Exploring the context in which close-to-community sexual and reproductive health service providers operate in Bangladesh

BACKGROUND

Significant shortages in the health workforce have sparked interest in the role and potential of community health workers (CHWs) as a bridge between communities and formal health systems. Evidence shows that CHWs, as the first point of contact in the community for health care, can deliver health services cost-effectively. The health system in Bangladesh is diverse, blending traditional and modern medicine, with blurred lines between public and private sectors. Apart from both government and NGO linked CHWs, there is a wide range of informal "close-to-community" (CTC) health service providers such as drugstore salespeople, traditional birth attendants and traditional healers. These accessible informal CTC health service providers - often the first point of contact for any health care needs in urban slums - constitute a substantial and yet under-valued part of the health system.

As the number of CTC health service providers in poor urban and rural communities in Bangladesh grows, it is helpful to understand their interactions with the community in order to shape policy and programming. Very few studies, however, look at the context in which different CTC providers of sexual and reproductive health (SRH) services operate in both urban slums and poor rural communities in Bangladesh. To address this gap, the international consortium, REACHOUT, conducted qualitative research to explore the factors influencing women's choice of CTC providers of SRH and to study the relationships between formal (government, NGO and private sector) and informal CTC service providers and the community. Researchers held 24 in-depth interviews with clients who had received menstrual regulation (MR)1 services, 24 interviews with formal and informal CTC service providers, and 12 focus group discussions with married men and women in the community. Data was collected in 2013 from three urban slums and one rural area in Dhaka and Sylhet, sites where informal CTC health care providers make up 68 per cent of the total health service providers.

[1] Manual vacuum aspiration to safely establish non-pregnancy up to 8–10 weeks after a missed menstruation period.

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KEY FINDINGS

"We go to the pharmacies without consulting a doctor. We talk about our problems to the drugstore salespeople, and they give us medicines. If their medicines work, then we are saved."

Focus group Discussion with community members

- Poor women in urban slums and rural areas in Bangladesh use a wide range of CTC service providers for their SRH needs, including formal and informal providers. Informal CTC service providers are the favourite option and first point of contact. Most women preferred local drugstore salespeople as the provider of SRH services, while others favoured traditional healers and traditional birth attendants. Women visited hospitals if complications arose or if drugs salespeople could not help, however, some participants reported dissatisfaction with the cost, shortage of medicine, unavailability of doctors and poor quality of care.
- Factors determining women's choice of provider include accessibility and availability of SRH services; expense; as well as a relationship based on respect, trust and familiarity, often built up over a period of time. Women felt more comfortable when service providers shared a cultural understanding of illness: this fostered easy communication. Informal service providers valued the trust their clients placed in them and enjoyed the respect of the community; they found this motivating. Formal service providers also sought and valued their clients' trust.
- The cost of SRH services influences clients' preference for informal CTC health service providers and NGOs rather than government providers. Participants in just over half of the focus group discussions said that drugstore salespeople were their first choice for low-cost SRH services, including contraceptives. Traditional healers, who would often not charge, were also popular. Some women were discouraged from visiting government hospitals due to the presence of "brokers" who demand money in return for access to a doctor. Payment to informal CTC health service providers could be in the form of gifts rather than money: service providers valued these gifts as a sign of the good rapport they enjoyed with their clients.
- Various interactions exist between formal and informal CTC health service providers, including cooperation and mutual support, with both sectors learning from each other. Nevertheless, in spite of the benefits of enhanced cooperation for women's SRH care, there is no effective link or partnership for referral or communication.

LIMITATIONS

Women who were interviewed in-depth after they received MR services were not enlisted from the community, and were questioned in clinics rather than at home. Because of the selection strategy, women who had received MR services from informal providers only were not included in the study, and their experiences were not recorded. A further limitation concerns perspective. Issues of trust and relationship between CTC providers and the community were viewed from the providers' point of view only rather than from the clients' perspective. Additional research should endeavour to capture clients' voice.

CONCLUSIONS

This study shows that women in urban and rural communities in Bangladesh usually prefer informal CTC service providers for their SRH needs, with drugstore salespeople emerging as a popular choice. Although accessibility of services and cost influence women's choice of providers, trust emerges as a key factor. As informal providers usually come from the community, they offer familiarity and comfort for the clients, particularly when discussing personal SRH issues such as miscarriage. Evidence suggests it may be the fact that these providers come from a similar background which puts women at ease.

This REACHOUT study shows that some communication takes place between formal and informal health service providers, with both sectors appreciating the advantages of interacting and the benefits for women's SRH services. Nevertheless, no effective links exist for referral, coordination and communication on SRH services. Enhancing cooperation could increase the number of appropriate and timely referrals, reduce service costs and improve the availability of quality SRH services for poor women at the community level. Training informal CTC health service providers and consolidating links between the informal and formal health sectors are worthwhile strategies.

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