enough PPE for doctors, at least PPE (level 1) should be ensured for all doctors dealing with any patient. 2. Need separate accommodations for all doctors throughout this pandemic, need to be away from family. 3. Should not utilize all doctors at a time, need to reserve some for future urgency, as other countries are doing. 4. Professor level/senior doctors should not be in duty station now (as they are more vulnerable because of having different NCDs or other comorbid conditions), they can provide services from home (over mobile phone/video call)."*
>
> ***- (Male_33_physician)***

Fourth, structured guidelines and protocol, as well as critical medical equipment like ventilator, ICUs should be arranged in this time. DGHS can take over the private hospitals for interim period, so that the existing ICUs can provide support as and if needed.

Fifth, building awareness of the people on the characteristics of the disease including preventive measures are urgently needed through a country wide IEC campaign.

Amidst the lockdown, people are not still maintaining social distancing as well as hiding history to the FLWs, increasing the risk of being exposed to COVID-19 for the FLWs. Government should make people aware of it

> *"We need to raise awareness among people. Like Meena cartoons taught us the importance of using toilets. Before that BD people were not aware of it. So, in every disease, there is some preventive mechanism and people should be aware of it."*
>
> ***- (Male_28_physician)***

> *"We have 279 PPE in stock (from government), already ordered for 300 more. There is adequate PPE at my upazilla, as we took steps timely. We deployed CHCPs to field level to create awareness and following up home quarantine of the overseas returnees. Home quarantine was maintained."*
>
> ***- (Male_39_physician)***

Last but not least, proper co-ordination among all these activities can provide safe, secure and productive professional life for the FLWs in this crisis period, they opined.

4. Summary of findings

The key findings can be summarized as follows:

- 60 respondents (different categories of FLWS) from 14 districts and 43 institutions participated in the telephone survey to respond to some closed and some open-ende questions presented as discussion topics during phone conversation;
- The FLWs were unequivocal about the necessity of using PPEs by all health care providers attending suspected/ confirmed COVID-19 patients since) the country has entered the stage of community transmission with asymptomatic cases, and ii) many patients are hiding facts due to stigma and fear; for OPDs, the PPEs should be at least Level 1 standard as specified by WHO guide line;
- The main problem underlying the stress and mental health disturbances faced by the FLWs appeared to be the safety concerns for the family members as they have to shuttle between hospital and home while they are on duty;
- The FLWs are more interested in having proper protection (PPE and others) while handling patients (suspected or confirmed) than monetary incentive in the form of insurance declared by the PM; they also appeared sceptical about its appropriate and justified distribution. Some of them rather preferred instant monetary incentive (mainly non-doctors);

[5] *Supplying of spurious masks to public hospitals with N95 labelling has been acknowledged by the government*

- Some suggestions for keeping the lives of the FLWs safe, secure and productive now by the respondents include:
  - IEDCR has to increase the number of tests for identification, isolation and treatment of positive symptomatic cases and contact tracing; this will help FLWs to assess the situation and take appropriate measures
  - Procurement of sufficient no. of PPEs of appropriate quality; arranging accommodations for FLWs to keep them away from the family members
  - Implementation of a 7/14 model (7 days of duty followed by 14 days of quarantine after Wuhan) of roster and rotation of FLWs to maintain reserve for future surge
  - Preparation of the facilities (logistics and supplies, extra beds and hospitals, ICUs and ventilators etc.) for impending surge of the quarantined people and patients at war footing
  - Intensive and focused country wide IEC campaign on basics of the disease and preventive measures to allay anxiety, fear and stigma; use of legal measures if and when necessary

5. Recommendations

Based upon the findings above following specific recommendations are made to implement ASAP:

- All measures should be undertaken to augment the supply of PPEs of appropriate quality (according to WHO guideline of 20th March, 2020) and should also include support staff like cleaners, ayas, ward boys etc.;
- Measures should be undertaken to accommodate the FLWs near to their work place and thus preventing the spread of infection to their family members and removing the major source of concern and anxiety for them;
- A 7/14 model (7 days of duty followed by 14 days of quarantine) of roster and rotation of FLWs should be implemented ASAP for) maintaining reserve of HRH for future surge and ii) maintaining physical and mental health of the FLWs to serve the patients stress-free;
- All types and levels of FLWs handling COVID-19 patients should receive standard training on the basics of the disease and its prevention as per WHO guideline; currently this is lacking to large sections of the FLWs;
- Intensive and focused country wide IEC campaign should be mounted on basics of the disease and preventive measures to allay anxiety, fear and stigma; use of legal measures if and when necessary to keep the FLWs safe, secure and professionally productive;
- Coordinated, multi-sectoral measures to prepare the facilities for the impending surge of patients in coming weeks involving all relevant ministries; the national committee should provide the necessary leadership and involve all non-government sectors;
- Activating the “One Health” and “Health Security” strategies and mobilise the different constituencies for joint actions to help health authorities.

This report was produced by

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