Non-professional health practitioners and referrals to facilities: lessons from maternal care in Bangladesh

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Over half a million women in the developing world die of pregnancy and childbirth related causes each year, despite well-known interventions to manage most maternal complications. One problem facing policy makers is that women in low-income settings often seek care from a range of non-professional sources when they have trouble with pregnancy and childbirth. Questions remain as to the best way to engage with such providers to encourage use of professional care, in part because little policy-oriented research has attempted to study the roles of non-professional practitioners, and the specific situations which can encourage or discourage referral behaviour. This paper investigates the roles played by alternative health practitioners in referral to facilities for maternal care in Bangladesh. In-depth case studies were used to investigate labour experiences, decision-making processes and the roles played by key individuals in deciding to use professional services. Findings show that the commonly used heading of ‘traditional birth attendant’ is often too broad for programmatic use, as it encompasses a range of individuals with different reasons to work with, or oppose, professional services. It was found that women seek care from multiple non-professional cadres who each have differing services, scopes and linkages to professional care. Policy makers need to understand the roles of different providers and potential links to professional care which can be built upon to encourage the use of professional emergency care for maternal complications in low-income settings.

Keywords Maternal health, skilled attendance, traditional birth attendant (TBA), alternative providers, referrals, Bangladesh

Key messages
• A multitude of types of non-professional practitioners can play roles in decision making for maternal health care, with the commonly used heading of ‘traditional birth attendant’ often too broad for programmatic use.
• Some non-professional practitioners may actually encourage referral of labouring women to professional facilities. The incentive structures to support or oppose referrals in specific contexts must therefore be addressed by planners wishing to engage with alternative providers to improve maternal care.

Introduction
Every year over 500,000 women die from pregnancy and childbirth related causes, with 95% of these deaths occurring in Africa and Asia (WHO 2005a; WHO 2005b). Of all comparative development indicators, risk of maternal death...
shows some of the greatest differences between rich and poor regions (Paxton et al. 2005), with women in some low-income settings facing over 100 times the lifetime risk of maternal death compared with their counterparts in the West (The Panos Institute 2001). Reducing maternal mortality has been enshrined as one of the Millennium Development Goals (MDGs), with Goal number 5 being a 75% reduction in maternal deaths by 2015 (United Nations 2000). Yet of all the health-related MDGs, there has been the least progress in this goal (UN Millennium Project 2005). This is despite the fact that most maternal deaths are easily avoidable with well-known interventions that have existed for decades (McCarthy and Maine 1992; WHO 1994; WHO et al. 1999). The challenge facing health systems in countries with a high burden of maternal death is not learning what is needed to save mothers lives, but establishing a pattern of access to effective professional services which can identify and treat life-threatening maternal complications when they arise (World Bank 1999; UN Millennium Project 2005).

The international community has in recent years placed emphasis on two strategies for maternal health promotion internationally: use of skilled birth attendants—which is the main indicator suggested to monitor progress towards achieving the maternal health MDG (United Nations 2000)—and the establishment of emergency obstetric care facilities to manage severe complications (Graham et al. 2001; Ronsonsma et al. 2003; Hussein et al. 2004). Yet while the importance of improving emergency services is not disputed, it is also well known that in many low-income settings, engagement with professional medical services is rare, and women may consult alternative health practitioners for pregnancy and delivery problems. In such contexts, policy development to promote use of professional services must also engage with the roles played by multiple providers. This paper uses a case study of health facility users in rural Bangladesh to understand these roles, particularly when they act to encourage or discourage the use of professional care for problems of pregnancy and childbirth.

The decision-making process around delivery care in low-income settings is typically presented as a choice between using a medical professional or a generalized category of ‘traditional birth attendant’ (TBA). In Bangladesh, as in many low-income countries, there are multiple health practitioners providing services, support or decision-making advice around pregnancy and childbirth. While some of these practitioners operate independently, others may have links to formal health systems, with possible financial incentives for referring women to professional care. TBAs are only one type of non-medical provider influencing the decision to seek professional care, and the term ‘TBA’ itself encompasses a range of individuals with differing incentives for referrals. Through an in-depth qualitative study of one group of women in rural Bangladesh, this paper helps to understand the ways non-professional cadres may influence decisions to seek professional maternal care, and illustrates some of the key situational factors which can play important roles in these decisions. It can guide further context-specific investigations, but also illustrates a number of questions many policy makers will need to ask when deciding how to engage with non-professional providers to promote maternal health in similar pluralistic medical settings.

Background

Bangladesh is a low-income country which has a widely distributed health care infrastructure reaching down to the village level, but with limited financial and human resource capacity. There is low utilization of health services, including maternal health care services, and the country faces a high maternal mortality ratio (MMR). Estimates vary, but the official government figure is 322 maternal deaths per 100,000 live births in 2001 (National Institute of Population Research and Training et al. 2003), with an adjusted United Nations (UN) estimate of 380, corresponding to a 1 in 59 lifetime risk of death from maternal causes (UNICEF et al. 2004). It is commonly understood that one of the contributing factors behind these high rates is a very low use of skilled attendance at birth. According to the 2004 national Demographic and Health Survey, only 9.3% of women give birth in a health facility, and 13.2% of births were attended by a doctor, nurse, midwife or paramedic (National Institute of Population Research and Training et al. 2005).

As such a vast majority of women in Bangladesh attempt to deliver their children at home, this can place them at high risk for adverse maternal outcomes, including maternal death if it delays them from reaching appropriate emergency care (Thaddeus and Maine 1994). Utilization of professional maternal care facilities in Bangladesh has been found in the past to be highly correlated with complications of home labour (Paul and Rumsey 2002), but there are a number of known barriers to utilization of professional services. These have been previously described and include distance to health centres, lack of transportation, high costs of services and perceived low quality of care in facilities (Goodburn et al. 1995; Nahar and Costello 1998; Rahman 2000; Afsana and Rashid 2001; Afsana et al. 2004). Anthropological studies further illustrate how visiting facilities can be seen as problematic in Bangladeshi communities due to social regulations such as the isolation of women, stigma of being seen by strangers and men, or the expectations of women to endure childbirth without asking for help (Blanchet 1984; Afsana and Rashid 2000).

Bangladeshi women have been found to pursue multiple health care paths, with biomedicine one of several options available to them (Paul 1983; Bhardwaj and Paul 1986). At crisis moments, when facing complications at home, women and their families often call on the services of alternative health practitioners, who may play important roles in the decision to seek professional medical care, and whose opinions may extend or reduce the delay in reaching a facility.

Claquin (1981) identifies seven categories of healers outside the public sector in Bangladesh in general, which are:

- Private professional (MBBS) allopathic doctors;
- Unqualified allopathic practitioners;
- Homeopaths;
- Ayurvedic or Unanic practitioners;
- Traditional midwives;
- Spiritual healers;
- ‘Others’.

The World Bank has also assessed the extent of private sector health provision in Bangladesh, with discussion of what are termed ‘alternative private practitioners’ (APPs), under which it
appears to include unqualified allopathic practitioners and spiritual healers. The report states:

It has long been recognized that APPs provide the majority of health care in Bangladesh, particularly in rural areas. APPs are also becoming more organized, forming their own professional associations in local areas. Despite the dominance of these types of providers, relatively little is known about the actual number of the different types of alternative private providers, the types of practices they have, or how their behavior can be influenced.

(World Bank 2003: p. 9–10)

More recently, Sen and Faiz (2004) estimated there to be 110,000 unqualified allopathic and 173,000 ‘traditional’ practitioners (including Unanic, Ayurvedic and homeopathic practitioners) in Bangladesh, compared with a total of 117,000 qualified professional practitioners (including doctors, nurses and midwives).

Claquin has argued that, as private healers play a large role in care provision, they could be involved in health care improvements, such as better childbirth practices. Others have argued that it may be worthwhile to encourage TBAs to refer women for emergency care in Bangladesh as they are the primary source of care sought for delivery (Chowdhury 1998). Yet these calls stand in contrast to recent shifts in thinking in the maternal health field, away from efforts to engage with TBAs. Calls stand in contrast to recent shifts in thinking in the maternal health field, away from efforts to engage with TBAs.

...The questions on the potential roles of alternative providers, and reasons they may have to refer women to facilities, remain unsolved. International organizations recommend some form of engagement with non-medical providers, but appear ill-informed on how to go about this; while training courses rarely engage with the complex roles alternative providers play in decision making. Much confusion is due to a lack of investigation of the roles and situations of these providers which can help guide policies to engage with them. In Bangladesh, it is a national priority to increase skilled attendance (Bangladesh Ministry of Health and Family Welfare 2001), and the government is training new health workers specifically for this. Yet increasing the proportion of women attended by professionals will be a slow process, and with 87% of women currently delivering without such an attendant, it will remain important to understand how these women might be referred to professional care if they face delivery problems at home.

Methods

As part of a larger study on the use of professional maternal services in Bangladesh (Parkhurst and Rahman 2005), 30 qualitative interviews were conducted with women who recently gave birth in a professional medical facility. The choice to select women who had delivered in facilities arose from the fact that most past work looking at norms of delivery has focused on women who have delivered at home without professional attendance. Such studies often resulted in simple lists or descriptions of potential barriers to facility use. To understand the processes by which barriers are faced, and may be overcome, it was felt necessary to learn how some women (even poor women in remote areas) are able to use facilities. It was hypothesized that there may be particular enabling factors which influence decisions to use services which could only be explored by interviewing facility users. The interviews conducted were open in format, probing for a detailed narrative of the delivery process, including information on decision-making processes and the roles played by different individuals leading up to the use of a facility.

The interviews took place in Jhenaidah district—a rural district in the south-west of the country—with women who delivered in the previous year at a health centre. Women were selected purposively from facility registers, with the sole selection criteria being the area of the district in which they lived, so as to achieve a geographic spread across the district (the fieldwork team were not from the local area and did not know any of the interviewees personally). The principal reason for choosing women from across the district was to avoid the possibility of sampling only women who lived close to facilities, who may be of particular social or economic status. This could have occurred if names were selected at random from registers, as often the rate of use of health facilities drops with distance from facilities. The respondents selected were between 16 and 35 years of age. All women were married, and only one had employment outside of the homestead. Education levels ranged from no formal education \( (n = 10) \) to some secondary \( (n = 8) \), with one woman having complete secondary education.
Interviews were conducted primarily in subjects’ homes, in Bangla, by Bangladeshi researchers who were trained by the authors before commencing the field work. Tape recorders were not used due to the sensitivity of the topic and to reduce anxiety of respondents. Interview reports were written up in English in the form of case studies, documenting the woman’s delivery experience. Once completed, the case study reports were theme-wise coded and analysed with assistance of the NVivo qualitative analysis software package.

Results
In 22 out of the 30 cases, the respondent attempted delivery at home in the first instance. For these women, health facilities were only reached after home delivery did not progress as expected and problems were perceived. In such situations, women and their families typically sought help from a range of healers to manage the difficulties faced, before finally visiting a health centre. These cases allow an exploration into the specific choices between healers, and the roles those healers played in the decision to seek care.

A multiplicity of healers
Case reports identified four basic categories of healers providing services for pregnancy and childbirth, categorized as follows:

1. **Herbalists/spiritualists**: These provided herbal and spiritual items to prevent or treat ailments of pregnancy and childbirth. Included were those referred to as Kabinaji (traditional herbalists who were found to also provide spiritual remedies), Fakir or Maulavi (traditional holy men providing spiritual remedies).

2. **Homeopaths**: While homeopathic medicine was understood to be foreign in origin, homeopaths consulted were based in the communities and seen as an appropriate local source of care in many instances.

3. **Traditional birth attendants (TBAs)**: These were most commonly used by women, but the term could refer to a wide category of individuals, from family members who assisted a few deliveries per year, to non-relatives who conducted delivery as a profession.

4. **‘Village doctors’ (Pallichikitshaks)**: These were unqualiﬁed practitioners based in the community who purported to practice biomedicine. These correspond to the ‘unqualiﬁed allopathic doctors’ identiﬁed by Claquin (1981) and the ‘alternative unqualiﬁed allopathic providers’ described by Sen and Faiz (2004).

It was common for family members to visit some kind of herbalist or spiritualist before delivery for a protective amulet or item. At times, spiritual remedies were also sought during labour, but it was typically a family member visiting a spiritualist to collect some remedy—oil or holy water, for instance—to apply to the labouring woman. In only one case did a woman explain that she was taken to see a spiritualist (who was a neighbour) while in labour (IDI#11), and in one other, a spiritualist was brought in to attend to a labouring woman (IDI#26). In both cases, the woman reported the spiritual treatment to be ineffective, leading to seeking advice from other types of healers.

Homeopaths were found to serve similar roles in providing treatments during pregnancy, but they were not found to have any contact with women during labour. They were usually consulted earlier in pregnancy, with one woman reporting receiving ‘antenatal care’ from a homeopath (IDI#10). As with spiritualists, family members would sometimes visit homeopaths to bring treatments back to women. In these roles, spiritualists and homeopaths were found to play minor roles in decision-making processes during delivery, and had little input into the decision to visit a health facility, apart from indirectly by presenting an alternative source of care when problems were perceived.

**TBAs and pallichikitshaks**
Instead, it was TBAs who were found to primarily attend delivery at home, and the so-called ‘village doctors’ (locally called pallichikitshaks) who were commonly brought in when problems were faced in home delivery. These individuals were often looked to as experts on delivery or complications. Pallichikitshak opinions were particularly respected, and their recommendations followed even when key family members were opposed to using professional services. Excerpts from two cases are given below to illustrate how these providers were regarded. (NB: Case excerpts have been edited only for obvious spelling and grammatical errors, but otherwise have been left as close to the original reports as possible. All names have been changed/removed.)

[after a TBA failed to conduct delivery overnight]...a village doctor, a distant uncle of the respondent was called. The village doctor consulted with the TBA...and told the respondent’s father that there was little chance of normal delivery...He advised [them] to shift the respondent to [a private clinic] for delivery. The father of the respondent and other members of the family were illiterate and had no idea about pregnancy or delivery. They considered the advice of the village doctor as the best one...
(IDI#6: 18 years old, first pregnancy, Muslim, some primary education)

*When the labour pain started, the respondent’s uncle (a pallichikitshak) took the decision to conduct the delivery at health centre X. The respondent’s husband and mother-in-law opposed the decision. But after a mild quarrel between them, the respondent’s husband and mother-in-law agreed to the proposal.*
(IDI#11: 16 years old, first pregnancy, Muslim, some secondary education)

Women who mentioned having a pallichikitshak attend their delivery provided surprisingly similar accounts of these practitioners’ roles in referral to health facilities. In all 10 interview cases where a pallichikitshak was called on, the healer actively supported the decision to use a facility. This decision could be made unilaterally by the pallichikitshak, or with consultation of attending TBAs. Pallichikitshak’s opinions appeared to be valued above those of TBAs in matters of managing complications, and they were typically called on after a problem with the labour was perceived. In only one case did the family not act on the recommendation of the pallichikitshak until other
influential individuals from the family and community also pressed them to take the woman to a facility (IDI#26).

Women’s explanations of the roles of TBAs in referral to facilities were much less consistent than those describing the roles of pallichikutshaks. Some TBAs did encourage use of facilities when problems arose and there were cases where TBAs accompanied the women to the facilities. But there were also four cases of facility use where TBAs opposed taking the woman to a professional facility. In one case, the respondent explained that it was in the TBA’s personal interest to conduct the delivery herself, but the opinion of a pallichikutshak ‘foiled’ her plan, illustrated in the following excerpt:

_The village doctor examined the respondent and advised to take her to health centre Y. But the respondent’s mother called in a birth attendant who opposed taking the respondent to the service centre. She said that the delivery would take place at due time. When the village doctor was again called in, he expressed his anger for not taking the respondent to the health centre and asked to take the respondent to health centre Y immediately. After that the respondent’s mother decided to take the respondent to health centre Y as per the advice of the village doctor._

(IDI#24: 16 year old, first pregnancy, Muslim, primary education)

Differing referral behaviour of TBAs may reflect the fact that a number of distinct sub-categories of individuals can be classified under this heading. Three types of TBAs were identified from women’s interviews. The first type was older relatives who do not perform many deliveries, and do not receive payment for their help. Second were ‘village’ TBAs, seen as more professional and consisting of local non-relatives who most likely earned some form of income or received gifts for undertaking deliveries. Finally, in two cases, women made a distinction between TBAs and officially ‘trained’ TBAs, indicating some further hierarchy in the concept (possibly trained by past government initiatives). The trained TBAs were seen as particularly skilled, and women mentioned how they could assist a regular TBA at times of difficulty. Understanding these differences between TBAs is important, as varying types may have differing reasons to promote or resist referral to facilities, and some may be more (or less) likely to convince family members of the need to seek professional care. Further study could investigate the specifics of these in particular locations, but there is clearly a need to look beyond a simplistic reduction of ‘TBAs’ to a single group, particularly when planning policies around engagement with them to promote skilled attendance.

Links to facilities

There may be a number of reasons for non-professional practitioners to refer women to facilities, which can be built upon in interventions promoting the use of facilities. In this study, several women described specific financial links between the pallichikutshaks they consulted and health facilities, illustrating that ‘professional’ and ‘alternative’ providers may, at times, have close relationships. Informal links to facilities were illustrated in a case of a 28-year-old woman in her fourth pregnancy (IDI#19). The woman explained that a pallichikutshak was specifically called in to accompany her to the facility, as he arranged services at health facilities through ‘under-handed’ dealings. Indeed, in her case, after a doctor in the public facility had advised the respondent for a caesarean section, the pallichikutshak negotiated with nurses to undertake a normal delivery in the labour ward for some payment from the family to the nurses (amount unspecified).

Some pallichikutshaks, however, have more formal links to facilities. One woman explained that the pallichikutshak her family consulted owned a private surgical clinic (IDI#18). She reported how he advised the family to take her to the clinic, and once there he phoned a professional (MBBS) doctor to attend the woman. Eventually the doctor arrived and recommended a caesarean delivery. Having an untrained healer own and run a private facility employing MBBS doctors appeared a surprising result at first, but other examples were found. Another woman, for instance, reported visiting a private clinic (employing medical doctors) named the ‘Palli Hospital’ which was owned by—and, indeed, named after—pallichikutshaks.

Discussion

There is a historical policy debate around engagement with TBAs as a maternal health promotion strategy, with questions remaining around whether or how such providers can be utilized. Yet while it has been commonly stated that TBAs lack the abilities to manage or treat complications, there has been much less discussion of the roles alternative providers may play in the referral process. Most literature discussing non-professional birth attendants falls into two traps: the first is to limit the understanding of these providers by lumping them under the generalized heading of ‘TBA’; the second is to assume that the only means to influence their behaviour is to provide them with education through training courses. This focus on training takes an overly simple view of the determinants of behaviour of these providers, ignoring how their actions may be shaped by a range of contextualized social and economic concerns. This work helps to illustrate how a variety of non-professional providers may play important roles in the decision-making process around the use of professional care.

Health roles of alternative providers

Policies to engage with alternative health providers in Bangladesh will require understanding their roles in the provision of health services in the country. However, some information is already available from past reviews. Sen and Faiz (2004) explain that ‘amongst alternative private practitioners, village doctors are the main source of services for the poor’ (p. 25). The World Bank (2003) further explain how (based on two local studies) village doctors ‘nearly always sell medicines… and the majority provide dressings’ (p. 10), with Sen and Faiz explaining that unqualified practitioners were found to treat a wide range of ailments, from diarrhoea, asthma and fever, to more serious conditions such as cancer and sexually transmitted infections. However, they also warn that quality of care ‘is widely perceived to be poor, and indeed in some cases dangerous’ (p. 24).

In terms of their training, the World Bank found that most alternative providers had no formal medical education,
although many had some ‘semi-formal’ training. It is further reported that one regional study found ‘a near unanimous interest among village doctors in working in partnership with the public sector’ (World Bank 2003: p. 11); and the government of Bangladesh also briefly sponsored a pallichikitshak training programme in the early 1980s (p. 605).

Most recently, Salim et al. (2006) reported on a programme to train village doctors in tuberculosis treatment. Village doctors collected sputum samples, referred suspected cases and provided directly observed treatment, with high levels of treatment success (around 90%). No financial incentives were used, and the authors hypothesized that the free training, increased prestige and recognition may have driven continued involvement by village doctors. As a result of the project they explain how village doctors have been included in national policies for TB detection and treatment.

Potential for maternal service improvement

Alternative providers are clearly widespread in Bangladesh, and have been engaged with by government in the past. There may be potential, therefore, to consider the roles they might be able to play in increasing referral to professional maternal services, although this will require better understanding of the specific incentives and needs of each type of alternative delivery care provider. For TBAs who are older relatives of labouring women, these women may be more likely to admit their own skills limitations and encourage referral to a facility for management of problems. Yet, as family members, they may have a stronger interest in preserving social norms to deliver at home, which could act as a barrier to referral for care. As such, education through training to promote referrals may work for these groups, but only if social norms and stigma are addressed, possibly through group mobilization. For non-familial village TBAs who use deliveries as a means of financial support, there will clearly be economic incentives opposing referral of women. Simple education messages cannot address these issues, and further investigation may be needed to develop interventions which maintain their prestige or financial incentives while enabling them to refer complicated cases to facilities. For any TBA training, however, clearly the content of their training will be crucial. Training should not expect TBAs to manage complications, as past evidence has shown this approach does not improve outcomes and may, in fact, increase the delays faced in seeking help for complications. Instead, recognition of complications and knowledge of referral procedures should be emphasized.

The cases of pallichikitshaks described by interviewees are particularly illustrative of how specific incentives may exist for some alternative providers to support the decision to use a health centre. It may be that, unlike TBAs, these providers do not specialize in deliveries and so may feel less confident in managing delivery problems. But additionally, and again in contrast to TBAs, pallichikitshaks often present themselves as practicing western medicine. As such, visiting a facility may, in fact, build their legitimacy by appearing to be part of the medical establishment. A few cases also illustrated how some pallichikitshaks can have links to health centres through personal relationships or ownership of private clinics. These can provide clear financial incentives to refer women for medical care, although it should be noted that the use of private facilities can involve high charges for services, with such facilities found to specialize in surgical deliveries (Parkhurst and Rahman 2005). It is unclear, however, if TBAs in this area of Bangladesh have similar links to facilities, or what proportion of pallichikitshaks have such links to professional facilities.

Study limitations

There are some limitations to this study which must be acknowledged as well. First, the narratives of village doctors described above were obtained by sampling users of facilities. There may be many village doctors who convince women to deliver at home, but whose roles were not identified due to the sampling frame. However, the importance of their opinions to families, and the supportive role played by those described in included cases, remain new and relevant findings. Little past work has been done to elaborate on potential roles of these providers in delivery care, possibly due to assumptions that TBAs are the only relevant alternative providers for such services.

In addition, it is accepted that there are limitations to data when translating between languages and by having interviewers write up case notes, in particular for obtaining the subtleties and nuances of interview communication. This was controlled to some extent through training of fieldworkers and piloting of methods. In addition, the fieldwork team met with their field coordinator each evening to review notes and cases of the day. As it was the narrative sequence of events of women’s experiences which were of paramount importance (as opposed to emotional responses, for instance), these limitations were seen to be acceptable.

Conclusions

In many countries a large proportion of women attempt delivery at home in the first instance. Many of these women will develop complications and engage with alternative healers in a process that may or may not end in receiving professional care. Simply dividing women’s health care options between western medicine and ‘traditional’ healers limits our understanding of the roles that alternative practitioners can play in these crucial decision-making circumstances. This study investigates the range of alternative practitioners available to women and families in Bangladesh, and engages with how some of these practitioners may influence women’s utilization of professional delivery care. It further discusses some contextually specific factors which shape the behaviour of alternative providers. Future public health planning must recognize the variety of alternative practitioners consulted by families, the roles they may play and the incentives to which they respond. Only with such understandings can strategies of engagement be developed to promote the use of professional medical care and improve maternal health outcomes.

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