Challenges faced by medical officers in providing healthcare services at upazila health complexes and district hospitals in Bangladesh – a qualitative study

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The Lancet Regional Health - Southeast Asia 2024;24: 100398

Published Online xxx
https://doi.org/10.1016/j.lansea.2024.100398

Summary

Background Upazila Health Complexes (UHCs) and District Hospitals (DHs) play a crucial role in the healthcare delivery system of Bangladesh. But very few research has been conducted to find out the prevailing challenges of the medical officers working in these tiers. The objective of the study was to identify the challenges faced by medical officers in providing healthcare services at UHCs and DHs.

Methods In-depth interviews of 51 medical officers from 17 UHCs and nine DHs were done between March and April 2021. All participants were purposively sampled. Data were transcribed verbatim and analysed using thematic analysis.

Findings Inadequate service rooms, unavailability of proper medical equipment, poor housing conditions, lack of public amenities, shortage of health workforce, lack of laboratory services, and excessive workload were the common challenges mentioned by the medical officers in providing healthcare services in UHCs and DHs. Lack of workplace safety, security, and undue pressure from local political leaders and journalists made the work environment fearful. The absence of proper implementation of policy related to higher education, posting, transfer, and promotion was also stated as challenge for the medical officers.

Interpretation Infrastructural improvements along with increased safety and security of the doctors at their workplace and transparent implementation of reformed policies are essential to reduce the workplace challenges of medical officers in UHCs and DHs of Bangladesh.

Funding The study was funded by Hospital Services Management, Directorate General Of Health Services (DGHS), Mohakhali, Dhaka, and Bangabandhu Sheikh Mujib Medical University.

Keywords: Medical officers; Workplace challenges; Bangladesh

Introduction

Human resources are one of the vital building blocks of a health system framework.[1] The role of doctors in patient care is diverse where they have unique expertise and abilities and are mostly used for healthcare delivery.[2] High absenteeism, low retention, lack of opportunity for skill development, structural and logistic support challenges are inextricably intertwined with the health workforce (HWF) strengthening as well as the sustainability of the health system.[3] In hospitals, problems like lack of surgical equipment, not having enough essential drugs, and unavailability of modern storage facilities are common challenges for the healthcare practitioners.[4–7] Due to the above-mentioned struggles, patients are deprived of quality services and tend to seek healthcare from nonqualified providers in the informal sector.[8]

In Bangladesh, upazila health complexes (UHCs) from primary and district hospitals (DHs) from secondary healthcare delivery tiers play a vital role in the healthcare delivery system by comprising 31.0% and 40.0% of the in-patient admissions, respectively in the

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Research in context

Evidence before this study

In the pursuit of understanding the workplace challenges faced by medical officers in Upazila Health Complexes (UHCs) and District Hospitals (DHs) in Bangladesh, extensive literature searches were conducted across different databases. We searched "workplace challenges", "hardships", 'medical officers", medical doctors", "Upazila Health Complexes", "District Hospitals" in PubMed, Google Scholar and BanglaJOL to identify workplace challenges of medical officers posted in Upazila Health Complexes (UHCs) and District Hospitals (DHs) in Bangladesh. Limited skill development opportunities, and inadequate infrastructure were identified as key challenges in previous studies.

Added value of this study

This study explored the challenges faced by medical officers in Bangladesh. It highlighted the need for improved healthcare infrastructure, adequate medical logistics, and diagnostic facilities, as well as staff shortages and unrealistic workloads. It also emphasized the importance of creating a supportive work environment, addressing political interference, ensuring workplace safety, and providing equitable opportunities for higher education and specialized training. Additionally, it highlighted the importance of addressing challenges arising from the immediate environment, such as accommodation, educational facilities, road access, and transport facilities.

Implications of all the available evidence

Based on the current study findings, an appropriate policy can be developed for improving the working conditions, professional development, and overall well-being of medical officers. This policy would lead to a strengthened healthcare system and implementation of better healthcare services by the medical officers in UHCs and DHs.

public health sector.[9] It is important to reduce the challenges of the medical officers working in these crucial blocks of the healthcare delivery system.

However, limited research has been conducted to generate evidence to comprehend the challenges that medical officers experience during their service in different tiers of the healthcare system of Bangladesh. Thus, this study aimed to observe and investigate such to escalate needful attention to improve the condition.

Methods

Study design

The current study employed an ethnographic methodological approach for identifying the challenges faced by medical officers in providing healthcare services at DHs and UHCs in Bangladesh. In-depth interviews (IDIs) were taken to collect data. Observation notes and field notes of each interview allowed the richness of the data.

Study site and time frame

For selection of study sites, a cluster sampling technique was followed (Fig. 1). One DH from each of the eight divisions of Bangladesh and one hard-to-reach district was selected randomly. Divisional DHs were excluded from the study as those hospitals are supposedly well organised, equipped, and backed up by a large workforce.[10] From each of the selected districts, there was a plan to select two UHCs randomly, but finally ended up with 17 UHCs. The data collection of the study was done from March to April 2021.

Study population and sampling

A purposive sampling strategy was followed. One male and one female Medical Officer (MO) (entry level post for medical doctors in Bangladesh) from each UHC and DH who were working for more than 6 months in the selected hospitals were interviewed face to face in their workplace. In case of the absence of one male and one female MO, both interviews were taken from male or female MOs. In one of the UHCs, only one MO was available for interview. So, a total of 51 IDIs were conducted from 17 UHCs and nine DHs. However, the sample size of this study was dependent on the researcher's satisfaction upon richness and quality of data. When researcher found stalling in generation of new data, then sample size was determined considering the data saturation. Here, both code saturation and meaning saturation took place.[11]

Data collection

For maintaining research integrity, trained and experienced data collectors with at least a bachelor's degree were deployed to collect data. Data collectors received seven days training prior to field data collection. The interview guideline of IDI was developed in English which was translated into Bangla for better utilisation during the interview for collecting clear and quality data. Pre-test was conducted at one DH and one UHC other than selected study sites.

Before conducting the interview, the research objectives and interests were explicitly explained to the respondents and any kind of leading questions were avoided. A good rapport was built with the respondents through a few icebreaking questions so that they could comfortably answer the questions related to the research objectives. IDIs with the MOs investigated the challenges and frustrations that a MO faces in UHCs and DHs while serving the population. Each interview lasted for 45–60 min and was moderated in Bangla, the native language of both the respondents and the interviewers.

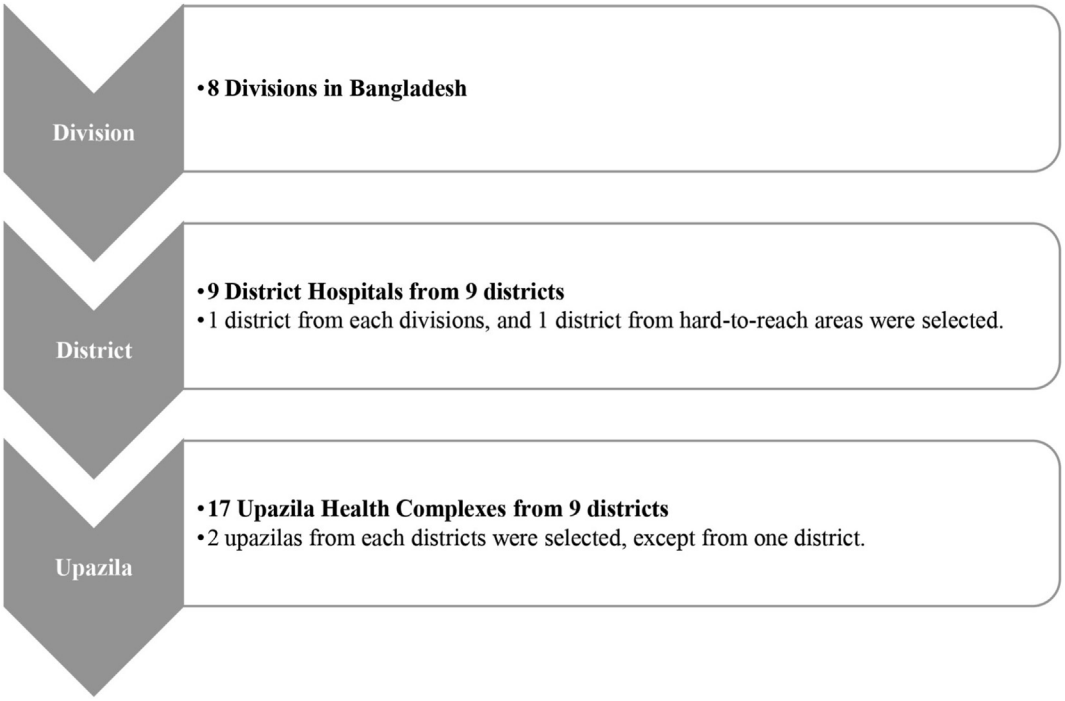

Fig. 1: **Graphical representation of study site selection**.

The IDIs were audio recorded with permission from the respondents.

Data synthesis and analysis

The recorded audio files were downloaded, and the researchers responsible for transcription followed the field notes and audio files during transcription. Field notes were finalised on the same day of the interview and then aligned with each related transcript. The members of the core research team listened to the audio, checked the transcriptions thoroughly, and updated the transcripts if anything was found missing according to the audio clip. Different a-priori codes were developed according to the IDI guideline. Data familiarisation was done by reading and re-reading the transcripts, which helped in the identification of repeated patterns of information, regularities, and irregularities in the data. Thereby, many inductive codes were prepared. A-priori codes also had many subcodes. Transcripts were coded according to the code book through which data were clustered, compared, and categorised under each theme. Cleaning and strengthening of the codes as needed were done. Extracted codes from the entire data set were placed under specific themes and those themes were analysed manually. Thematic analysis was conducted to analyse the data of current study. This study also used COREQ checklist including the aspects such as research team, study methods, context of the study, findings, analysis and interpretations for comprehensive reporting of this study.[12]

Data validity was checked. For increasing validity, few transcripts were coded independently then matching was done with two researchers for ensuring the intra-coder and inter-coder reliability. All the quantitative data were cleaned and analysed for frequency distribution using MS Excel 2019.

Ethical approval

All the ethical issues related to this study were properly identified and implemented. An informed consent form was developed and was signed by each participant prior to starting data collection. The right of the participants, to withdraw themselves from the study at any point during the interview without any negative consequences, was also mentioned. The participants were informed that during transcription, data will be anonymised, and non-identifiable codes will be used in the written transcripts. To maintain privacy and anonymity of the participant, interview was conducted in private place with a sensitive and non-judgmental manner. The study protocol including the guideline used in data collection was approved by the Institutional Review Board of Bangabandhu Sheikh Mujib Medical University *(BSMMU/2021/158, Date: Jan 6, 2021)*.

Role of the funding source

The funders of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.

Results

A total of 51 MOs from 17 UHCs and nine DHs were interviewed. The summary of the participants are provided in Table 1.

Table 1 presents the demography of the participants. Out of the 51 participants, 47.1% were female and 52.9% were male. The gender distribution was similar between the two groups, with DH having equal number of male and female MOs, and UHC having 45.5% female and 54.5% male participants. Among all participants, 62.7% lived with their family. The distribution was different between the two groups, with DH having 88.9% participants lived with their family while in UHC 48.5% participants who lived with their family. The majority (86.3%) of the participants had only a Bachelor of Medicine and Surgery (MBBS) degree. The education level was similar between the two groups, with DH having 94.4% participants with an MBBS degree and UHC had 81.8% participants with an MBBS degree.

The key challenges identified from the IDIs were grouped into four broad categories (Fig. 2): (i) challenges related to hospital infrastructure, (ii) influence from an interest group and workplace violence, (iii) policy-related challenges, and (iv) challenges from the immediate environment.

Infrastructural constraints

Infrastructural constraints of the hospitals were identified as the most prevalent challenge for the doctors at their workplace where most discussed challenges include poor hospital architecture with lack of public amenities, unavailability of proper medical logistics, limited supply of essential drugs, lack of diagnostic facilities, staffing shortage, and excessive workload.

Poor hospital infrastructure

Dire working conditions in the hospital were the main concern discussed by all the doctors. The most prevailing challenges mentioned was the lack of appropriate space for working, since the consultation rooms or emergency rooms were usually small, lacked proper technological support, and were always overcrowded with the patient's friends and family members. At times, two or more MOs shared the same room for providing health services, incapable of maintaining the patient's confidentiality and privacy. Additionally, a common space to sit and rest after providing service usually added up to the disappointment and demotivation of the doctors.

> *"Patients always think if I go to a well-established, well-maintained hospital, I will get good service. But after coming to the emergency department of this hospital, they see a small, congested room, with a broken door and bad distemper on the wall. They have a dreadful first impression, and they think they will not receive good services. (MD12)"*

Unavailability of proper medical logistics and diagnostic facilities

The unavailability, or inadequate amount of available proper medical logistics, equipment, and technologies for ensuring proper health service to the patients was another important challenge the doctors faced. Likewise, in some hospitals, only a few common diagnostic tests

Variables	Total (N = 51) N (%)	DH (n = 18) n (%)	UHC (n = 33) n (%)
Age (mean ± SD)	30.6 ± 4.2	31.1 ± 5.3	30.3 ± 3.5
Gender			
Female	24 (47.1)	9 (50.0)	15 (45.5)
Male	27 (52.9)	9 (50.0)	18 (54.5)
Marital status			
Married	40 (78.4)	14 (77.8)	26 (78.8)
Unmarried	11 (21.6)	4 (22.2)	7 (21.2)
Living with family			
Yes	32 (62.7)	16 (88.9)	16 (48.5)
No	19 (37.3)	2 (11.1)	17 (51.5)
Service duration			
6–12 months	13 (25.5)	8 (44.4)	5 (15.1)
13–24 months	32 (62.7)	8 (44.4)	24 (72.7)
>24 months	6 (11.8)	2 (11.1)	4 (12.1)
Education			
MBBS	44 (86.3)	17 (94.4)	27 (81.8)
MBBS and post-graduation	7 (13.7)	1 (5.6)	6 (18.2)

UHC, Upazila Health Complex; DH, District Hospital.

Table 1: **Demographic characteristics of participants.**

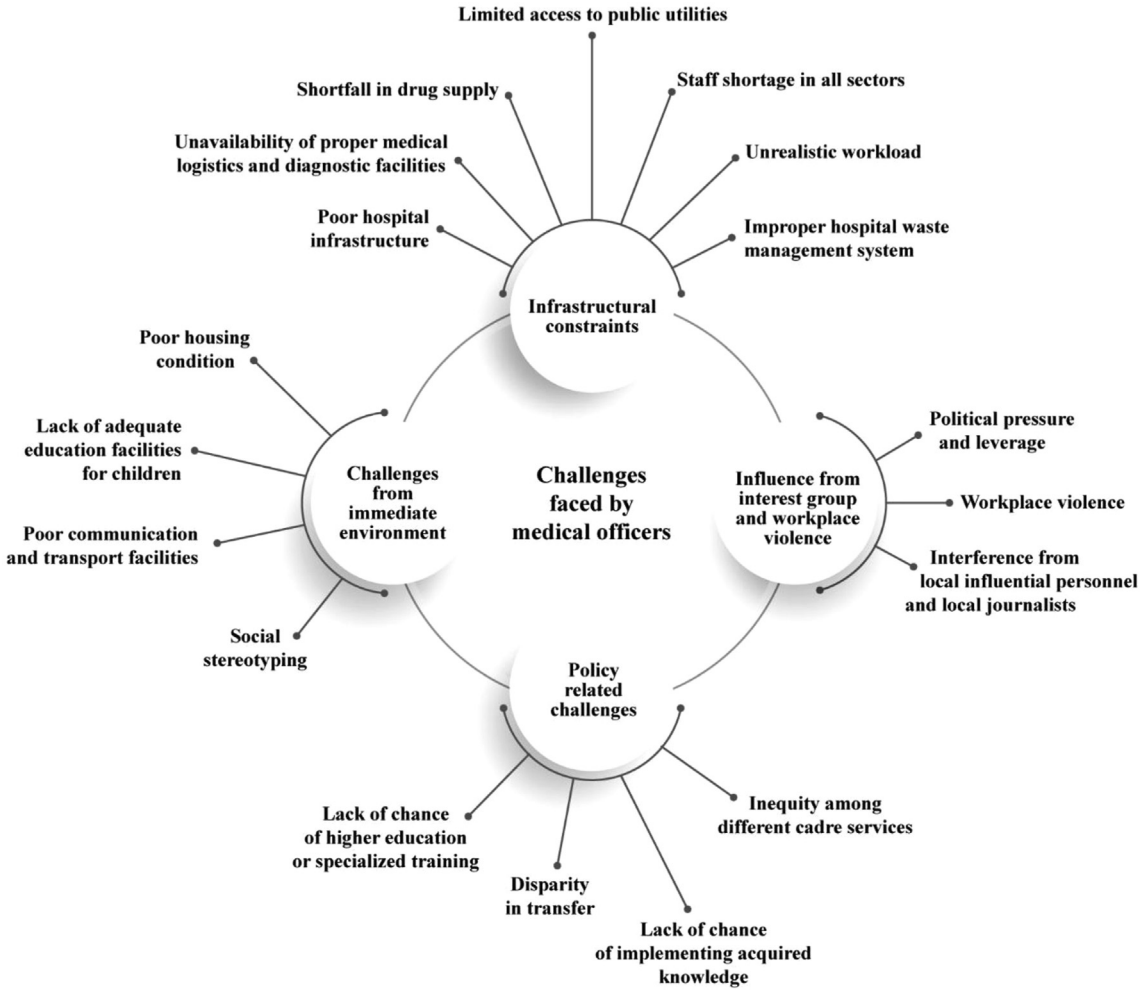

Fig. 2: Thematic diagram of challenges faced by the medical officers.

were done, whereas, in some, no diagnostics were available at all. Many participants specifically mentioned the lack of presence of faulty ultrasound machines, X-ray machines, and pathological labs.

> *"We do not have all the lab facilities or investigation here. But have some blood tests here. In medical side we can do thousands of tests, but here we have only Complete Blood Count (CBC), and Random Blood Sugar (RBS) test facilities. We do not have ultrasound facility here. do not have CT-scan facility here. (MU7)"*

Apart from the mentioned diagnostic facilities and tests, the lack of some crucial facilities to manage cardiovascular emergencies were evident. This was more dire for facilities located in hard-to-reach areas. When they present with emergencies, the inadequacy of proper emergency services, diagnostic facilities, etc., increases the casualty risk of that patient considerably.

Staff shortage in all sectors

The challenge of staff shortage was noted at every level of the hospitals. It included doctors, nurses, pathologists, lab technologists, office assistants, cleaners, etc. MOs play an important role for providing continuous service at both indoor and outdoor departments. But an adequate number of MOs was not found in any of the hospitals. A common reason cited by the participants was that recruitment according to the patient load was not done, which resulted in an excessive workload for the available workforce. Due to workforce shortage, maintaining the quality of care often falls behind.

> *"... If we work at the indoor ward, and at that time if a patient comes to the emergency unit, he will not be attended by any doctor for that instance. So, then they might complain that they do not get any doctor at emergencies... (MU22)"*

Correspondingly, staff for laboratory services was also not posted adequately. While some hospitals had well-equipped laboratories but lacked the appropriate sonologists, radiologists, and pathologists.

> *"Lab facilities are minimum here. We have ultrasound and X-ray facilities. But we do not have any radiologists. So, we get only X-ray film. If there were a radiologist, he or she might write the interpretation, which would be helpful for us. (MU9)"*

Paucity in the number of nurses, ward boys, supporting staff and hospital cleaners was also mentioned as challenge by the study participants.

Unrealistic workload

The excessive workload of the doctors was iterated by almost all the physicians participating in this research. They also mentioned working excessively for long hours without having a proper break or duty roster; about which they were agitated. Due to the workforce shortage, many doctors work both the morning and the evening shifts, consecutively.

> *"In this hospital, a doctor performs duty equal to three doctors due to a shortage of workforce and excessive patient visits. It is nothing less than physical and mental torture. (MD15)"*

At the same time, the doctors had to deal with extra administrative responsibilities, which they found extremely annoying. Along with the undesirable impact on their day-to-day working lives, there was a consensus among the respondents that their current workloads will also negatively impact their career progression.

Limited access to public utilities

The availability of public utilities in the hospitals was also an important issue discussed during the interviews, where the limited access to electricity, water supply, internet access, etc., came to light. All the hospitals had a continuous power supply with irregular disruptions, hampering the hospital's daily operations.

> *"We have been facing electricity problems. We can't run our X-ray facility round the clock because of the absence of continuous electricity supply and improper voltage. It overall hampers our department. (MU4)"*

Besides electricity, water, and internet availability issues were also mentioned during the interviews. Some respondents said, that though they have a water connection, they are afraid of the high electricity bill generated by the electric motor used to fill the water tank. As the high cost of the electricity bill is not included in their budget, it poses a challenge to use an uninterrupted water supply. Simultaneously, the unavailability of clean drinking water also came out from an interview. The majority of the respondents stated that there was no internet facility within the hospitals. In some facilities, MOs reported that they had internet connections in the hospital premises before, which were not working anymore.

Shortfall in drug supply

Even though most of the respondents mentioned the adequate flow of medicines in the hospital, however, they stated that at times of crisis, medications were not always readily available.

> *"Usually, we have enough medicines in stock, but sometimes during emergencies, we face a crisis. Once it happened that the patient got aggressive and tore the ticket slip on my face as I couldn't give him any medicine. (MD7)"*

This scarcity often happened in situations when expensive medicines were needed, else ways, medicines for general health problems were mostly available at the hospital.

Influence from interest group and workplace violence

Concerns regarding the occupational risks of doctors were reported by most of the respondents with particular regard to political pressures, adversity from local influential persons, and lack of workplace safety. Several MOs revealed challenges related to this firmly, conversely, some avoided mentioning it.

Pressure, leverage, and interference from political and/or local authoritative personnel

Most of the respondents had to deal with interference or pressure at their workplace, from political and/or local authoritative persons. Their demands ranged from delivering prioritised medical treatments, managing administrative affairs for their relatives and friends, and also to issuing false medical certificates in many instances.

> *"Political leaders create inconveniences here often. They demand us to give their patients immediate attention by expediting the queue. If they need to get admitted, we need to arrange a bed for them, despite having a shortage of beds. They misbehave with us if we fail to comply. (MD14)"*

> *"Local hooligans and gangsters sometimes try to physically assault us if we don't keep their unethical requests. We even don't have any police posting here to ensure our security. It is very demotivating and scary. (MU18)"*

Such pressure was usually exerted on both the doctors and administrative bodies to prioritise the needs of

their people of interest to avail healthcare services with extra and injudicious benefits.

The issue of supporting staff recruitment using political leverage was also mentioned by a few doctors, where the staff with political clout often do not follow the institutional codebook, hospital rules, and responsibilities imposed on the staff. This in turn led to a conflicting and unhealthy work environment.

> *"The use of political leverage is evident among the doctors as well. … there are many MOs with political backup who are reluctant to work there regularly. On one occasion, a phone call from the superiors came to our superintendent sir for them. As a result, our superintendent and Resident Medical Officer (RMO) became helpless, and could not assign them any work during an emergency situation. (MD11)"*

Doctors also mentioned the lack of cooperation from journalists in their designated workplaces. They grieved over the behavior and malpractice of some local journalists toward them.

> *"The journalists here don't cover good and supporting stories for us. Few are looking for the opportunity to defame us. But they could write and make news on the unavailability of resources and manpower to grab the attention of authority and government to help us. But they don't do it! (MU5)"*

Lack of workplace safety and security

The issue of lack of safety and security along with the related workplace violence faced by the doctors was distinctly identified by respondents from all levels. Even though some respondents conveyed partial dissatisfaction, most of them expressed unavoidable concerns regarding their safety and security.

> *"Is there any safety for the doctors? If anyone physically assaults any doctor, there is nothing we can do. If we seek assistance from the police, by the time they reach here, the doctor gets assaulted. There are no security guards here. Security is not even available in the emergency department! (MD3)"*

The need for strengthening the security services for the doctors of every department (indoor, outdoor, and emergency) at the DHs and UHCs was voiced by all respondents. They also lamented about the unwanted behavior from the relatives or friends of the patients, and sometimes by the patient themselves, which at times escalated to violent acts. They reported getting physically and verbally assaulted by patients' attendants several times.

> *"Our doctors don't get enough security. Many times, patients' relatives physically assault doctors. It restricts doctor's ability to provide proper service. (MU12)"*

Policy related challenges

All the respondents stated the importance of developing and/or modifying evidence-based policies to improve the recruitment, deployment, and retention of qualified health workers to health facilities. It was mentioned by the respondents that the existing policies often pulled back doctors in escalating their potential in their respective desired career paths and restrained them from maneuvering their knowledge in real settings. It was reported by the MOs that political hinges tended to be associated with policy limitations.

> *"Doctors who have higher-level political connections usually can avail better placement and chances of higher study easily than others. In that case, a good student or doctor might not get the chance, but an average might get the opportunity. That is unfortunate. (MD2)"*

Lack of chance of higher education or specialised training

The hindrance in the career development of the doctors was voiced by almost all the participants of the study. Their dissatisfaction with the policies related to higher education and training stemmed from the shortage of trained workforce in the UHCs and DHs since the MOs posted there, do not receive approval for further education or specialised training upon request.

> *"There is no doubt that we do not receive enough training. For instance, the entire emergency team including doctors, nurses, MOs, and ward boys need training for their respective positions to handle a patient with a spinal injury. Without training, one may make mistakes and cause more injuries to the patient. It may cause paralysis too. (MU19)"*

Lack of chance of implementing the acquired knowledge

Few of the respondents mentioned the inadequacy of opportunities to implement their knowledge at their workplace, which they received from different specialised training and courses. Instead, they were posted to other departments, where they did not get the chance to utilise their acquired skills.

> *"I have completed four years long training on surgery, but here I can't apply it. I have to treat general patients and due to lack of practice, I am forgetting what I have learned. (MD16)"*

Disparity in transfer

Respondents expressed their dissatisfaction regarding the policy and procedure related to transfers and postings. Nearly all the respondents agreed that the transfer issue is heavily dominated by political lobbying.

> *"There is no specific system for transfer, wherever there is a vacant post available, the government deploys a doctor*

there. People who have a higher-level political connection, use it to work in hospitals near the capital. (MD14)"

Inequality between health and other cadres of Bangladesh Civil Service (BCS)

The doctors expressed their disappointment regarding the inequality of the work environment, and scope of professional growth when compared to other BCS cadres in equivalent grades. They thought the disparity was evident to them from the first day of joining. Many doctors mentioned that they were not able to avail promotions even after working as a senior MO for 10–12 years, whereas in other cadre services, they are promoted regularly, every few years (range varies according to cadre) as per schedule.

"I think the problem is in policy implementation. If we pass the senior scale examination, we are supposed to get a promotion. In other cadre services, they are getting promotions. Why are we not getting the same?" We are now scared. Are we going to retire as MOs as promotion in this cadre is not happening on time! (MU25)"

Challenges from immediate environment (accommodation and living conditions)

Inadequate accommodation facilities

The struggle in having standard accommodation for the MOs was identified as a vital challenge. There were no accommodation facilities designated for the doctors in some districts. Even if there were specified, the housing was in a deplorable condition which was not fit for accommodation.

"We have accommodation problems. As first-class officers, we do not get a standard house to live in. Often it is observed that the door of the house is broken, the water tap is not working, and the roof at times is falling apart, it is hazardous to safely live under it. (MU13)"

Similarly, in a few interviews, it was stated that doctors' dormitories were not being allotted properly to those who needed them, which restricted the MOs to live. In such instances, the doctors preferred to live outside the allotted accommodations. Although most of the doctors had rented houses near to their workplaces, they were eager to live in a government dormitory as they believed it would be safer, especially during night shifts.

"I live in a rented apartment here. But if we have a hospital quarter for living that would be great. They are safe for living. (MD17)"

Even though the doctors expressed their interest in living in the government quarters, they simultaneously doubted the quality of accommodation that would be allocated in return for the amount of money deducted from their salary, as their living allowance. Since they could avail better houses outside the hospital perimeter with lesser rent. Moreover, the doctors who were working the DHs or UHCs located in their paternal or maternal hometowns favored living in their familial houses.

Lack of educational facilities for children

Another common challenge faced by them when they transferred to a workplace away from the capital or large cities, was ensuring quality schooling facilities for their children. In such circumstances, the doctors' families did not accompany them to their workplace and stayed behind to secure their children's education in a good academic institution. As a result, retention of doctors at the DHs and UHCs became difficult.

"Here, we do not have a good school to admit our children. As a result, doctors do not want to live here with their families. There is no standard school for primary or mid-level. (MD9)"

Poor road access and transport facilities

A variety of responses were identified with regard to communication and transport facilities from the doctors. In rural areas, where the roads were poorly built or were in a state of erosion, abetted in their daily commuting. For doctors working in hard-to-reach areas, going to their health complex was a daily struggle.

"Movement is really difficult here (flood-prone area). I could not go to the health complex because of the remoteness. The boat is not going there now as the water body has dried... There is no ambulance or proper transport system here. (MU17)"

Furthermore, even if transport was available in the daytime, they were usually unavailable in the late afternoon and evening, which was troublesome for many doctors after finishing their evening and night shifts.

Social stereotyping

Due to patriarchal social norms, female doctors are often subjected to prejudice while serving patients. There are still people who deny the ability of a female to be a doctor, even though, she endows tremendous efforts to maintain both her career and family life simultaneously despite facing enormous obstacles. One of the female MOs sadly stated that,

"People still cannot accept the fact that women can also be a doctor. Still, we do not get that respect from people. When I serve at the emergency unit, people come and ask me where the doctor is, although I am present there wearing my apron. I am sure, male doctors do not face this issue. I always have to prove that I am the doctor. (MU14)"

Worryingly, she also added that the third or fourth-grade employees at times did not respect the competency and efficiency of a female doctor as much as they did for male doctors.

Discussion

The findings of this study contribute to the understanding of the challenges faced by the doctors at UHCs and DHs of Bangladesh. Among the constraints identified, inadequate hospital infrastructure and equipment, political pressure and leverage, and ineffectiveness of policies and disparities related to education, training, and transfers, were noted as important challenges. Additionally, local people with clout, workplace violence, bad journalism, and social stereotyping were also recognised as a frequent hindrances to the doctors providing healthcare services.

Most of the participants complained about the poor condition of their hospital, ongoing lack of maintenance, inadequate and irregular supply of medicine, and underutilisation of the available services due to staff shortage. These issues in turn influenced the workload of the doctors causing them to be demotivated and fatigued. Similar challenges such as the unavailability of surgical equipment, lack of essential drugs, and no modern storage facilities, in hospitals located in rural and remote areas, were the reported challenges for health workers in other studies.[4–7] Evidence suggests that doctors perform better when essential supplies and equipment, along with the appropriate staff are availed to them for a comprehensive service delivery.[7,13] Substandard accommodation facilities, lack of basic amenities, poor roads and transport facilities, and the absence of adequate schooling environment for the children of the doctors were also important challenges the doctors faced in their designated workplace. These findings were consistent with other studies[7,14–16] where it was identified that improved living conditions of doctors and decent educational facilities for their children motivate them better. Despite the existence of a network of hospitals and health centers in the upazila and district levels of Bangladesh, there is a considerable lack of development and maintenance of the hospitals, doctor's accommodations, roads, and transport facilities, to ensure a robust infrastructure.

The current study identified the profound impact of political pressure and leverage on the doctor's working conditions. The reported accounts where the doctors were compelled through political personnel or local influential and hooligans, usually ranged from delivering immediate medical treatments, hastening the patients' queue, not paying the hospital bills, issuing sham or false medical certificates, demanding at-home visits, etc. Most of the time the doctors had to comply with such demands in fear of verbal aggression, and physical violence, if they denied. Such fear and insecurity among doctors were also aggravated by the lack of hospital security. In many cases, media is known to have portrayed doctors in a negative image which has known to spark hostility towards them.[17,18] Therefore the need to take steps for ensuring the safety of doctors is pertinent, which can be managed by hiring security guards, particularly for night shifts, requiring health care providers to work in teams, community watch, and alert systems, etc.[14]

The majority of the doctors interviewed were not satisfied with the current policies related to recruitment, deployment, transfer, and career development, because they perceive that the administrative procedures lack fairness and transparency. Such results were consistent with other studies in low-income and middle-income countries like Ghana[19] and Malawi,[20] where the doctors were demotivated by the lack of sufficient professional and career growth opportunities at their jobs. Moreover, many participants in the current study mentioned the practice of political leverage to secure choice postings and transfers, which resulted in demotivation among their peers. Other studies reported that, if the doctor was unsuccessful in receiving his chosen post, either they would not join or might join for a brief period and take extended leave and remain continually absent from the workplace,[21] adding to the patient overload on the remaining doctors. Thus, there is a need for transparency in the recruitment, postings, transfers, and promotions of doctors, which is known to motivate and satisfy doctors as reported by a study from Tanzania.[22]

Many doctors expressed their dissatisfaction with the disproportionate facilities they received in comparison to other BCS cadre services of a corresponding grade from the very beginning of their career.

This study employed randomization in the sampling process, which minimizes the bias. Also, participants were recruited from DHs and UHCs of all the eight divisions, which increases the scope of generalizability. The gender ratio among the participants were almost equal. Hence, this study ensured bringing out the perspective from both male and female doctors making this study gender neutral.

This study has few limitations. The scope of the study was to explore the challenges of MOs in government health facilities thus the opportunity to explore the scenario of the private health facilities as the current study was missed. Also, the study could not include the health-related decision makers, administrators and did not get their views on the workplace challenges of the MOs. As mentioned earlier, the sample size of this study was dependent on the researcher's satisfaction upon richness and quality of data. When researcher found stalling in generation of new data, then sample size was determined considering the data saturation.

The current study concludes that, the challenges faced by healthcare providers in Upazila Health Complexes and District Hospitals in Bangladesh are diverse

and encompass poor workplace environment, inadequate laboratory facilities and lack of accommodation facilities. Workplace violence and lack of rapport between doctors and patient attendants, local influential personnel as well as local journalists along with overall security for doctors are major obstacles for the MOs in their workplace. Further concerns were shared by the MOs regarding the policy for higher education, posting, transfer, promotion and disparity between different cadre services.

Proper governance of HWFs with better workspaces, laboratory services, and lodging options should be ensured. In addition to increasing overall security for doctors in the workplace, efforts should be made to improve the relationship between doctors and patient attendants, as well as with local journalists and influential individuals. Transparent reform and implementation are necessary for time-demanding policies related to higher education, posting, transfers, promotions. Cadre service disparity should also be taken care of. Further studies need to be conducted including private healthcare facilities, health administrators, and decision makers.

Contributors

KMTR, SER, FAK, MZI, MK contributed in conceptualisation, methodology, investigation, and supervision, MK, SS, SSI contributed in funding acquisition, KMTR, SER, FAK, FR, SE contributed in data curation, formal analysis, validation, and visualisation of data, KMTR, SER, FAK, MZI contributed in project administration and management of resources, KMTR contributed in writing original draft, and SER, FAK, MMHK, FR, SE, MZI, SS, SSI, MK contributed in review, editing and final approval of the manuscript.

Data sharing statement

After getting institutional approval, the corresponding author will share the data upon reasonable request.

Declaration of interests

The study was funded by Hospital Services Management, DGHS, Mohakhali, Dhaka-1212, and Bangabandhu Sheikh Mujib Medical University. We declare no competing interests.

Acknowledgements

The authors would like to thank the medical officers who participated in the study. The authors are grateful to all the Upazila Health and Family Planning Officers (UH&FPO) and Civil Surgeons (CS) of the respective hospitals for providing permission and valuable support during the research work. The authors also would like to acknowledge the technical support provided by Bangabandhu Sheikh Mujib Medical University (BSMMU) and administrative help from Directorate General of Health Services (DGHS), Bangladesh.

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