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ABSTRACT

Statement of Problem: Globally 75 countries had fewer than 2.5 health worker per 1000. According to World Health Report countries with a density of fewer than 2.28 doctor, nurses and midwives per 1000 population generally failed to achieve a targeted 80% coverage skilled birth attendance and child immunization. This shortage pushed patients especially the poor and disadvantaged mostly seek health care from informal sectors as they are more socially and community focused. Purpose of Study: To develop an effective, efficient and equitable health system to improved population health, appropriate formal health workforce needed. There are shortage and crisis of it. It is nearly impossible to produce the required formal health workforce by the public and private sectors combined. Transform informal health care service providers (HCSP) into a well-trained government registered HCSP. It would able to stop malpractice, ensure standard treatment and accountable for referral responsibility. Methodology: Both Primary and secondary data were taken. Face to face interview and focus group discussion was done. Findings- Both illiterate (no education) and literate (complete primary to a higher level degree) people visit informal healthcare providers. Income group started from 10000 to 30000 were classified as low, middle and upper middle groups household people having age zero to sixty choices to received health services from a traditional healer (kobiraj), homeopathic, RMP and drug seller respectively.

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Statement of Problem: Globally 75 countries had fewer than 2.5 health worker per 1000. According to World Health Report countries with a density of fewer than 2.28 doctor, nurses and midwives per 1000 population generally failed to achieve a targeted 80% coverage skilled birth attendance and child immunization. This shortage pushed patients especially the poor and disadvantaged mostly seek health care from informal sectors as they are more socially and community focused. Purpose of Study: To develop an effective, efficient and equitable health system to improved population health, appropriate formal health workforce needed. There are shortage and crisis of it. It is nearly impossible to produce the required formal health workforce by the public and private sectors combined. Transform informal health care service providers (HCSP) into a well-trained government registered HCSP. It would able to stop malpractice, ensure standard treatment and accountable for referral responsibility. Methodology: Both Primary and secondary data were taken. Face to face interview and focus group discussion was done. Findings- Both illiterate (no education) and literate (complete primary to a higher level degree) people visit informal healthcare providers. Income group started from 10000 to 30000 were classified as low, middle and upper middle groups household people having age zero to sixty choices to received health services from a traditional healer (kobiraj), homeopathic, RMP and drug seller respectively. Village people most likely visit kobiraj and drug sellers. Respondents also revealed that they visit them for maternal and child health care, RTI/STI treatment, the problem of reproductive and sexuality, nutrition, limited curative Care and usually male person of household take medicine for the family. For child usually, mother or grandparents were taken services from informal health care providers.

Conclusion and significant- the possibility of faulty diagnosis, underdiagnosis and non-useful medication to an individual is very harmful that may lead the person even death. A standard, knowledgeable and skilled health workforce can prepare by proving a fix duration of training, conduct and maintain by Government Regulatory Authority of Health Sector, using a standard curriculum. It will certify them to provide health care service formally. Health care accessibility, quality, equity, and efficiency will increase. And it is very possible to abolish the term informal health care provider for providing and received health care services from anywhere on the globe.

Keyword: informal health care provider (kobiraj, homeopathic, rmp, drug seller), rmp- rural medical practitioner.

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I. INTRODUCTION

Cost of services, distance to health facilities, cultural beliefs, level of education and health facility inadequacies such as stock-out of drugs etc. may influence the utilization of health facilities. Health seeking behavior is associated with socio-demographic factors, such as age, sex,

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education, socioeconomic status, race and ethnicity, religion and marital. But also socio-cultural dimensions are important, such as social networks, lay advice seeking, country economics, geographic and other dimensions. Like many developing countries, Bangladesh has given much priority to the government-owned healthcare establishments which are basically financed by tax revenues. The country currently has a wide government healthcare service-delivery system which includes primary healthcare centers and public hospitals throughout the country. The private sector is also contributing to healthcare service delivery for country citizens.

Healthcare-seeking is not a simple human behavioral nature. According to many studies it is seen that the choice of care depends upon the distance to facility, the cost involved for it, and the quality of care. Healthcare-seeking can also depend on illness-related factors, such as severity or nature of morbidity. Many studies also suggest that socioeconomic status is not a barrier to the use when sufferer realize that the benefit of service more than the cost. In spite of very well health service delivery system network with skill formal health care service provider's sick people visit informal health providers mostly in the rural areas. The informal health provider includes paraprofessionals, community health workers, rural medical practitioners, drug store salespeople, traditional healers (kabiraj), traditional birth attendants, homeopaths etc.

This study was carried out in a village to see the wisdom, nature, and behavior of villagers to received health care services from informal health care service providers. The village "NamaSutrapur" located in Sutrapur union, Kaliakair upazila, Gazipur district peripheral to capital (Dhaka city) was selected for the study. According to the population and housing census 2011, the area of the Sutrapur union is 3,869 acre. There is a total of 5,487 households in the union. The total number of population in this union is 25,089 which include 12912 males and 12177 females. The average literacy rate of the population of that area is 54.7%. For males, it is 59.3% and for females, it is 49.9%. According to the organization registry of the Ministry of Health and Family Welfare of Government of the People's Republic of Bangladesh, there are total 45 health organizations including one Union health center in Sutrapur union. Still, villagers visit and received health care services from informal health care providers, so it makes a real challenge for health protection for peoples living in rural Bangladesh.

Having available opportunities for receive healthcare services from formal healthcare providers, villagers received services from informal health care providers like RMP, Drug sellers, Ojha and Kabiraj. The aim of this study is to see, which type of health service provider people choose for themselves when they become sick. As they take health care from non-qualified informal health care provides their disease burden not only increase but also worse. Cure or healing of sick person generally not happened. The result of this health protection for citizens of developing countries like Bangladesh especially villagers become a great challenge for policymakers.

Receiving healthcare from the qualified formal healthcare provider for acute and chronic diseases could get an accurate required proper guideline of the treatment protocol. That makes sure of reducing disease suffering; cure and healing from disease and can prolong life. That assist sick person leads a quality life by reducing the probability of disability and burden related to suffering disease (DALY, QALY). And economic productivity also ensures according to disease suffering from. So taking health care from the informal health care providers this can be avoided. As it may push them in a vicious circle of poverty in the long run due to receive treatment for worse health condition later from formal health care service providing facilities.

The objective is to know for what type of disease people receive or seek health care services from informal health workers. To know the socio-economic condition of the people who visit informal health workers.

For study purpose informal healthcare providers were considering as follows; the informal health care provider is categorized into the following group: community Health workers, unqualified allopathic providers, homeopaths, traditional healers (kabiraj, ojha), non-secular faith healers, traditional birth attendants, drug store salespeople, village doctors, Para-professionals etc.

Community health workers (CHWs) are those who work in both the public and the non-governmental organization (NGO) sector. Who work along by giving knowledge about preventive health care by raising awareness among the village women, children, teenage girls, and eligible couple.

Unqualified allopathic providers are village doctors and drugstore salespeople/drug vendors. The village doctors are also known as rural medical practitioners or PalliChikitsok.

Traditional healers, called Kabiraj, whose practice is based on diet, herbs, and exercise. They are mostly self-trained.

Traditional birth attendants are both trained and untrained providers who provide home-based delivery services. Mainly unskilled village women are recognized for this delivery system.

Homeopaths are those people who mostly self-educated, but some possess recognized qualifications from the government or private homeopath.

Non-secular faith healers, use sanctified water, oil for treatment of the patient.

Finally, the most important category of informal health worker is village doctors and drug sellers who have short training on some common illness, people also reliance on them in case of availability and financial satisfaction.

To provide medical treatment or exact medical advice informal healthcare providers does not have minimum required medical knowledge. But they are choice of provider for the poor especially for the rural people. In a study, it has been seen that the traditional healers (43%), traditional birth attendants (TBAs, 22%), and unqualified allopathic providers (village doctors and drug sellers, 16%) emerged as major providers in the health care scenario of Bangladesh. Community health workers (CHWs) comprised about 7% of the providers. The TBAs/traditional healers had less than 5 years of schooling on average compared with 10 years for the others. The TBAs/traditional healers were professionally more experienced (average 18 years) than the unqualified allopath (average 12 years) and CHWs (average 8 years). Their main routes of entry into the profession were apprenticeship and inheritance (traditional healers, TBAs, drug sellers), and short training (village doctors) of few weeks to a few months from semi-formal, unregulated private institutions. Their professional knowledge base was not at a level necessary for providing basic curative services with minimum acceptable quality of care. The CHWs trained by the NGOs (46%) were relatively better in the rational use of drugs (e.g. use of antibiotics) than the unqualified allopathic providers. It is essential that the public sector, instead of ignoring, recognize the importance of the informal providers for the health care of the poor. Consequently, their capacity should be developed through training, supportive supervision and regulatory measures so as to accommodate them in the mainstream health system until constraints on the supply of qualified and motivated health care providers into the system can be alleviated.

Drug retail shops are often the first and only source of health care outside the home for a majority of poor patients in developing countries like Bangladesh. According to an estimate, there are about 80,000 unlicensed drug stores in the country. Also, 70% of household out-of-pocket expenditure on healthcare is spent at drug shops in Bangladesh. Irrational use of antibiotics and polypharmacy are the most common problems found with drugstore salespeople.

Unqualified allopathic providers are village doctors and drugstore salespeople/drug vendors. The village doctors (also known as rural medical practitioners) mostly received short training (from a few weeks to few months) on common illnesses/conditions from semi-formal private institutions which are unregistered and unregulated and do not follow a standard curriculum. A negligible proportion of them received 12 months training from a short-lived government-sponsored program in the 1980s (PalliChikitsok training program after the model of barefoot doctors in Mao's China). Traditional healers are called Kabiraj, whose practice is based on diet, herbs, and exercise. They are mostly self-trained, but some may have training from the government or private colleges of Ayurvedic medicine. The majority of the village doctors and the homeopaths had some kind of semi-formal training spanning from a few weeks to a few months, the traditional healers entered the profession mainly through apprenticeship and inheritance latter experience gained from selling medicines at drug shops. The Community Health Workers were found to be relatively better in the rational use of drugs. This cadre of health workers has been increasing in size since the 1990s, with the expansion of both the government health system as well as the NGO network in the country. Regarding folk practitioners (faith healers of different types), it can be said that their strength lies in 'healing' patients rather than 'curing' them, i.e. giving meaning for bio-medical events rather than controlling them.

Method and materials: According to the population and housing census 2011, the population of the "Sutrapur" union is 25,089. But it is not possible to interview all the people or to visit each and every household for interviewing. A random selection of people will be taken for interviews. This will be a survey because the interview will be taken by visiting the households.

During the data collection period, 37 households were visited. The total of 163 people was taken. Among those 81 was male and 82 was female. There was two paras in the village. One known as "Majhi Para" located beside the river "Bangshi". Another para is quite developed than the "Majhi Para". This is mainly known as a central Sutrapur village.

A structured questionnaire was prepared and used for data collection by visiting the household and interviewing them. Also, secondary data was required for this study. The secondary data was collected for the BDHS website. The population and housing data were taken from the population and housing census 2011.

The primary was collected by visiting the households and interviewing them. The face to face interview of the household members was taken for the data collection. Also, an in-depth interview of the elite persons and the social leaders of the village were for the study. In case of secondary data previous research on this topic was taken. Also, different useful data from different authentic websites was taken.

This study was conducted that reiterates the importance of informal sector providers in the health care scenario of Bangladesh, as has also been observed by. However, there is a lack of knowledge about this large body of practitioners who are the major providers of healthcare to the poor, especially in rural areas. Findings from many studies reveal that the majority of these providers lack the necessary training and capacity to provide basic curative services rationally.

In two para of the village 37 households were visited. A total of 163 people were interviewed among them 81 were male and 82 were female.

Result:Regard literacy level it was seen that 45 complete primary education. 56 people were completed in secondary education. Only two persons have higher education. And most of the persons are not educated. The number of illiterate persons is 55. 34% of people were illiterate, 30% and 35% of people were completed primary and secondary education. Finally only 1% respondent complete higher education.

The age of 163 persons was divided into four groups. Age belong to 0-15 is group one, group two includes age between 16-30 years, group three includes age between 31-60 years and the last group include age above 60 years. It was seen that in the first group that is the group include age between 0-15 years, there are 54 persons. In the second group which includes age between 16 -30 years, it was 45 persons. 57 persons include in group three that consisting of age between 30-60 years. And in the last group which includes 60+ age was only 7 persons.

Income of study population was taken. The highest income of the household was seen 60000 takas. The reason for this high income is a member of this household stays abroad for job purpose. The lowest monthly earning was seen in 7500 takas. There was two households who didn't have any monthly income. They live hand to mouth. For them, their monthly income is considered equal to the lowest household income that is 7500 taka.

The income was divided into three groups. Income consisting of 0-10000 taka are in the 1st group and considered as a low-income group. Income having BDT 10001-30000 are in the middle-class group. And income having more than 30000 takas are considered as an upper-middle-class group. A number of people include lower income group is 22. 119 people are in the middle-class group. And 21 people are in an upper-middle-class group.

Here the bar chart beside revealed that upper-middle-income group people usually received healthcare advice and treatment from drug seller. Other low and middle-income group people visit kobiraj, homeopath, RMP, and drug sellers also. Among them, middle-income group people mostly take healthcare services from informal health care providers (kobiraj, homeopath, RMP and drug seller).

Regard the time interval for visit informal providers shows 89 people visited informal healthcare service providers without having any health problem. With present or recent (hours to few days) health problem 18 people received healthcare services from informal healthcare providers. Likewise suffering from any kind of health-related problem from three to six weeks 10 people consult informal healthcare providers.

Similarly, peoples suffer from less than six months and less than one year consult and received healthcare services from informal healthcare providers was 12 and 19 respectively.

It can assume that not only the underprivileged illiterate low-income group people but also literate middle and upper-middle income groups of people also take consultation advice and healthcare services from informal healthcare providers. Furthermore, data revealed that all group of people visit informal providers suffering from any of health problems or even no problem at all.

There is a total of 82 females among 163 persons. Out of this 82 females, 7 females went to kabiraj to seek health care. Basically only the persons who live in the majhi para(study village) visit to the kabiraj. Due to the high wind flow beside the river, the people occasionally suffered from cold and fever. They term as this disease is “Batsah Laga” (it is actually viral infection but people's perception is disease from supernatural wind blow). Mainly they go to kabiraj to be cured of this disease. And Kabiraj does not charge money from the people. H gives healthcare services for free. In the case of males, there were 81 males in a total of 163 people. Only 2 male seek healthcare from the kabiraj.

Among 81 males 2 were seen who have gone to Homeopath for seeking health care for their health problems. In the case of a female, it is seen that only one went to a homeopath for seeking health care for their health problem.

The case for seeking health care is somewhat better than homeopathy. It was seen that among 81 men 6 went to seek health care from RMP within last 1 year. Among 82 females 5 went to

RM to seek health care in last 1 year. Now we come to the case of a drug seller. Among 81 men 6 were seen who took health care from the drug seller within last year. They told that they bought drugs from the drug seller according to the previous experience of suffering the disease. Sometimes he uses the old prescription to buy disease from the drug seller. In the case of females, it is seen that a total of 3 women went to seek health care from the drug seller among 82 women.

It is seen that, 12 people whose age between 0-15 years visited Kabiraj. 2 person whose age is between 16-30 years and three having 31 to 60 years old visited Kabiraj. The number of persons whose age is between 31-60 visited Kabiraj. And none was found from age group four that is of whose age is above 60 years was seen visiting the Kabiraj. Sixty plus people not ever visit kobiraj and homeopathic but non significant number visit RMP and drug seller only. Seven, six and ten number of people having zero to fifteen years old received healthcare services from homeopathic, RMP and drug seller. Negligible number from 16 to 30 and 31 to 60 age group people visit homeopathic service providers.

Similarly, a few numbers of people from 16 to 30 and 31 to 60 take healthcare services from RMP and the number is 3 and 6 only. Data revealed that irrespective of the age group all were consul and received services from drug sellers. From zero to sixty years old people were take treatment and advice from drug sellers. And the client number is almost the same that is 10, 09 and 10 persons. It is due to drug sellers were always in touch of medical representatives, so they have the latest update regards new coming medicine and applications of medicine. This is very alarming as without any diagnosis of drug sellers providing medicine to their clients without knowing the compliance and completion of a full dose of medicine given. For this initiative, patients feel good health and perceive satisfaction to respected drug seller but germ may remain hidden result late patient suffer more. Another problem for this practice is some medicines did not work for those specific patients who received irregularly frequently.

Besides the pie chart showing the percentage of informal healthcare providers, those clients were choice for received treatment and advice for any kind of health-related problem even no problem at all. Fifty-five percent of clients were choice kobiraj for them. They are mostly from the Majhi Para and they are a fisherman in the profession. As they live beside the river due to cold wind flow sometimes they suffer from cold and fever. So they generally take health care from the Kabiraj who stays nearby. The Kabiraj charges no money from them for the treatment. The most probable cases of their cold and fever can be a viral fever. Usually, viral fever cured within one week without human intervention. Likewise, 24%, 15%, and 6% healthcare services were given by drug seller, RMP and homeopathics respectively.

In FGD respondents revealed that for female their spouse usually takes medicine from the pharmacy. Generally burning urination, whitish vaginal discharge, contraceptive, abdominal ache, and abdominal discomfort. For children's age, one month to four years usually mother along or mother with mother in law or grandparents take them to providers for medication. They are satisfied with the services they get from them. The reasons behind this they said; providers were very apathy, listen to them with patience, give them enough time, no questions of waiting time were required, they can get service even free of cost. Few were said they can take medicine with due payment so they can get medicine any time that is with or without cash payment. With the request, informal providers send then to visit a medical doctor and sometimes they go along with the patient.

Conclusion and recommendation: The human resource related problems are complex and rooted in political, economic and cultural factors. Solutions to these problems must be worked out at the local as well as at the national levels and must involve the public and private sectors, health professionals' organizations and community

leaders. Human capital should aim at appropriate quantity, mix and distribution of quality workforce across health services. To ensure such a balance, it will require continuous monitoring, careful choices between the population's health need and reality, and evidence drawn from health research. The existing alternative initiatives for minimizing human resource gaps, viz., training of female community health workers to serve as skilled birth attendants, building national capacity not only for control of emerging and re-emerging communicable diseases but also prevent the rising rates of non-communicable diseases. To avoid losing patients informal healthcare service providers used allopathic medicine to supplement their treatment and maintain the practice. However, improving the quality of traditional medicine through institutional training, registration and licensing so that practitioners are dependable may reduce the cost of therapeutic care. To increase the knowledge and capacity of these informal providers regard the rational use of drugs (especially antibiotics), education and training can play a key role.

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