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November 30, 2022

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Health Entrepreneurship and Women's Economic Empowerment in 300 Social Health
Entrepreneurs (SHE)

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Abstract

Health Entrepreneurship and Women's Economic Empowerment in 300 Social Health Entrepreneurs (SHE)

By Md Jahirul Alam Azad

Background: This study assessed women's economic empowerment through a Skilled Health Entrepreneur (SHE) program implemented in Sunamganj District, Bangladesh. The SHE programs prepared community women as community-based skilled birth attendants (CSBAs) who offered safe home-based delivery, other maternal & child health, family planning, and non-communicable diseases services. The program incorporated activities designed to increase the empowerment of SHE in their social context.

Objectives: This study aimed to identify the relationship between health entrepreneurship and women's economic empowerment in the Sunamganj District of Bangladesh. This study captured the perspectives of individuals and groups of SHEs, community leaders, community support group members, household heads, and government and private service providers to assess power, agency, and economic advancement in thematic areas of economic empowerment.

Methods: Data were analyzed using MAXQDA22 of nine in-depth interviews and two focus group discussions with SHEs. It captured the data/information of focus group discussions with SHEs, Community Leaders, and group members, and five Key Informant Interviews with SHE's husbands, government, and private service providers in three sub-districts in Sunamganj, Bangladesh. The qualitative data are related to control over assets, decision making, self-confidence, income, gender norms, gender roles and responsibilities, productivity and skills, and prosperity. This study also used secondary data from project studies and quantitative analyses done by project and another researcher related to SHE service delivery performance and empowerment. In addition, a literature review incorporated findings from references in PubMed using EndNote software.

Results: The SHE program built SHEs' entrepreneurial skills, professional confidence, and individual decision making. This approach supported women from the community, government, and private health sectors in becoming recognized as health entrepreneurs and contributing to their livelihoods. This study found remarkably increased power, agency, and economic advances in the SHEs.

Discussion: The SHE program design increased SHEs' economic advancement by improving individual and family wealth, health, and nutritional status, reinforcing positive gender norms, roles, and responsibilities. Training on government-affiliated certification courses, linking with existing public-private health institutions, and developing supervised training and monitoring by existing public health care systems exist or can be scaled up in other remote communities. In addition, SHEs have become an inspiration for other women in their communities.

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Chapter 1

Introduction

From December 2012 to 2022, CARE Bangladesh, GlaxoSmithKline (GSK), the Ministry of Health and Family Welfare (MOH&FW), and other key stakeholders implemented a Community Health Workers (CHWs) project to address the lack of skilled human resources in remote and underserved sub-districts in Sunamganj district, Bangladesh. The overall goal of the CHW project was to improve maternal and child health outcomes in poor communities by increasing access to quality healthcare services in close proximity to their homes. Through a unique Public-Private Partnership (PPP) model, the project trained 319 community women throughout the project period on the CSBA's curriculum, which is affiliated with the Bangladesh Nursing Council (BNC). These trained women provide maternal and child health services, including primary screening and health consultation for non-communicable diseases (NCDs) such as diabetes and hypertension, in the entire Sunamganj district. In the long run, the project invested resources and accomplished several activities, such as linkage with pharmaceutical companies for medicine and health commodities, capacity building on market assessment, and facilitation of an individual business plan to develop women as Social Health Entrepreneurs (SHE). The project was intended to increase access to high-quality frontline health worker services for remote communities, and was designed to enhance the power, agency, and economic advancement of SHEs as elements of the program. The project can improve financial independence, health and nutritional outcomes, and livelihoods, leading to economic empowerment.

Background

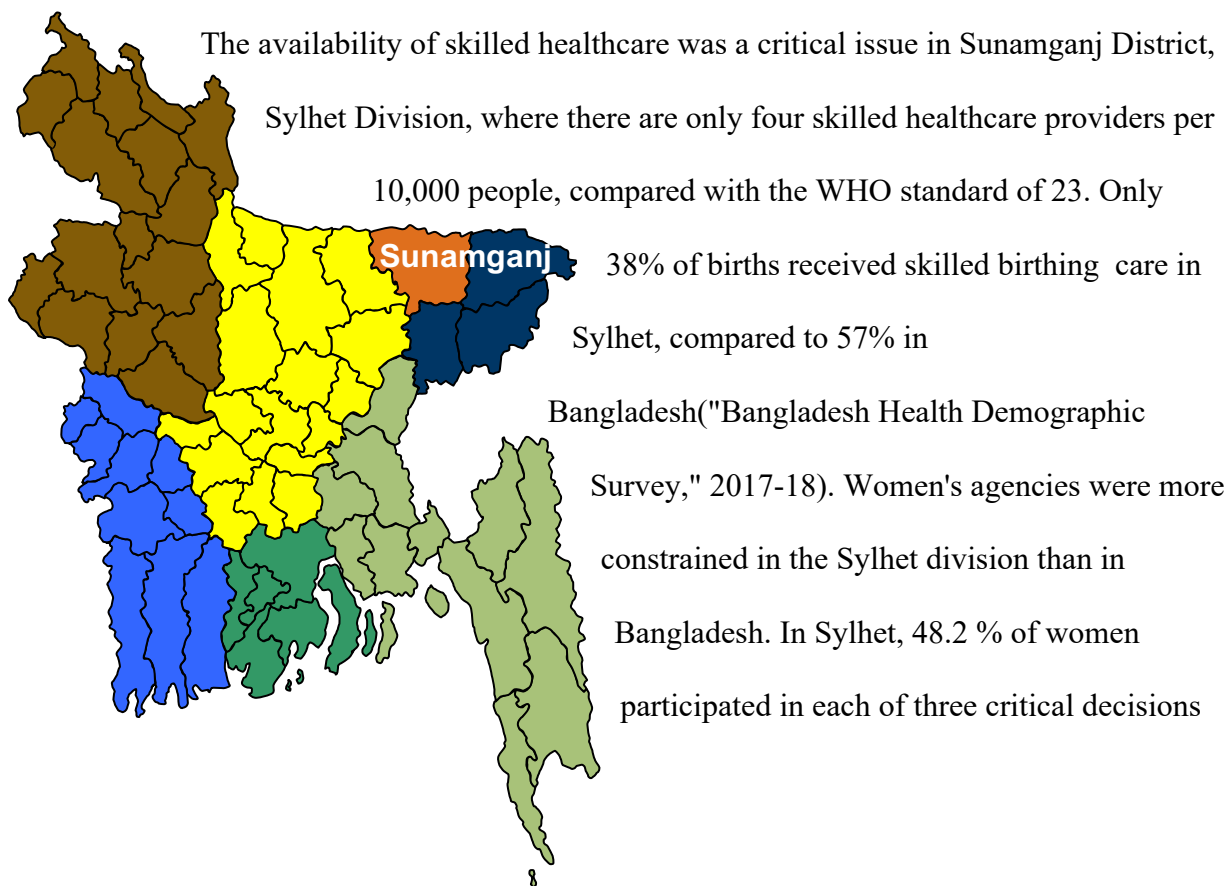
Women's economic empowerment is one of the essential tools for the 'effective development' of any society or country. Economic empowerment is the ability to make and act on decisions involving controlling and allocating financial resources (Golla, Malhotra, Nanda, & Mehra, 2011). It facilitates women's freedom from the vicious circles of social, political, religious, and gender discrimination. Developing women's capacity and improving their confidence in their rights are central issues. They need to be skilled in serving their families and communities to achieve better health outcomes. Skill development creates employment opportunities and empowers women to participate in decision-making processes on household expenditure, big purchases for the family and health of their own and that of their children. Women's influence over financial decisions is associated with increased use of preventive health services by children and women (Ahmed, Creanga, Gillespie, & Tsui, 2010; Lagarde, Haines, & Palmer, 2009), including the use of modern contraceptive methods (Ahmed et al., 2010; Do & Kurimoto, 2012).

The importance of expanding access to frontline health workers (FLHWs), mainly skilled birth attendants (SBAs), has been widely acknowledged and discussed (Organization, 2018). The role of gender norms and power dynamics in health systems has received significant attention (Gupta, 2019; Hay et al., 2019). This ongoing discussion covers the effects of gender inequities and power imbalances on the health workforce and the dynamics within the health system and wider community. This study assessed the effects of interventions on frontline health workers (FLHWs)/SHEs regarding their power and agency, and economic advancement.

Context

Sunamganj district in Bangladesh

The context of the Sunamganj district influenced the SHE program's design in significant ways.



compared with 59.4% in Bangladesh ("Bangladesh Health Demographic Survey," 2017-18). For example, in the Sylhet division, only 5.8% of ever-married women were employed, and only 5.7% worked in professional or business occupations ("Bangladesh Health Demographic Survey," 2017-18). This background highlights the importance of improving the availability and uptake of SBA in the area and the critical gender equity there.

A study conducted by Ghose et al. in 2017 based on the Bangladesh Health and Demographic Survey (BDHS) revealed that maternal healthcare seeking varied unpredictably among women based on whether they decided on their healthcare alone or with their partners and urban or rural residence (Ghose et al., 2017). Another study conducted by Story and Burgard (2012) also found that associations between decision-making and maternal health care seeking were unpredictable in urban and rural contexts and affected by men's involvement in decision-making, coupled concordance on how decision-making happened, and other demographic factors (A.Burgard, December 2012).

Program Description

CARE International in Bangladesh collaborated with Bangladesh's Ministry of Health and Family Welfare (MOH&FW), Ministry of Local Government Rural Development & Cooperatives (MLGRD&C), and other district-level partners to develop the Skill Health Entrepreneurship (SHE) model. This model aims to be a sustainable system to ensure Skilled Birth Attendance (SBA) services are available in the remote, underserved, rural Sunamganj District in the northeast region of the Sylhet Division of Bangladesh. Skilled health workers employed in government facilities are scarce because of absenteeism or vacancies. Additionally,



Photo credit : CARE Bangladesh

knowledge gap with health providers. The SHEs presented a new community-based option as a unique class of skilled providers. These providers offer distinct advantages: they are drawn from within the community, recognize the health system, and are financially sustainable (Dora Curry, March 2022). The program invested in SHEs with the social powers of income, autonomy, and external professional recognition. These changes enhanced the availability of SBA services and potentially their perceived accessibility and perceived quality.

The SHE program selected and identified women from the community to practice as private SBAs certified to attend normal home deliveries and refer complicated cases to governmental health facilities. The program's objectives were to increase the availability of high-quality care and stabilize access to care from SHEs by selecting the inhabitants of the area. They also facilitated negotiations with community leaders on a standardized sliding-scale fee schedule to allow SHEs to charge for their services while ensuring access to low-income women (Hossain et al., 2020).

A key distinctive feature of this program is that its goals include increasing SHE agency, financial independence, livelihood, and better health and nutrition outcomes. These significantly linked with their improved social status and quality of life. The program incorporated training and ongoing support to SHEs' entrepreneurial skills, personal agency, and professional engagement. Overall, the approach built SHEs' agency, sustained livelihoods, and improved dignity as professional health providers at the community level (Dora Curry, March 2022).

The introduction of the FLHW in this new SHE model created an opportunity for community women to break the cultural norms for work traditionally regarded as domestic, unpaid care work that placed an economic value on women's social labour. The introduction of SHEs may directly increase women's acceptance as entrepreneurs. In addition, SHEs' work upheld the freedom to

move around the community alone and interact with local officials as equals, which is unusual for women in the project-implemented area (Dora Curry, March 2022). The project's purpose was to provide the option of a maternal health service provider that meets the clients' needs and preferences. Women in the community preferred traditional birth attendants because they were available outside business hours, accepted non-monetary payments, were connected with family, and shared social norms and beliefs. The SHE program provided training to fellow community members so that women could receive services from their trusted, culturally congruent providers, while ensuring that the services offered were safe, of high quality, low cost, and linked to referral facilities for complications. The program design included measures to increase the capacities of SHEs in ways beyond traditional techno-managerial training and supervision in technical skills, such as increasing and controlling their earnings and expanding their professional skills. Overall, the program intended to support women from the community, as social peers of clients and community, in becoming recognized, respected health workers linked to the public-private system, while protecting their livelihood and improving quality and access to maternal and child health services.

The project included five central interventions: selection and training of private birth attendants, formation and training of community members for community engagement, development of linkages to quality monitoring and referral facilities with the public and private sectors, development of capacity for social entrepreneurship, and mechanisms to enhance the community's financial support for the program's activities. The program selected participants by inviting applications, conducting interviews, and writing exams. Women in the age group of 25–40 years with at least ten years of schooling were eligible for the apply. Over the five-year life span of the project, 319 completed the training.

The project delivered three months of training in health services and promotions. Clinical and health promotion training prepares SHEs to support a comprehensive maternal and child package, including antenatal care, assistance in uncomplicated deliveries, postnatal and newborn care, family planning counseling, short-term family planning method provision, and referral for complications. The program also linked SHEs to community support groups, community health workers, government health facilities, and supervisors (Hossain et al., 2020). Once SHEs were prepared to start services, the program arranged a community orientation meeting in which community members, including *Union Parishod Members*, were invited. SHEs shared their training experiences and described their services. The meeting ended with an agreed-upon list of service prices. In addition, the program facilitated support from the Upazila Health Complex (UHC) for ongoing supervision and professional development, including skill labs.

The program also coordinated an alignment between local government authorities, the health and family planning department, and SHEs. As a result of CARE's coordination, the health and family planning department provided health commodities, such as iron folate tablets and misoprostol, and refresher training to SHEs. The SHEs are charged to clients on provided services as per the approved price list. The prices paid were monitored independently and periodically by first-line supervisors from health and family planning departments, Union Parishod Members, and Community Group Members. Program staff collaborated with Union Parishod and the local influential to explore mechanisms to extend care to the lowest wealth quintile free of charge.

Over the project's life, SHEs accomplished 47,123 skilled deliveries and dispensed 2.7 million folic acid tablets. SHEs earned 7659.78 takas (or roughly 90 USD) more per month at the endline than at the baseline, in the context of an average annual household income of approximately 600

USD ("Bangladesh Household Income per Capita," 2000-2016). The SHEs' professional engagement increased from an average of 10.41 presentations given per reporting period to one of 16.10. The proportion of SHEs making decisions independently increased on three out of the three decision-making items: seeking healthcare for herself, seeking healthcare for her children, and use of contraception. The endline combined social power score was 8.65, compared with a baseline of 6.18. All the results were statistically significant (Dora Curry, March 2022). A mid-term analysis found that women in the coverage area were more than twice as likely to have delivered with a skilled birth attendant present at their most recent childbirth than at the beginning of the programme (Hossain et al., 2020). The endline assessment conducted in 2018 has demonstrated significant achievements. The percentage of women using a skilled attendant during birth increased from 13.4% to 37.4% in the intervention area and from 21.4% to 35.8% in the comparison district. Neonatal, infant, and under-five mortality rates showed similar improvements (Dora Curry, March 2022).

Skilled Health Entrepreneurs (SHE): a new approach

There are two unique elements in the SHE model. The first is a public – private partnership (PPP). Bangladesh's MOH&FW and MOLGRD&C are public entities and SHEs are private entities. CARE International acts as a catalyst to strengthen partnerships by facilitating coordination, capacity development, and ensuring logistical support. This PPP proposed creating a sustainable system to ensure that SBA services



are available in the remote, underserved, and low-performing rural Sunamganj District, as well as to increase the availability of high-quality care and ensure access to care from SHEs by targeted communities. Thus, community people are getting benefits since it is very hard for them to leave the community, but they need quality health care services, especially childbirth services. Furthermore, with support from program staff, SHEs are negotiated with a standardized, user-friendly service price that allows them to continue to generate revenue independently, while also ensuring that low-income women can access their services (Hossain et al., 2020). The Bangladesh Government has taken part in the partnership to address two interrelated and foundational challenges that are long-standing and that partners are struggling to overcome. The Bangladeshi Government introduced a community-skilled birth attendant cadre and found that they attended less than 1% of births (GOVERNMENT, 2000-2015). This is because they were busy

providing other (non-maternal health) services, and women often still preferred home-based deliveries offered by traditional birth attendants because of the respectful care they provided and their trust as members of the family and community. CSBAs often came from other districts (Turkmani & Gohar, 2015). Likewise, policies to recruit and retain skilled providers in more rural areas have often been ineffective due to sub-optimal execution and inconsistent coverage or application (Rawal, Joarder, Islam, Uddin, & Ahmed, 2015). In remote and rural regions, pregnant women and their families are wary of traveling long distances to health facilities because they are unsure that a skilled provider and the necessary equipment will be there when they arrive. There is a critical need to employ new context-specific solutions that specifically address the shortcomings of these previous efforts and have proven effective in addressing persistent inequities in maternal health outcomes in rural and hard-to-reach areas.

Second, the program includes the formation and promotion of the “Shusheva Network” to enhance the leadership capacity among SHEs. “Shusheva Networks” is a governance and leadership structure for developing SHEs’ leadership capacity, in addition to facilitating coordination with existing public-private health systems, local government institutions and other relevant stakeholders to ensure support for the long-run implementation of the SHE model without external efforts. There is a Upazila-based executive committee, and members are elected/nominated by the SHEs of the respective Upazila, which generally provides long-term continuity of supportive supervision and monitoring after the project ends. The project introduced “Shusheva Network” as a self-help group. Self-help groups are informal groups of people that come together to address common problems. While self-help might imply a focus on the individual, an important characteristic of self-help groups is the idea of mutual support – people helping each other. Self-help groups can serve many different purposes, depending on the

situation and need (Thomas M, 2003). For example, within the development sector, self-help groups have been used as effective strategies for poverty alleviation, human development, and social empowerment (Karnataka, 2006).

Financial and marketing skills building for SHEs

At the outset of program implementation, CARE Bangladesh engaged “JITA("Jita Bangladesh,")” to develop financial, marketing, and business skills of SHEs. The main focus was to build the capacity of the SHE to earn adequate income for financial sustainability. SHEs have developed two potential sources of revenue: direct fee-for-service charges for maternal health services and the sale of health-related products. SHE revenue is not the sole source of household income. They may have some additional household income from another adult earner and some may have had other sources of revenue as individuals unrelated to SHE duties. Additionally, SHEs must compete with other providers of similar goods and services. Including income as an element of SHE empowerment should not be considered a comprehensive economic analysis but rather one of the multiple components influencing SHEs' social power and agency.

This program facilitated the market analysis process using SHEs. The intervention included a two-day social entrepreneurship capacity-building workshop, drawing on a market analysis of the local market, and developing business plans. The workshop covered how to target their service offerings and minimize conflicts with untrained traditional birth attendants. SHEs received coaching from facilitators skilled in entrepreneurship to determine their potential clients' market size and characteristics. They developed individual business plans targeting their communities, including outreach, for potential clients. The project also conducted promotional and marketing activities, ranging from health awareness days to stakeholder meetings to print, video, and media outreach. Another program element connected the SHEs to a supply chain of saleable commodities such as

non-prescription medicine, nutritional supplements, and baby care articles at wholesale prices. The SHEs then resold these items for a small profit.

Relevance and importance

In 2018, the endline evaluation of the SHE project was conducted to assess the changes in Maternal Neonatal Child Health (MNCH)-related knowledge and practice and early child mortality since baseline, which was conducted in 2012 to end line in both the intervention and comparison areas. In addition, the effect of ‘CARE-GSK-CHW’ (SHE) intervention compared to the comparison area over time. This evaluation mainly focused on the clinical performance, coverage, and quality of service delivery. Therefore, there is a gap in understanding the comprehensiveness of the project regarding synergetic effects related to SHEs’ power, agency, and economic empowerment. In addition, it is also important to understand family and community engagement to overcome challenges and resource limitations in order to establish a female-led health carder in the remote community. Therefore, the primary purpose of the current study was to gather knowledge and perceptions related to SHEs' power, agency, and economic advancement, along with their potential effects on their families and communities. This is also part of the significant efforts of the global health community to explore diverse models for transforming the health workforce to promote gender equity in health systems and communities. The global public health community must identify and be motivated to describe such models with wider stakeholders. Thus, it is necessary to understand the longer-term implications for individual actors in the community-based health system and the larger community structures in which they work and live.

The SHE project focused on strengthening the evidence that more empowered SHEs with more agency contribute to gender equity in the health system and wider community. The project

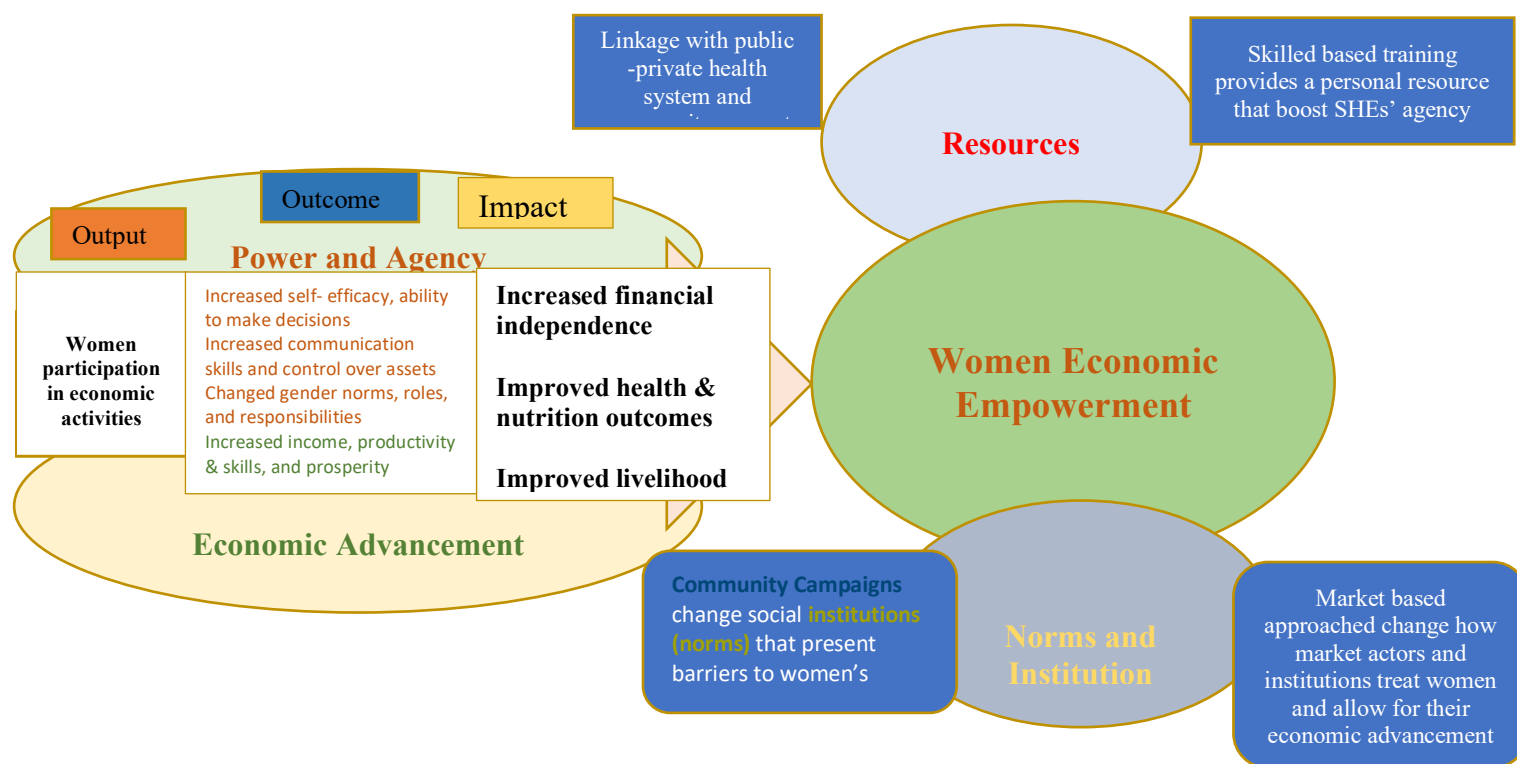
demonstrated many significant outcomes that can be used as evidence for academic audiences, fellow practitioners, and policymakers to advocate for more significant investment in community health systems, particularly in the professionalization support of SHEs. Many initiatives have been shared with the aim of creating cadres of providers with basic clinical skills to increase access to higher care for underserved populations. Some interventions also established a stable strategy for these SHEs to earn adequate income and remain in practice in the area. The SHE project aimed to demonstrate a model that could also provide a way to support providers in their visible roles in the community and recognize them as legitimate health providers and self-employed entrepreneurs (Dora Curry, March 2022).

One area that needs to be explored through the current study is that the project invested resources and was designed to increase the empowerment of the project participants, both SHEs and women in the general community. Thus, the extent to which newly introduced health cadres of female health workers ensure the availability of quality healthcare without positively affecting gender inequities. It is important to generate more evidence to establish the effectiveness of gender equity in increasing female FLHWs' power and agency. In other words, this study qualitatively tests and integrates the project's quantitative analysis of whether SHEs' agency and power increased over the interventions, as predicted in the SHE project. Since the stated objective of program design is health workers' agency and power, the program's effects on those characteristics deserve thorough, direct assessment, and a final question for this project is whether increased social power and agency among SHEs affect their larger context regarding health and nutrition outcomes at the family and community levels. Despite much discussion of the potential for SHEs to serve as models and advocates for the community, particularly for women, evidence that the program can realize that potential remains incomplete.

Extending skilled birthing care to a setting outside a facility is critical only in settings where geographic distance, cultural incongruence, or a combination of both make a focus on achieving higher levels of facility birth unrealistic. Ideally, in the long term, women's increasing wealth and educational level will create a drive for improved perceived quality (both meeting clinical quality standards and culturally acceptable) among private and public care and greater availability in geographically remote areas.

The strength of the SHE model is that it contributes in the near- to mid-term and has benefits in the longer term, addressing the underlying causes of poor health. A model such as SHEs provides acceptable, accessible care in remote areas that can reduce maternal and infant mortality. In addition, these results suggest that approaches such as the SHE model may also contribute to shifting gendered power dynamics in the community by investing in the cadres of resident women with increased agency, recognition, and wealth. Innovative approaches to FLHW struggles may offer the potential for even more transformative changes. SHEs may potentially influence social norms by being models of recognized women from the community, health providers, and successful self-employed entrepreneurs. Combining more immediate improvements in coverage of maternal care and related health outcomes with the demonstrated enhancement in the social power of this critical group of women in the community, the SHE model can simultaneously improve health outcomes and contribute to a pathway to more meaningful change (Dora Curry, March 2022).

Conceptual Framework (Golla et al., 2011):



This conceptual framework represents the pathways of SHEs' economic empowerment through two channels: power and agency and economic advancement (Golla et al., 2011). The framework highlighted the changes in SHEs after their involvement in economic activities through CSBA training.

First, SHEs' power and agency are upheld through increased self-efficacy, ability to make decisions, communication skills, control over assets, and changed gender norms, roles, and responsibilities. Further, enhancing SHEs' social power increases the community's perception of the accessibility and quality of CSBA services. The project model proposes that introducing SHEs with proper respect and support from the family, community, and health system causes clients to perceive CSBA care as being more accessible and of higher quality. The SHEs model

offers skilled healthcare one-stop services at the doorstep level. In addition, SHEs with enhanced social recognition can better negotiate on clients' behalf and provide culturally accepted care, increasing women's perceptions of quality care. These effects have been previously described in prior publications (Hossain et al., 2020).

In the second mechanism, the economic advancement of SHEs enhances their production, skills, income, and prosperity. Introduction to the community as health professionals among lay women already residing in the community creates a powerful model of women more similar to clients than other health professionals. This project proposes that SHEs strengthen women's ability to generate income, control assets, and exercise decision-making power in the broader community. This conceptualization draws on various approaches to operationalize social power. It proposes financial independence, better health and nutrition outcomes, and improved livelihood as three critical impacts of SHEs' economic empowerment pathways. The income-generating aspect of the SHE program may create a gap in income between SHEs and their clients, even if there had not been one before. These gaps may have inevitably influenced the relationship between SHEs and their clients, such as power imbalance. Still, SHEs remain far more similar to their clients than to nurses or physicians. The relationship between SBA and clients powerfully affects their decisions to seek care. A woman's choice to seek services from an SBA is a function of the interaction between many factors: her wealth and education, the clinical quality and geographic distance of skilled care, and her experience of the care available to her. Conceptualize these relationships by describing perceived quality, need, and accessibility as mediating processes, alongside wealth and education as proximal determinants. Thinking about the influence of women's perceptions of quality and accessibility as mediating pathways offers a valuable framework for understanding the effect of this intervention. The increase in social power may

have been the mechanism for women's perceptions of increased quality, need, and accessibility of care. In addition to explaining additional variations in women's choices, these mediating pathways may be especially susceptible to short-term interventions that improve perceived quality, geographic access, and trust between SBAs and clients (Dora Curry, March 2022).

Objectives and Research Questions

This study aimed to identify the relationship between health entrepreneurship and women's economic empowerment among 300 SHEs in Sunamganj District, Bangladesh. The findings of this study will be a resource and document for stakeholders to advocate and promote effective interventions and health system design that deliberately address the gender and power dynamics of SHEs.

This study captured the perspective of individuals and groups of SHEs, community leaders, community support group members, household heads, and government and private service providers to assess power and agency, and economic advancement in thematic areas of economic empowerment. However, several questions must be answered more thoroughly to justify investment in such programming. In addition, it is important to understand which features of SHEs' focused interventions might enhance SHE's agency and power vital for expanding the health workforce. Introducing new cadres for female health workers expands economic and professional opportunities for women in the community by perpetuating inequities and reinforcing harmful norms. Careful consideration of the theories of change underlying the different approaches is important.

One area to be explored is the features of focused interventions proposed to enhance SHE's agency and power. Introducing a new cadres of female health workers might increase the availability of skilled birthing care without positively affecting gender inequality. Many possible

variations in program design have been proposed to "empower" FLHWs, but more evidence is needed to establish which are most effective. Careful description of the elements of interventions designed to address gender inequality and power dynamics is a critical first step in assessing the effectiveness of these tactics.

Next, the study attempts to answer a specific question regarding the project elements of SHEs' gender and power dynamics that had an effect on SHEs. In other words, this analysis qualitatively tests whether SHEs' agency and power increase over the interventions, as predicted. Most research in this field assesses health workers' effectiveness in terms of clinical quality, efficiency, or client satisfaction.

A final question for this project is whether increased social power, agency, and economic advancement among SHEs affects their larger context. Despite much discussion of the potential for SHEs to serve as models and advocates for the community, particularly for women, evidence that the program can realize that potential remains incomplete.

This study will strengthen the evidence base that more empowered SHEs with more agency contribute to gender equity in the health system and wider community. This project will contribute to the evidence for academic audiences, fellow practitioners, and policymakers to advocate for more significant investments in community health systems, particularly in the professionalization support of FLHWs.

Specifically, this study explores these two questions under the main research question.

Key Research Question:

- What is the relationship between health entrepreneurship and women's economic empowerment?

Sub-questions:

1. What were the major areas that SHEs identified as transformational changes at the family and community levels that affected SHEs' social power and gender dynamics?
2. Did the SHE model result in increased economic advancement among the SHEs?

Chapter 2

Literature Review

In 2016, the WHO called for significant investments in frontline health workers (FLHWs) as a critical component in achieving Sustainable Development Goals (Organization, 2018). The SDG Goal 3 target 3c elevates the expansion of the health workforce and financial and human resources systems to support it (WHO, May 2016). This report specifically calls for enhanced women's participation and leadership and the creation of financial support for more fully remunerated, appropriately distributed health providers. From academic journals such as The Lancet series on Gender Equality, Norms, and Health (Hawkes, Allotey, Elhadj, Clark, & Horton, 2020) to civil society stakeholders such as the Frontline Health Worker Coalition ("Frontline Health Workers Coalition Publishes Commentaries, Fact Sheet Addressing Women's Roles In Health, Recognizing International Women's Day," May 2018) and the WHO Global Health Workforce Network (WHO, March 2019), global health actors have led inquiry and position statements on gender equity and the health workforce. There is emerging support for the importance of properly designed and deployed investments in the workforce for gender transformation in the global health community (WHO, 2021).

The SHE program included significant investments in elements designed to improve the income, agency, and professional engagement of SHEs. These quantifiable aspects comprise a reasonable measure of social power among the SHEs. Some policy dialogues concentrate on observational data supporting an association between gender equity in context, health service uptake, and outcomes. Others explicitly focus on the potential for increasing women's power and agency through features incorporated into the design of FLHW programming. An underlying assumption throughout these dialogues is that improved gender equity in the health workforce, improved

gender equity in the community at large, and positive health behaviors and outcomes are mutually reinforcing. In this context, the Skilled Health Entrepreneur (SHE) program in Bangladesh offers a valuable opportunity to explore the effects of increasing the power and agency of female frontline health workers on gender and power dynamics in their community. The SHE program provided laywomen with clinical training, social entrepreneurship skills, and recognition as legitimate health workers by local authorities and the Health Ministry. The women became certified private provider FLHWs, specifically skilled birth attendants (SBAs) known as SHEs (Hossain et al., 2020). This project will examine how this distinctive approach may interact with women's autonomy and power among SHEs and the larger community.

This literature review covered three major areas of inquiry. First, the review summarizes FLHWs' scope, composition, and effectiveness of FLHWs, paying particular attention to claims and assumptions related to gender, power, and economic advancement. It also covers evidence related to the effectiveness of FLHWs, especially community-based health workers, as a crucial context for the design of FLHW support structures. Current approaches can offer insights into opportunities for improvement in future efforts. In addition, this section examines the analyses of gender and power dynamics in current FLHW programming.

The concept of "economic empowerment" has been widely used to describe increases in economic advancement and in other forms of power. The review will cover the definition of empowerment and critical elements of the research conducted on the "economic empowerment" of FLHWs and women in low- and middle-income countries. This section also introduces the concept of social power and provides the theoretical background needed to draw on research conducted using the "empowerment" framework while using a social power framework for the analysis in this project. The concept of social power is more suitable to this work than

"empowerment" for at least two reasons. Empowerment implies a characteristic conferred on those with little power. Social power is an alternative measure of a neutral attribute that can increase or decrease for many reasons. The concept of empowerment is also widely used with many different permutations, variations, and adaptations for which a single definition is impossible. The operationalization of empowerment is even more challenging, and no single approach to measurement exists. This project will present social power as a more straightforward concept to describe similar social phenomena with a more direct approach to operationalization (Dora Curry, March 2022).

The effects of FLHW-focused interventions on FLHWs' power and agency are concentrated on interventions related explicitly to shifts in social power and gender dynamics. This review covers the arguments supporting investments in FLHWs using claims of positive effects on gender and power dynamics. It will also examine the effects of interventions specifically designed to directly affect those areas among FLHWs or the community more broadly.

Research linking improvements in power dynamics and gender equity to FLHW interventions, deliberately incorporating that impact as an objective, is not extensive. However, such linkages are often used to justify investments in FLHW power and agencies. This research project aims to strengthen the general argument that investments in FLHW support can advance gender transformation while also offering new insights into the design elements that best serve that objective.

In addition to these three significant lines of inquiry, the review includes a brief overview of the context of gender, power dynamics, and maternal health outcomes in rural Bangladesh. This additional information will provide a valuable context for understanding the research questions and conclusions of larger projects.

Methods for Literature Review

This literature review includes peer-reviewed literature on global health, human resources for health, and social psychology. Journal articles, including original research, commentaries, reviews, and meta-analyses, were solicited from PubMed and Google Scholar databases, with additional searches for works cited in and works citing identified articles. This review considered only resources published in English. In addition, the review included grey literature from key stakeholders and influencers in human resources for health globally: the World Health Organization, UNICEF, the Frontline Health Worker Coalition, the Global Health Workforce Alliance, and NGOs such as CARE International.

Search terms related to health workers included frontline health workers, effectiveness, and community health workers combined with economic empowerment. The search terms related to social power and empowerment included social power, empowerment, and women's empowerment. The search terms related to economic empowerment include financial incentives, remuneration, and financial independence. The search terms related to Bangladesh included low- and middle-income countries, low- and middle-income countries in Asia, and low- and middle-income countries in Africa.

Frontline health worker definition, composition, role, and effectiveness

The extensive discourse on frontline health workers is relevant, although the term includes more than skilled birth attendants alone (SBAs, the primary function of SHEs). Before exploring the scholarship on performance, effectiveness, and power dynamics among health worker cadres, it is crucial to clarify the scope and definition of these various categories: FLHWs, SBAs, and community health workers (CHWs) (Dora Curry, March 2022).

FLHW definition and composition

Frontline health workers "are comprised of all types of health workers—including nurses, midwives, community health workers, doctors, pharmacists, and more—who provide care directly to their communities (Coalition)." They work in settings where the public can access their services directly, and they provide health services, sometimes in addition to non-clinical activities such as health education. Many terms in the general FLHW category refer to workers. Health workers in this category include SBAs, CHWs, health promoters, health extension workers, community health extension workers, health aides, midwives, nurse assistants, nurses, and more (Coalition). SBAs are usually, but not exclusively, FLHWs. Most SBAs provide services directly to the community at large by definition. However, a minority of SBAs may be practiced in referral facilities and therefore be considered specialist care instead of frontline workers.

One sub-categorization within FLHWs comes from the site of workers' practice: community-based or facility-based. This distinction is particularly relevant to this project because the SBAs in the SHE program were community-based. Many FLHWs are community-based, and much of the literature on FLHWs focuses specifically on CHWs (Perry, Zulliger, & Rogers, 2014).

A significant majority of FLHWs are female (approximately 70 %)(WHO, 2016). More powerful roles in the health system are predominantly male; only approximately one-third of health ministers are women(Hay et al., 2019; Michael R. Reich, July 2016). Women are overrepresented in low-pay, low-status roles in the healthcare system. Simultaneously, they are underrepresented in high-status decision-making roles(Hay et al., 2019). These macro-level dynamics provide an essential context when considering health workers' roles in the frontline health system. Women health workers are viewed as less skilled and experience social backlash from co-workers and superiors for assertive behavior. (Hay et al., 2019) With reliance on

FLHWs growing because of efforts to achieve universal health coverage goals and approximately half of all FLHWs being nurses and midwives, the effects of gender and power dynamics on the effectiveness of FLHW programming is becoming even more critical.

Frontline health workers' role and effectiveness

A common approach to improve FLHW quality is to increase support through training and supervision interventions (Bailey et al., 2016). In general, the effect of techno-managerial interventions to improve FLHW performance, such as training and supervision, can be challenging to assess (Källander et al., 2015) and must be carefully designed and implemented to justify investment. A systematic review of community health workers' effectiveness found that neither training alone nor supervision was strongly linked to improved CHW effectiveness (Scott et al., 2018). However, the effect of financial incentives on recruitment illustrates the importance of ensuring adequate income for health workers, as an element of a robust solution to ensure the availability of services in underserved areas.

Frontline health worker interventions to increase social power and women's agency

Instead of viewing performance management as a mechanical, linear intervention, the SHE model is grounded in a client-centred model that improves SHEs' agency, capacity, and communal support. The SHE model improved performance and health outcomes by blending more technical standards with elements that increased the social power of these predominantly female community-based providers by increasing their autonomy in decision-making, independent control of economic resources, and engagement in the community as professionals (Dora Curry, March 2022). Both the "hardware" and "software" elements of a system influence the FLHW level characteristics associated with performance (Kok et al., 2017). These authors used "software" to refer to FLHW outcomes, such as agency, self-efficacy, and motivation, and

found that they require feelings of connectedness and recognition. These findings illustrate that techno-managerial inputs (aimed at improving technical skills, conditions of supplies and equipment, etc.) and supportive social structures (social norms, working conditions, etc. that engender FLHW empowerment and feelings of connectedness) are interrelated. They must be coordinated to sustain a high-performance FLHW cadre; enhancing the social power of the SHEs may enhance their ability to gain their clients' trust and link them to services and the clients' perception of the SHE's skills. To some extent, increasing status and influence may contribute to the observed increase in the uptake of skilled care (Hossain et al., 2020).

Social entrepreneurship/FLHW/CHW to increase women's economic empowerment

Women's economic empowerment is a multi-faceted concept. Given how project- and context-specific measurements must be, it is not possible to define a universal set of indicators suitable for every project. However, we can provide an illustrative set of indicators for the three key areas emphasized in the depicted framework: 1. Reach and Process Indicators; 2. Economic Advancement Indicators 3. Agency and Power Indicators (Golla et al., 2011). There is a need to remunerate CHVs work and provide support in the form of basic training and capital on entrepreneurship to implement the identified income-generating activities such as farming and event management (Lusambili et al., 2021). This article also mentions that strategies to support the livelihoods of CHVs through context-relevant income-generating activities should be identified and co-developed by the Ministry of Health and other stakeholders in consultation with CHVs. Key programme-level factors reported to enhance CHV performance in urban informal settlements in LMICs included both financial and non-financial incentives, training, the availability of supplies and resources, health system linkage, family support, and supportive

supervision(Ogutu, Muraya, Mockler, & Darker, 2021). Women's influence on financial decisions is associated with the increased use of preventive health services by children and women(Lagarde et al., 2009), including the use of modern contraceptive methods(Hossain et al., 2020). The income-generating aspect of the SHE program may create a gap in income between SHEs and their clients, even if there had not been one before. These gaps may have influenced the relationship between SHEs and their clients in some inevitable ways. Still, SHEs remain far more similar to their clients than to nurses or physicians(Dora Curry, March 2022).

Summary of the Literature Review

The role of FLHWs is important and evident in the SDGs calls for health workforce expansion and support. This review of relevant literature demonstrates that addressing the underlying issues affecting FLHWs is a necessary element of human resources for health planning to meet these global goals. The evidence on FLHW support and effectiveness is built on technical and managerial interventions targeting FLHWs' behavior change. This review revealed broad support for the idea that techno-managerial solutions alone are insufficient to build a stable, sustainable frontline health workforce to achieve these global goals. The need for system design and direct interventions that enhance respect and support for FLHWs and specifically address gender-related constraints is widely accepted among academics and global health policymakers.

This review also enforced that the increased agency of FLHWs has been effectively linked with the financial independence of FLHWs and increases decision-making capacity on sexual and reproductive health. Even more significantly, a growing body of evidence demonstrates the potential for FLHWs to contribute to gender equity in their communities and improve their social status and quality of life. By expanding and strengthening the health workforce, the global health community has the opportunity to align with and reinforce efforts to make the community-based

healthcare system more accessible and accountable. A comprehensive model such as the SHEs provides acceptable, accessible care in remote areas that can reduce maternal and infant mortality. In addition, these results suggest that approaches such as the SHE model may also contribute to shifting gendered power dynamics in the community by investing in the cadres of resident women with increased agency, recognition, and wealth.

Chapter 3

Methodology

Introduction

In 2018, there was a pre and post cross-sectional quantitative endline study to assess the changes in MNCH-related knowledge and practice and early child mortality since baseline, which was conducted in 2012 to end line in both the intervention and comparison areas. In addition, the study determined the effect of the SHE intervention in comparison with the comparison area over time. This evaluation study focused mainly on clinical performance, coverage, and quality of service delivery. Thus, there is a gap in the endline study to understand the comprehensiveness of the project regarding synergetic effects related to SHEs' power, agency, and economic empowerment. In addition, it is also important to understand family and community engagement to overcome challenges and resource limitations in order to establish a female-led health center in the remote community. Moreover, it is important to understand the elements of the professional development of female-led FLHWs. Therefore, the current study focused on qualitative issues regarding power, agency, and economic advancement of SHEs and followed a qualitative research methodology.

Population and sample

The study captured data and information from 21 SHEs from three cohorts of CSBA training, five Community Support Group (CSG) members, two household members, and three health service providers from the GoB and the private health system from three sub-districts of Sunamganj, Bangladesh. In addition, the study collected information and verified data through a one-to-one discussion with project staff at the field and Head Office levels.

Research design

The study followed qualitative methods for data and information collection, in-depth interviews (IDI), Focus Group Discussion (FGD), and key informant interviews (KII) to gather personal stories, views of individuals and groups of SHEs, community leaders, community support group members, household heads, and government and private service providers about the process of economic empowerment of SHEs. This design is intended to be iterative, allowing for tweaking and improving the interview questions or areas of interest as the research progresses.

Study Aims:

- Assess power, agency, and economic advancement of SHEs regarding self-efficiency, decision making, control over assets, gender norms, gender responsibilities, income, productivity and skills, and prosperity at the individual, family, and community levels.
- To understand SHEs' individual and relevant stakeholders such as family and community members, service providers, and project staff members' perceptions of the SHE overall model and its effects on SHEs' position at the family and community levels. In addition, it is important to understand SHEs' respect, recognition, perceived quality, and leadership quality and how they are linked to economic empowerment. The study utilized Qualitative in-depth interviews were conducted to question participants' experiences after becoming SHEs, and qualitative interviews were appropriate for this research to understand the complexity and nuances involved in the entire process of skilled health professionals.

Procedures

First, a meeting was held with the project staff and the interviewer briefed them about the purpose of the study. Three sub-districts were identified for the study, considering the recent

flood situation in the project areas. Interview participants were selected based on the convenience of road communication and availability of transportation. An interview schedule was finalized after communication with the president of three “Shusheva Networks.” It was agreed that FGD participants from community members and KII participants would be selected on the day of the interview, and the relevant participants would be invited to participate in the FGD and KII. Participants were approached to visit the nearest Community Clinic or Shusheva Network Office for convenience. However, the interviewer confirmed the inclusion and exclusion criteria and conducted all interviews with informed consent. After discussing and obtaining consent, the participants answered a few qualitative questions regarding their personal background and the changes they noticed in their lives after becoming SHE. These questions were considered icebreaking and rapport building between the interviewer and the participants. Next, participants were interviewed using semi-structured in-depth interview guidelines containing a series of qualitative questions regarding their experiences and perceptions about control over assets, decision-making, self-efficiency, gender norms, and gender roles and responsibilities. In-person interviews were used because the region is a highly remote rural area with a poor mobile network, making it the only feasible way to connect with people. In addition, the interviewer was involved with the project at the beginning of its implementation. Thus, the interviewer can identify and realize changes based on personal experience. After obtaining consent, qualitative interviews were recorded using a digital audio recorder.

Study Instruments

This study used three separate, but similar, interview guides. The SHE In-Depth Exit Interview Guide (Annex A) was used to interview SHE to collect information about their experiences after becoming SHE, what changes they have observed in their personal life, which change they

identified as most significant among the other changes, what progress and advancement they have notified in decision-making, control over assets, income, self-efficiency, productivity and skills, gender norms, gender roles and responsibilities, and prosperity. In addition, FGD tools for SHE and community members (Annex B) and (Annex C) were used to gather information about changes in SHEs' life of SHEs regarding decision-making, control over assets, income, self-efficiency, productivity and skills, gender norms, gender roles and responsibilities, and prosperity. Moreover, these tools were helpful in assessing perceived SHEs' service quality, respect, and upgrading of social power and dynamics in their community.

The IDI tool for SHE has a series of questions that focus on an SHE's experience and changes before and after becoming an SHE at the personal, family, and community levels. The scope and wording of these instruments are similar; separate interview guides assist interviewers in phrasing questions appropriately for the participant. The instrument related to FGD with community members and KII was used to interview community members, family members, and service providers to understand their perceptions and comments regarding family and community support and SHEs' contributions to improving maternal and child health status in their community. Instruments were developed in English and shared with the thesis Chair and CARE project staff for their review and feedback. It was finalized after accommodating feedback and comments.

Indicators and Operationalization (Dora Curry, March 2022)

- ***SHE agency and power*** - Independent decision making, i.e., a response that she makes decisions on these four items alone or jointly with a spouse: seeking health care for herself, making household purchases, savings and using contraception
- ***SHE economic advancement***: Self-reported income for her activities, not including other

household income, measured in taka per month. Economic independence is the most straightforward variable to measure, but the relationship between income and social power is complex. Increased household income alone is insufficient to ensure increased social power. This analysis uses the reported income from women's independent economic endeavours, a more relevant metric than household wealth or income in this case.

- **SHE professional engagement:** Several times, SHE chose to report her professional activities orally in public in addition to submitting the required written report. The number of times SHEs presented their results at professional meetings represents their professional engagement. The SHEs were only required to submit written reports. At the beginning of the program, few participants chose to present their results individually to the group. Over time, many chose the more visible option of a solo presentation to a large group in the presence of superiors from the MOH&FW. This change over time marks an increase in confidence and professionalization among SHEs. The SHEs' increasing confidence and willingness to speak publicly can be considered a reasonable indication of increased professional engagement. This analysis assesses SHEs' increased social power in three domains: economic independence, personal agency, and professional engagement.

Agency represents an individual's power over his/her actions (Guides & Team). This analysis uses individuals' responses to their decision-making power in order to signal agency.

Independent decision-making was defined as a response that the respondent alone or she and her husband jointly made decisions on each of two items: expenses of income and household purchases. This is in line with the operationalization of decision-making variables used in the most recent Bangladeshi household survey methodology ("Bangladesh Health Demographic

Survey," 2017-18). SHEs responded to two questions about who decides to 1) seek contraceptives for themselves and 2) seek other health care for themselves.

The analysis recalculated decision making into dichotomous variables. The woman making the decision herself or jointly with her husband was categorized as "independent decision-making" and not all other options. This approach was applied to all decision-making variables considered here: general healthcare seeking for oneself, expenses for children, household purchases, and contraceptive use.

The summary assessment of the SHEs' social power and agency was based on the variables assessed in five domains, and economic advancement was based on three domains. The responses of all domains were analysed and summarized using the MAXQDA22 software.

Data analysis

The study analyzed data using the MAXQDA22 software for nine in-depth interviews and two FGDs with SHE. All transcripts were read and stored. A thorough coding scheme was created using the ideas generated through memos to identify essential ideas from the data. Inductive and deductive codes were identified, defined, and applied to transcripts. Eight unique codes have been created. "Self-confidence" is a frequently applied code used to describe how a participant feels about themselves regarding communication with counterparts, starting any work, and communicating decisions or opinions with others, or how the participants react to what others may feel about them, including both positive and negative perceptions. For example, I received training recently, and I have channels to regularly obtain updated information. I attended monthly meetings with the Health Department. So, I know the new techniques of delivery." a SHE confidently communicated with her husband. He is also a competitor in the same market. The second commonly used code was "Income." This covers the average monthly income of the

SHE. How it contributes to increasing their family income is also linked to the financial independence of SHEs. The third commonly used code was “Decision- making.” It captures SHEs’ participation in the decision-making process at the family level, which is related to family expenditure, large purchases, education, and health-related decisions for children. It is also associated with contraceptive use and childbirth. This code overlaps with “gender norms” and “gender roles & responsibilities.” A codebook was developed for recurrent themes, and the data were labeled accordingly, which aided in maintaining consistency in the open coding process. Descriptive analysis and constant comparison across interviews highlight commonalities and differences among participants based on the interview location and type of service received. In addition, the data and information were analyzed through Focus Group Discussions with SHEs, Community Leaders, and group members and Key Informant Interviews with SHE’s husband, government, and private service providers. These data and information are also related to control over assets, decision making, self-confidence, income, gender norms, gender roles and responsibilities, productivity and skills, and prosperity. This study also used secondary data from project studies and quantitative analyses related to SHE services delivery performance and empowerment. In addition, a literature review incorporated findings from references in PubMed using EndNote software.

Ethical considerations:

The project's research design was reviewed and approved by the Institutional Review Board at the Bangladeshi Research Institute, International Center for Diarrheal Disease Research, Bangladesh (icddr, b). No additional approval was obtained for the study.

Limitations and delimitations

The main limitation was sudden flash floods in the project implementation district. This disrupted regular road communications. Therefore, the study was conducted in three sub-districts of project implementation. Moreover, the interviewer planned to spend more time in the field to conduct more interviews, talk with relevant stakeholders formally and informally, observe SHEs' activities, and attend monthly health meetings where SHEs present their monthly performance. However, forecasting the flood again forced him to leave the place immediately. There was a flood in Sunamganj at that time, and it was historic for 120 years, considering the devastation. Some minor limitations are time management, community group members, and the availability of public health service providers. Just after the flood and upcoming flood, community people were busy collecting and managing their crops. Public health service providers are busy with the COVID-19 vaccination program. Delimitations of the study keep the research focused on the experiences and behaviors of SHEs who are now active and conducting birth delivery in their community. To reduce inaccuracies in participant recall, interviews were conducted during the last three months of their performance.

Chapter 4

Result

The SHE program built the SHEs' entrepreneurial skills, professional confidence, and individual decision-making power. The program approach supported SHEs from the community, government, and private health sectors in becoming recognized as health entrepreneurs, contributing to their livelihood, and improving quality of life. The study found an aspirational increase in the SHE's power and agency.

Findings of the qualitative analysis

A. Increased SHEs' Power and Agency"

One of the important of the research questions of the study asked "What were the major areas that SHEs identified as transformational changes at the family and community levels that affected SHEs' social power and gender dynamics?"

Therefore, it is important to assess the participation of SHEs in decision-making processes and their ability to make decisions at the family and community levels. Ninety-five percent (20 out of 21) of the participants mentioned their changed role in the decision-making processes individually or jointly with their husband/in laws. All had no or limited role in the family level decision-making process before becoming the SHE. The main decision-making areas are household expenditure, large purchases for the family, savings, seeking health care for themselves, contraceptive taking, and child births. A few participants mentioned that they were participating in the decision-making process regarding their community. The most common thing that all participants said was that they could decide to go for delivery whenever needed, and some of the example statements regarding "decision making" by the participants are as follows:

“My husband always gives me the authority on a big purchase for the family. For example, consider the decision for Eid shopping. Even it was me to take decision on purchase the land for the family.” Shuhena, SHE, South Sunamganj.

“Nargis: I have some money in my account nearly 15-16 K BDT as a savings. I also have a shop in our village market and some crop-producing land.

I: Who made the decision about this?

*Nargis: This was my decision. I have consulted with my husband.” ----- SHE,
Bishamborpur, Sunamganj*

“I: You are using a family planning method. How did you make the decision?

Shoha: I decided to do so.

I: Since you got married after becoming, SHE. Therefore, you delivered the child after becoming SHE. So, my question is to you, who made the decision to get a child? Or how it was taken?

Shoha: We jointly decided to have a child after marriage. So, in the six months of my marriage, I conceived. After my first child, we decided not to have another child within five years. So, when my first child crossed 4th year. Then we planned for second baby” -----Shoa, SHE,

Bishamborpur

IDI participants were asked to rate themselves on a 5-grade scale where 0 indicated less confidence, and five indicated highly confidence. 67% of the participants (6 out of 9) scored 5 out of 5, 22% scored 4 (2 out of 9), and 11% scored 2 (1 out of 9). It has been observed that the participants who rated low in the “Self -confidence/self-efficiency” variable were also frail in decision-making ability. She stated that –

I: If I again ask you to give a score on your self-confidence, where 0 always means confused and five means – highly confident about doing any work. What would you score?

Mahamudra: In that case, I will give me two. I do not have much confidence in myself to do any work.

I: What freedom do you have to spend your income?

Mahamudra: Sorry, I did not understand your points.

I: Okay, no worries. Let me explain this better. For example, at the last time, you earned 1500 tk. How much can you spend on these earnings, if you want?

Mahamudra: In that case, I must consult with my mother-in-law.

I: What role do you usually play for family big purchases like – festive shopping, assets purchase

Mahamudra: I do not have a role in this issue. They, my husband, and my mother-in-law, take decisions.

In addition to scoring confidence levels, participants were asked about articulateness and confidence in speaking with authorities, communicating with their supervisor or local health authority, and making performance presentations before the health authority.

It was observed that the participants who scored 5 on self-confidence/self-efficiency” were also powerful in communication and presentation with the health authority and high-level government officials. For example:

I: if I again ask you to give a score on your self-confidence,, where 0 always means confused and five means – highly confident about doing any work. What would you score?

Ruksana: In that case, I will give me 5.

How frequently do you need to communicate with the local health department?

Ruksana: I need to communicate with them every week. However, I have regular communications with them.

I: Have you ever shared your performance at the district or local health team meetings?

Ruksana: Yes, I did. Since I am the president, I need to present my overall performance in the district meeting.

Did you make oral presentations?

Ruksana: Yes, I am presenting at the Upazila and District levels regularly.

Of the participants, 88% reported regular communication with local health authorities. They attended monthly performance meetings with other health service providers. Among the participants who are the President of “Shusheva Networks” attend the meeting at the district level where all govts. high officials were also presented.

To assess SHEs' power in control over assets, IDI and FGD participants were asked to respond on ownership of productive assets (Land, Animals, Machinery), percentage of share in their monthly household income, role on family expenditure, and savings. 90% of participants (19 out of 21) mentioned that their contribution to monthly household income is more than 50%. 100% of participants mentioned their own savings, either in the bank or deposited in the "Shusheva Network." More than 70% mentioned ownership of physical assets; gold ornaments, lands, livestock, sewing machines, and sandlifting machines are the list of physical assets owned by the participants.

I: Which productive assets do you own?

Shoha: I have a sewing machine and sand-lifting machine.

I: The next issue is. Does your family earn monthly income? What is the average monthly income of your family?

Shoha: On average, it is 10K

I: So, what contributes to the family's monthly income?

Shoha: It was entirely my income. My husband does not earn any income.

I: There are monthly expenses for the family. What is your role in the decision regarding monthly expenses?

Shoha: I usually make decisions regarding family expenses. My husband does not interfere with this decision. SHE, Bishomborpur, Sunamganj

In the study, “Gender norms” and “Gender Roles and Responsibilities” were used as sub-variables of “Gender.” For the “Gender norms,” participants of IDI were assessed regarding their ability to negotiate sexual and reproductive decisions by responding about the decision to use FP methods currently. In this regard, 63% of the participants (five out of eight; one participant was unmarried) made a joint decision. Two participants strongly mentioned their own decisions, and one participant mentioned that her husband was the decision-maker. However, most participants mentioned using condoms and oral pills simultaneously.

I: You are using a family planning method. How did you make the decision?

Kobita: We jointly made the decision. I am not using any methods. He is using the method. SHE, South Sunamganj.

Participants were also asked about childbirth after becoming SHE and the decision maker to visit a doctor or hospital for their last health problem. Two participants mentioned childbirth after the SHE. One mentioned that it was her own decision, and one mentioned that it was a joint decision. Regarding health-seeking behavior, 77% of the participants mentioned that a joint decision was made to visit a doctor or hospital for their health problems. Participants’ responses regarding childbirth and visits to a doctor or hospital are as follows:

"I: Did you have childbirth after becoming SHE?"

Chandona: Yes, I give birth to a daughter after becoming SHE.

I: How was the decision made?"

Chandona: This was my primary interest. I have two daughters. So I was expecting a boy and decided to have a baby.

I: In the last three months, have you experienced any health-related problems?"

Chandona: Yes, I have some problems. I had a dental ache.

I: How was the decision to visit the doctor?"

Chandona: This was my decision. My husband is supportive of my health problems. He accompanied me to visit a doctor or hospital during my health problems. If he does not have time, he follows up with me and encourages me to visit a doctor" SHE,

Bishamborpur, Sunamganj.

Regarding "Gender Roles & Responsibilities," participants from IDI and FGD were asked to respond about the number of hours spent on household chores and equity of domestic duty load. All participants mentioned fewer hours spent on household chores after becoming SHE. However, they had no problems or issues and spent less time in the house. They strongly mentioned getting enough support from other household members such as their husbands, in-laws, and daughters. The participants also mentioned that household work are now distributed to all family members. It is not like formally, but now, no one is waiting for them, as previously. Family members are now oriented towards their outside work. Some participants shared that it was initially difficult to manage at the beginning time. One participant mentioned that – "my family members were taking dried food (puffed rice) for lunch and waiting for my return. I came late afternoon and cooked for them. Many times, we ate lunch and dinner together".

Another example of this is the following.

I: Do you see any differences in household chores after the SHE? Are you giving enough time to your family like other housewives?

Nargis: Yes, I cannot spend enough time on household work. My husband usually helps me, and my daughter helps me. Additionally, I have reduced my work. For example: previously, my floor was muddy. Currently, this has become concrete. I used firewood as fuel, but now use natural gas. I bought a refrigerator. Therefore, I do not need regular cooking.

SHE, Bishamborpur, Sunamganj.

B. Increased economic advancement

Another thematic area of the study is “economic advancement”. This study explored the research question, “Did the SHE model result in increased economic advancement among SHEs?”. The study designed questions for three variables: productivity, skills, income, and prosperity.

Participants from both IDI were asked to respond to their income level after becoming SHE. In addition, financial planning and access to financial services. All participants strongly mentioned an increased income. Most of them had no income before becoming SHE. Thus, they identified income as one of the major changes in their lives after becoming SHE. For example, one participant mentioned that *“I think the most crucial change is overcoming the financial crisis. Since my husband had been unemployed for a long time, we had no other source of income, except for my earnings. I had a hard time managing daily food for my family members. It was some days that I bought food based on my daily earnings. So, financial change is the most essential for me to”*.

All participants mentioned that their income contributed to their household income and mostly to expenses for household purposes. Their income increased their financial independence, and 95%

of the participants mentioned that they could expense their own income without prior consent from their husbands or elderly family members. They can spend whatever amount from their income for their own purposes and their children. The participants also mentioned that the increased income level improved their social and economic status in their community. One participant shared her experiences in this way:

“If I talk about my financial changes, it is tremendous. Initially, I received 500 – 800 tks for conducting a delivery. I could perform, on average, ten deliveries per month. Therefore, I could earn 12 K tk per month after reduced the medicine costs. This was a large amount of money at the time. I cannot say where I would go if I could not earn that amount of money. I would have been a garment worker or a housemaid. But now I can hire a housemaid”.

Some participants also mentioned that their families are now run only by their income. For example:

"I: Your family has a monthly income? What is your contribution to your family's monthly income?"

Ruksana: I am the only earning member of my family

I: There are monthly expenses for the family. What is your role in the decision regarding monthly expenses?"

Ruksana: In my family, I usually make decisions. Since I am the only earning member, I consulted my mother. SHE, Sadar Upazila, Sunamganj.

The study also explored the financial management and access to the financial services of SHEs. All the participants mentioned cash savings, and in most cases, the savings are from their income and money saved in a bank through the Deposit Pension Scheme (DPS). They saved money in the “Shusheva Network” beside a bank. It was observed that all participants saved in the

“Shusheva Network”. A few participants mentioned that they also considered gold ornaments, lands, and leasing property as their savings. Some of the reflections are as follows:

“I: Do you have any savings?”

Nargis: I have some money in my account, nearly 15-16 K BDT as savings. I also have a shop in our village market and some crop-producing land.

I: Who made the decision about this?”

Nargis: This was my decision. I have consulted with my husband. SHE, Bishamborpur, Sunamganj.

“I: Do you have any savings”

Mahamuda: I do not have any individual savings in the bank, but I have group savings with other members of the Shusheva network” SHE, South Sunamganj, Sunamganj.

“Productivity and Skills” is another crucial variable under economic advancement. Participants from the IDI and FGD were asked about their access to technology and means of information gathering. Participants from FGD with SHEs, community group members, and KII with service providers were also asked about SHEs’ access to the market as sellers and their position compared to other community-based health service providers. Additionally, community members were asked to respond to the support they had arranged for the SHEs and any financial waiver they ensured for the SHEs’ better performance at the community level.

All the participants with IDI and FGD with SHEs had android/smart mobile phones. None of the participants used IT devices other than mobile phones. Most participants mentioned monthly meetings with the health department and personal communications with health officials and peer members as sources of updated information regarding their services. One IDI participant mentioned that she was connected to the Facebook platform, which the health and family

planning department operated. She also mentioned receiving mail from the Health and Family Planning Department. Her statement is as follows.

“I: Previously, you were in a system for getting updated information regarding your work through attending training & meeting organized by CARE. Currently, CARE is not with you. How do you get updated information related to your work?”

Nargis: Now, this is the internet era. I have added this to the Facebook group of the Health and Family Planning Department. Therefore, I am getting an update there. In addition, I regularly attend monthly meetings with them where UHFPO sir and Senior FWVs present and provide updated information to us. I am also getting e-mails from them regarding updated information”.

Regarding market access and SHEs’ position compared to other competitors, participants of FGD with SHE confidently mentioned their control in the market, considering their quality of service and equipment. One participant mentioned that *“after some days, when I started delivery conduction after training, people started to believe that I am a skilled provider regarding delivery conduction. “I have all weapons to fight. Ten people conduct delivery, but do not have any weapons. Since I have weapons and necessary techniques, people have trust in me”.*

Participants from the community group also mentioned SHEs’ quality and competence of the SHEs in delivery. One community group member, who was also a Traditional Birth Attendant (TBA), mentioned that *“now people do not call me for conducting deliveries; rather, they prefer SHE for that purpose. I am happy with that since she is more competent than me, and she often asked me to perform the delivery with her”.*

Many SHEs are now conducting deliveries in Community Clinic because community groups are arranged spaces and other logistics there for them. One family member during KII stated that

they received a financial waiver from the electricity bill payment. Since his wife is a SHE and has her own pharmacy, she conducts deliveries.

FGD Participants of community group members were asked to evaluate SHEs' economic, health, and nutritional status after becoming SHE as part of the "Propensity" variable. In response, they mentioned good progress in three components. All SHEs in their community are well known to community members, and they can easily visualize their changes before and after becoming SHE. They recognized that most families of SHEs were not economically solvent, and they were not healthy before becoming SHE. However, they are now doing well.

C. Other Observation:

In the IDI and FGD, participants were asked about the differences between general women in their communities and them. They strongly mentioned that they were now very advanced from other women in their community. Before becoming SHE, they were also housewives, like other women. Currently, they have technical skills for delivery. Previously, they had to go to other people for health problems, but now, people come to them for health consultations. They are known as "Dakterni" or "Shastho Apa. People not only come to them for health problems but also seek advice on other issues. One issue that most of the participants mentioned is that they are not solely dependent on their husbands for money; they now have money and help their families. They have highlighted that they now have their own identities. One participant shared her experience: *"Compared to other women, I can say that I can take any decision from my family. For example, one of our colleagues from CARE wanted to visit our area and ask us where he could visit. I have just said that you could come to my house. He then asked me how to identify your house. I said, after arriving at my union, you can ask any person that you want to go to "Nargis Apa's" house. Everyone will help you to reach my home. When he was here and*

said, Yes, Nargis Apa, you are right. Everyone knows you with your name. This is a difference from other women. Everyone knows me by name; I do not need to mention my husband's name. This is not my own village; it is my in-law's village. How many women are known about their own identities? I am working here like as a doctor. I can conduct delivery, push saline, and help people by providing health advice. Why do they not call me as a "doctor". Nargis Akter, SHE, Bishamborpur, Sunamganj.

Some other examples:

"In the initial stage, I had many problems going outside of home. I faced many hurdles, but now I do not see any deep problems. I am getting much support from my family and community. Another important change is that everyone now knows me very well. Although it is my father's and in-law's village, but people know me by my own name. It makes me proud. The most important issue is that I am financially independent. I do not need to consult my husband or other family members at any expense. I can do this through my own decisions. Sometimes, I buy things for my husband, which is a very happy matter for me" Shuhena, SHE, South Sunamganj, Sunamganj.

"Compared to other women, I can say they do not know many things that I know. I do know everything about delivery, but they come to me for delivery and for other medical advice.

Khohinoara Begum, SHE, Sadar Upazila, Sunamganj.

IDI participants were also asked about their mental health status through scores of 0 – 5, where 0 is for always tensed and upset, and 5 is for everything is okay/entirely mentally sound. An equal number of participants scored five or four. One participant had a score of 3. Some examples of these findings are as follows.

“I will give 3 out of 5 to me regarding my mental health situation. I experience some family level tensions. I also have some frustrations since I cannot perform field performance regularly.

Mahamuda Khatun, SHE, South Sunamganj, Sunamganj.

“I do not have any mental issues right now. Therefore, I will give myself full marks considering my current mental health state” Shuhena, SHE, South Sunamganj, Sunamganj.

Inspiration for Other Women

Many SHEs and community members mentioned that other community women come to them not only for health services, but they are also interested to get consultation for other issues. They felt encouraged to see SHEs’ financial independence. SHEs also guide women on livelihood options and income-generating activities. One participant shared her experience related this issue: *“many women come to me for advice, and it is not only for health advice rather seeks advice for financial improvement. I ask them to raise ducks and hens. If a woman raises four ducks or hens, she can earn more than 200 takas per week. They did not need to depend on their husbands. I have also encouraged them for tailoring. This happened at the family level. I encouraged one of my nieces to tailor and motivated her to open a DPS account in a bank. Some women were also motivated to be involved in earning activities to see my success”.*

Increased Women Leadership Capacity

IDI and FGD participants were asked about their access to and participation in platforms and networks at the community level and above. The interview findings reflected that the SHE model increased SHEs' participation in community groups, platforms, and networks at the community, Upazila, and District levels. One participant also mentioned her access to IT/social media networks of government health and FP folks. Some participants also mentioned that they have been included in regular communication lops of the Upazila Health and Family Planning office

and receive official e-mails regularly regarding technical updates. Participants in "Shusheva Networks" strongly highlighted their leadership and representation skills at various levels. Interview participants also mentioned that many SHEs had been awarded "Joyita" by the Ministry of Women Affairs, considering their leadership and entrepreneurship skills to have graduated from poverty. Finally, one SHE had elected as a "Female Member" of Union Parishad.

Findings from Secondary Data and Information

The project's donor reports, evaluation reports, and documents were reviewed and scanned to find relevant information and data supporting or related to the SHE's economic findings. In this regard, the project evaluation studies' reports support the findings related to increased SHEs' individual decision-making power. One of the important research questions of the project endline evaluation study was to test the hypothesis that the proportion of women reporting independent decision-making abilities improved in the project area after the implementation of the SHE program. 52% women reported their ability to make decisions independently at baseline, which increased to 57% at the end. Over the five-year period, independent decision making increased by five percentage points. To test the hypothesis that this increase in decision making is statistically significant, a chi-square test was performed. The chi-square value indicated that the difference was statistically significant; that is, the project area saw statistically significant improvements in the percentage of women able to make decisions independently (see Table 1).

Table 1: Increased Independent Decision-Making Among Respondents in SHE Program Area

N=6395			
	Not independent # (%/N)	Independent # (N/%)	Pearson chi2 (probability)
Baseline	469 (47%)	527 (52%)	949.5202 (0.000)
Endline	2,314 (43%)	3,086 (57%)	

Through a study (Dora Curry, March 2022), the project analyzed the change in elements of social power among the SHE. The table below represents the fixed-effects regression analysis results for each element of the social power score independently and for the composite social power score.

Table 2: fixed-effects regression analysis results

	Summary statistics n (%) / mean (95% CI)		OLSB(SE)
	Initial N=252	Final N=252	<i>Initial to follow-up</i>
Monthly income+	1901.63 (1616.26 2187.00)	7989.84 (7280.82 - 8698.85)	3053.001*** (707.1888)
Professional engagement (number of presentations)	10.41 (9.33 – 11.39)	16.10 (15.36 – 16.90)	13.48 * (0.2006)
Decision maker for women's health~			
Herself	64 (25.40)	87 (34.52)	2.36*** (0.2281)
Others (includes husband, both, in-laws, etc.)	188 (74.60)	165 (65.48)	
Decision maker for children's health~			
Herself	64 (25.40)	100 (39.68)	2.34*** (0.2254)
Others (includes husband, both, in-laws, etc.)	188 (4.60)	152 (60.32)	
Decision maker for contraception			
Herself	188	197	1.40*** (0.2065)
Husband, both or N/A	58	49	
Social power score	6.12	8.18	8.30*** (0.3179)

Statistical significance - * p<0.05; ** p<0.01; *** p<0.001

SHEs earned 7659.78 takas (or roughly 90 USD) more per month at the end line than at the baseline. For reference, the average annual household income in Bangladesh as of 2016 was

estimated at approximately 600 USD. SHEs, while SHEs' professional engagement increased from an average of 10.41 presentations given to one of 16.10. The decision-making variables ranged from 0 to 4. The regression coefficient for health decision-making was 2.36, that for children's health decision-making was 2.34, and that for contraceptive decision-making was 1.40. All the results were statistically significant.

The endline combined social power score coefficient was 8.65, ranging from 3 to 12, which was statistically significant. These results provide robust support for the argument that SHEs experienced a meaningful change in social power between the beginning and end of the SHE program.

The endline evaluation report's findings regarding coverage and entrepreneurship of SHEs and community responsiveness showed that almost 77% of women reported that the quality of service provided by private CSBA was good and almost 18% regarded it as very good. Women in the lowest-to-middle wealth quintile are more likely to receive more services from private CSBA. Close proximity was mentioned by most women (75%) as a reason behind the selection of Private CSBA, and this was almost similar (73%) to getting services in the future.

Approximately 51% of the women said that Private CSBA took a reasonable amount of money to provide services. Services purchased from private CSBA other than health services included Iron Folic Acid/Calcium/Vitamin (21%) and medicines (10%).

Chapter 5

Discussion:

This study examined whether the SHE model contributed to economic empowerment among SHEs in addition to improving the clinical skills of maternal health. The results found a significant increase and sustained power, agency, and economic advancement among the SHEs in the project area over five years and beyond the post-project period. The results revealed that the SHE model is highly linked to financial independence, better health and nutrition outcomes, and sustainable livelihoods of SHEs. The SHE model of community-based healthcare provision has significantly improved the service delivery and health indicators of program implementation. The design of this intervention significantly increased agency, economic power, and professional engagement among the SHEs. These changes occurred in the context of a project that successfully improved birth preparedness, coverage with antenatal care, skilled attendance at birth, and complications (Hossain et al., 2020).

The increase in independent decision making among SHEs was significant and associated with control over assets and gender norms, improving their competencies to be empowered economically. Economic empowerment is the ability to make decisions by controlling and allocating financial resources (Guides & Team). Increased decision-making also contributes to contraceptive use, childbirth, and seeking health services. Women's influence on financial decisions is associated with the increased use of preventive health services by children and women (Ahmed et al., 2010; Guides & Team), including the use of modern contraceptive methods (Ahmed et al., 2010; Do & Kurimoto, 2012). Thus, interventions aimed at increasing the economic power of women and girls may improve reproductive health behaviors, including

the sustained use of modern contraception, mainly when linked with investments that directly address reproductive health, family planning, and gender norms. These results are consistent with the hypothesis that the change in SHEs' autonomy in the program area is an effect of the program, but they are also consistent with the hypothesis that women's autonomy shows inter-temporal improvements (Guides & Team).

This study assessed three significant elements of social power: compensation, agency and professional engagement. SHEs directly reported their income from SHE activities. Decision-making power is an indicator of SHEs' agency. The frequency of their presentations at professional meetings with health and family planning departments and other relevant platforms recognized them in the community as a professional health workforce.

The analysis found that all three elements of SHEs' social power increased significantly from the beginning to the end of the programme. These results illustrate that supporting a community-based health workforce can simultaneously expand accessibility and uptake of skilled birthing care and substantively change the role of these pivotal female frontline health workers. The design of this intervention significantly increased agency, economic power, and professional engagement among the SHEs. Furthermore, these changes occurred in the context of a project that successfully improved birth preparedness, coverage of antenatal care, skilled attendance at birth, and management of complications (Hossain et al., 2020).

This study also examined whether the introduction of SHEs affected the independent decision-making abilities of women in the family and community. The results suggest that SHEs' agency of SHEs in the project area improved significantly over time. The study results support the claim that there is a change in SHEs' agency in their families and communities as well. The project endline also reported that women's decision-making in the program area was higher than that in

the rest of the Sylhet district. In the program area, 58.19 percent of women made decisions independently, while in Sylhet District as a whole, only 48.2 percent of women did so, according to the 2017 Bangladesh Demographic Health Survey ("Bangladesh Health Demographic Survey," 2017-18). This study provides empirical evidence of the specific design elements of SHE interventions that help increase power and agency among female health workers. These elements can be used to counter gender inequity and power imbalances in the healthcare workforce.

Economic independence is the most straightforward variable to measure; however, the relationship between income and social power is critical. Increased household income alone is insufficient to ensure increased social power and positioning in the existing market system. Dora Curry et.al conducted an analysis that had access to the reported income from the woman's independent, professional endeavour (not her household wealth), a more relevant metric than household wealth. SHEs earned 7659.78 takas (or roughly 90 USD) more per month at the end line than at the baseline. For reference, the average annual household income in Bangladesh as of 2016 was estimated at approximately 600 USD. SHEs' professional engagement increased from an average of 10.41 presentations given per reporting period to one of 16.10. The decision-making variables ranged from 0 to 4. The percentage of women making decisions independently increased for all three decision-making items: from 25.40% to 34.52% for seeking their own health care, from 25.40% to 39.68% for seeking health care for their children, and from 74.61–78.17% for contraceptive use. All the results were statistically significant. The endline combined social power score was 8.65, ranging from 3 to 12, compared with 6.18 at baseline. The results were statistically significant. These results provide robust support for the argument that SHEs

experienced a meaningful change in social power between the beginning of the SHE program and the end (Dora Curry, March 2022).

The overall approach of the SHE programme attempted to combine traditional technical training and managerial support with efforts to enhance autonomy, economic independence, and solidarity among SHEs. The absolute magnitude and high probability of statistical significance of the change in the SHEs' social power score between the initial and final assessments provide strong evidence that the intervention design effectively increased the SHEs' social power, not only their technical skills. The strength of the SHE model is that it contributes in the near- to mid-term and has benefits in the longer term, addressing the underlying causes of poor health in the remote community. A model such as SHE provides acceptable, accessible care in remote areas and can reduce maternal and infant mortality. In addition, these results suggest that approaches such as the SHE model may also contribute to shifting gendered power dynamics in the community by investing in the cadres of resident women with increased agency, recognition, and wealth.

Increased Social Power Among Community-Based Skilled Birth Attendants: An Evaluation of a Frontline Health Workers Intervention, authors of this paper argued that innovative approaches to FLHW staffing might offer the potential for even more transformative change. SHEs may influence social norms by being models of women from the community who are recognized as health providers and successful self-employed entrepreneurs. Combining more immediate improvements in coverage of maternal care and related health outcomes with the demonstrated enhancement in the social power of this critical group of women in the community, the SHE model can simultaneously improve health outcomes and contribute to a pathway to more meaningful change (Dora Curry, March 2022).

Recommendations and Implications

These results reinforce the importance of exploring the effects of gender and power dynamics in the health workforce and the effectiveness of measures to improve gender equity and health worker agencies. Several specific recommendations have emerged from these results.

- Develop a new cadre of a community-based female workforce who can effectively address social and cultural barriers and gender norms and meet financial needs in a hard-to-reach community.
- Train on government-affiliated certification courses, linking with existing public-private health institutions, and developing supervision and monitoring by existing the public health care system of such a cadre exists or can be scaled up in other remote communities.
- Community-based health workers can practice sustainability independently and financially. It is a way to create economic opportunities for women and offer quality services to hard-to-reach populations.
- Consistence to support professional growth and business/management skills in the training and supervision of SHEs' potential future for community-based health-sector professionals.
- Engaging and collaborating with local government institutions is a strong strategy to implement the SHE model to increase the social accountability and sustainability of program interventions.
- Linking with government and private health systems is essential to consistently establish a community-based referral system and technical upgradation.

- Advanced technical training and supportive supervision are essential to align with policy implications and changed guidance related to community-based maternal and child health care services.
- The self-help group approach is a good decision for evolving the SHE model without external support, but it needs to be contextualized and consistently support oriented.

Conclusion:

This study explored the power, agency, and economic advancement of SHEs as frontline health workers (FLHW) through private initiatives in their communities. This model also represented a public-private partnership in a remote community, such as Sunamganj in Bangladesh. The SHE project provided an illustrative example of programming aimed at increasing access to high-quality frontline health worker services, and was designed intentionally to enhance the power and agency of female health workers as an element of the program.

This study explored a chain of features of a technical skill-focused intervention for female FLHWs that upholds agency and power, and their economic advancement. In addition, a new female-led cadre of health workers could contribute to improving maternal health status without hampering gender inequality.

The study also explored whether program interventions to shift gender and power dynamics had an intended effect on SHEs beyond their technical skill development. This study qualitatively tested whether SHEs' agency and power increased due to project interventions and support from existing communities and health facilities.

This study explored whether increased social power, agency, and economic advancement among SHEs affected their larger context regarding financial independence, better health and nutrition

outcomes, and livelihood. Despite much discussion of the potential for SHEs to serve as models and advocates for the community, particularly for women, evidence that the program can realize that potential remains incomplete.

Usually, academic literature documents technical and managerial interventions targeting FLHWs' behavioural changes. Recent work demonstrates that such solutions alone cannot sustain a stable, motivated, and effective workforce capable of providing responsive services in the long term (Källander et al., 2015). Academics and global health policymakers widely acknowledge the need for more respect and support for FLHW, including specific measures to increase gender equity in the health workforce (WHO, 2021). Cross-sectional analyses of these relationships have been conducted from various perspectives and data sources. Strong evidence from large national datasets across countries demonstrates the relationship between gender inequity in the workforce, gender inequity in broader society, and poorer health outcomes (. R. Gupta et al., 2019). Closser and Maes's work reveals potentially harmful dynamics related to undervalued female community health workers (Closser et al., 2017; Maes, Closser, Vorel, & Tesfaye, 2015; *Medicine*, June 2019). Several evaluations suggest that specific intervention design elements can affect gender norms and power dynamics in the healthcare workforce. For example, Hay et al. (2019) found that female frontline health worker cadres in settings using supervision and management designed to demonstrate respect and provide support resulted in higher job satisfaction, productivity, and health impact. Evidence suggests that the positive roles of FLHWs may contribute to gender equity in their communities. FLHWs with more voice and agency can provide more respectful, responsive care to their clients and address gaps in health service delivery arising from gender norms and power dynamics (Hay et al., 2019). They serve as

models of a predominantly female category of workers who receive fair remuneration and respect, and have the agency to move freely in the community for work.

As health systems worldwide expand their health workforce to meet critical and growing shortages, the global health community can also introduce measures to advance gender-equity goals. Empowerment is often used to capture the agency and other aspects of the power of health workers. Empowerment is a broad, complex concept, and rigorous measurement relies on complex, time-consuming approaches (Cyril, Smith, & Renzaho, 2016; Preeti Priya, July - August 2021; Richardson, 2018). The existing options for measuring power-related concepts among health workers present constraints in routine practice for assessing ongoing programming. The review also examined social power as a concept drawn from social psychology, which might be useful in this setting (Annika School, October 2017; Derek D Rucker, December 2017). The SHE program introduced elements beyond the traditional technical training and supervision of technical skills, such as increasing and controlling earnings, increasing participation in the decision-making process, and expanding professional skills. The program intended to gain support for SHEs from the community, recognition and respect as health workers, and link to the public system while protecting their livelihood and improving the quality of their services. The study found that elements in the SHE model may have contributed to increased social power and sustained livelihoods among SHEs. They also supported an increase in agency among community women. Broadly, these findings support the idea that health systems can successfully increase respect, agency, and economic independence for frontline health workers, and that FLHWs with increasing agency and social power enhance gender equity more widely in the community.

Finally, the SHE program developed traditional women as social entrepreneurs, recognized as professional health workers by local authorities and the health system, and opportunities to engage more prominently and visibly within the group over time. Women became certified private providers of FLHWs, specifically skilled birth attendants (SBAs), known as SHEs (Hossain et al., 2020). (Hossain, 2015; Hossain et al., 2020) The program also provided opportunities to connect to discuss strategy and problem-solving and one-on-one support from mentors. The SHE program included significant investment in these elements to improve the income, agency, and professional engagement of SHEs and greatly improve their economic empowerment.

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Annex A

IDI Questionnaire for SHE

Interviewee	
Interview (Code / location)	
Start time of interview	[__ __]: [__ __] AM/PM (Hour: Minute)

Introduction

Interviewer: Thank you for taking the time to meet with me today. My name is Md Jahirul Alam Azad and I'd like to talk with you about your professional development, engagement with your family and community and you're learning and changes while you working as a SHE. I have asked you to participate because I am interested in learning more about the perspectives of, SHE considering economic empowerment as part of my thesis work in master's program. This interview should last around 60 minutes. I'm going to ask you questions about your control over assets, decision-making, self-confidence/ self-efficacy, gender norms and gender roles/ responsibilities. For your participation today, I will offer you a snack at the end of the interview as a thank you. Your part in this interview is completely voluntary, and if at any point you decide you would not like to continue or if there are any questions you are not comfortable answering, please let me know. All interview transcriptions will be de-identified and kept confidential. We hope the experiences we hear about can help us identify areas where we can improve Prime Time Senior programming for current and future participants.

Before I begin the interview, I am going to ask a few questions.

- Do I have your permission to record our conversation, so that I can come back and listen to it later if needed? This recording won't be shared with anyone.
- Do I have your permission to include any of your responses in a de-identified format in potential reports or publications?
- Do you have any questions about this process or the project beyond what I have already told you?
- After hearing this information, would you still like to proceed with the interview?

[If answers yes to all 4 questions]: Great. Now we can begin with the interview. Please let me know if you need to stop at any time, if you don't want to answer any of the questions, or if you want me to clarify anything.

Demographic:

1. Age:
2. Educational status:

3. Years of working as SHE:

Introductory/ICE breaking:

1. What changes have you seen in your life after being a SHE.
2. Which change do you think most important in your life
3. Which change make you different from other women in your community

A. Control over assets:

A.1. Ownership of productive assets (Land, Animals, Machinery)

A.1.1: What type of productive assets do your family have?

A.1.1. Which assets own by you?

A.2. Share of household income:

A.2.1. What is your monthly household income?

A.2.2. What is your share in your household monthly income?

A.3. Control over how to spend cash or savings:

A.3.1. Who is the decision maker of your family for expenditure and savings?

A.3.2. What is your role for expenditure and savings?

B. Decision-making:

B.1. Proportion of income spent on herself or children

B.1.1. What proportion of HH income is being spent for herself?

B.1.2. What proportion of HH income is being spent for children?

B.2. Involvement in major household decisions, i.e., large purchases (car, house, household appliance,) agricultural decisions

B.2.1. How the major decisions are being taken in your family?

B.2.2. How many times have you been asked to participate in major decision-making meeting in your family?

B.3. Access to information and technology

B.3.1. How do you get updated work related/ other information?

B.3.2. What kinds of technology are using for your work or regular work?

C. Self-confidence/ Self-efficacy

C.1. Psychological wellbeing

C.1.1. How do you rate your mental status in a 5-grade scale where 0 is for always tensed and upset and 5 is for everything is okay/fully mentally sound?

C.2. Attitudes on own self-esteem:

C.2.1. How do you rate yourself in a 5-grade scale where 0 is for less confidence and 5 is highly confident on yourself?

C.3. Articulateness and confidence in speaking with authorities

C.3.1. How frequently do you communicate with your supervisor or local health authority?

C.3.2. How many times did you present your performance before local health authorities?

D. Gender Norms

D.1. Ability to negotiate sexual and reproductive decisions

D.1.1. Are you in Family Planning methods? Which method are you currently using for birth spacing?

D.1.2. How did you take the decision for the FP methods?

D.1.3. Did you birth any child after becoming a SHE? How did you take the decision for taking a baby?

D.1.4. Did you have any health problem in last 3 months? Did you visit any doctor/hospital for your health problems? Who was take decision for your treatment?

E. Gender Roles/ Responsibilities

E.1. Number of hours spent in housework

E.1.1. How many hours do you spend for HH chores after becoming SHE?

E.1.2. How many hours did you spend for HH chores before becoming SHE?

E.2. Equity of domestic duty load

E.2.1. How do you adjust less hours for HH chores?

E.2.2. How your family members help you to adjust the less hours for HH chores?

Thank you again for your participation. I have done the interview with you. Do you have anything/experience/learning/recommendation that you want to share with me.

Annex B

FGD Questionnaire for SHE

Interview (Code / location)	
Start time of interview	[__ __]:[__ __] AM/PM (Hour: Minute)

Introduction

Interviewer: Thank you for taking the time to meet with me today. My name is Md Jahirul Alam Azad and I'd like to talk with you about your professional development, engagement with your family and community and you're learning and changes while you working as a SHE. I have asked you to participate because I am interested in learning more about the perspectives of, SHE considering economic empowerment as part of my thesis work in master's program. This interview should last around 60 minutes. I'm going to ask you questions about your control over assets, decision-making, gender roles/ responsibilities, productivity and skills, income, and prosperity. For your participation today, I will offer you a snack at the end of the interview as a thank you. Your part in this interview is completely voluntary, and if at any point you decide you would not like to continue or if there are any questions you are not comfortable answering, please let me know. All interview transcriptions will be de-identified and kept confidential. We hope the experiences we hear about can help us identify areas where we can improve Prime Time Senior programming for current and future participants.

Before I begin the interview, I am going to ask a few questions.

- Do I have your permission to record our conversation, so that I can come back and listen to it later if needed? This recording won't be shared with anyone.
- Do I have your permission to include any of your responses in a de-identified format in potential reports or publications?
- Do you have any questions about this process or the project beyond what I have already told you?
- After hearing this information, would you still like to proceed with the interview?

[If answers yes to all 4 questions]: Great. Now we can begin with the interview. Please let me know if you need to stop at any time, if you don't want to answer any of the questions, or if you want me to clarify anything.

Introductory/Ice breaking:

4. What changes have you seen in your life after being a SHE.
5. Which change do you think most important in your life
6. Which change make you different from other women in your community

A. Control over assets:

A.1. Ownership of productive assets (Land, Animals, Machinery)

A.1.1: What type of productive assets do your family have?

A.1.1.1. Which assets own by you?

A.2. Share of household income:

A.2.1. What is your share in your household monthly income?

A.3. Control over how to spend cash or savings:

A.3.1. Who is the decision maker of your family for expenditure and savings?

A.3.2. What is your role for expenditure and savings?

B. Decision-making:

B.1. Proportion of income spent on herself or children

B.1.1. What proportion of HH income is being spent for herself?

B.1.2. What proportion of HH income is being spent for children?

B.2. Access to information and technology

B.2.1. How do you get updated on work related/ other information?

B.2.2. What kinds of technology are using for your work or regular work?

C. Gender Roles/ Responsibilities

C.1. Number of hours spent in housework

C1.1. How many hours do you spend for HH chores after becoming SHE?

C.1.2. How many hours did you spend for HH chores before becoming SHE?

C.2. Equity of domestic duty load

C.2.1. How do you adjust less hours for HH chores?

C.2.2. How your family members help you to adjust the less hours for HH chores?

D. Productivity and Skills:

D.1. Access to productive tools and technologies

D.1.1. How are you getting update about new tools, technique, information which are related with your work?

D.1.2. How do you evaluate the current process to get access on new tools and technology?

D.2. Access to markets as seller

D.2.1. How do you evaluate the current market in your community?

D.2.2. What is your position considering other competitors?

E. Income

E.1. How do you evaluate your income level after becoming SHE?

E.2. Do you have individual or family savings?

E.3. Where do you save your money?

F. Prosperity

F.1. How do you evaluate your individual and family wealth after becoming SHE?

F.2. How do you evaluate your individual and family health and nutritional status after becoming SHE?

Thank you again for your participation. I have done the interview with you. Do you have anything/experience/learning/recommendation that you want to share with me.

Annex C

FGD Questionnaire for Community/Family Stakeholders

Interview (Code / location)	
Start time of interview	[]:[] AM/PM (Hour: Minute)

Introduction

Interviewer: Thank you for taking the time to meet with me today. My name is Md Jahirul Alam Azad and I'd like to talk with you about SHE's professional development, engagement with their family and community and you're learning and changes while they became as a SHE. I have asked you to participate because I am interested in learning more about the perspectives of, SHE considering economic empowerment as part of my thesis work in master's program. This interview should last around 60 minutes. I'm going to ask you questions about SHE's control over assets, decision-making, self-confidence/ self-efficacy, gender norms, gender roles/ responsibilities, productivity and skills, income, and prosperity. For your participation today, I will offer you a snack at the end of the interview as a thank you. Your part in this interview is completely voluntary, and if at any point you decide you would not like to continue or if there are any questions you are not comfortable answering, please let me know. All interview transcriptions will be de-identified and kept confidential. We hope the experiences we hear about can help us identify areas where we can improve Prime Time Senior programming for current and future participants.

Before I begin the interview, I am going to ask a few questions.

- Do I have your permission to record our conversation, so that I can come back and listen to it later if needed? This recording won't be shared with anyone.
- Do I have your permission to include any of your responses in a de-identified format in potential reports or publications?
- Do you have any questions about this process or the project beyond what I have already told you?
- After hearing this information, would you still like to proceed with the interview?

[If answers yes to all 4 questions]: Great. Now we can begin with the interview. Please let me know if you need to stop at any time, if you don't want to answer any of the questions, or if you want me to clarify anything.

Introductory/Ice breaking:

7. What changes have you seen in SHEs' life after being as a SHE.

8. Which change do you think most important in their life
9. Which change make them different from other women in your community

A. Control over assets:

- A.1. What kinds of supports are you providing them to create a friendly working environment in your community?
- A.2. What is their share/coverage in existing health service delivery market in your community?
- A.3. What type of resources exist in your community? How SHEs are utilizing these resources?

B. Decision-making:

- B.1. How are SHEs' participation in community platforms and networks?
- B.2. How are they participating in community decision making process? Is there any example where SHE proactively participated in community decision making process for the benefit of community?
- B.3. Do they have any leadership role in your community? Is there any example where SHEs are leading any platforms/groups?

C. Gender Norms

- C.1. What is your evaluation about SHEs work in your community?
- C.2. What is your and community attitude towards them regarding their work in sexual and reproductive health?

D. Gender Roles/ Responsibilities

- D.1. What is the community attitudes on what work women should do?

D. Productivity and Skills:

- D.1. Does the community/family arrange anything for their further development?
- D.2. What kind of support are you providing to them to get money waive for their work?

E. Income

- E.1. What types of resources community/family spent for the SHEs?

F. Prosperity

- F.1. How do you evaluate SHEs economic status in your community?
- F.2. How do you evaluate their health and nutritional status after becoming SHE?

Thank you again for your participation. I have done the interview with you. Do you have anything/experience/learning/recommendation that you want to share with me.