EDITORIAL

First-Contact Healthcare in Bangladesh: Time to Strengthen Primary Care and Rational Prescribing

Bangladesh is undergoing a rapid social, economic, demographic, and epidemiologic transition. This has put the country in a situation with a high burden of infectious diseases on the one hand, and the emerging burden of non-communicable diseases on the other (Government of the People's Republic of Bangladesh 2008; World Health Organization 2008).The journey that patients take before reaching a tertiary-level hospital often reveals important strengths and weaknesses of a healthcare system. In Bangladesh, where access to healthcare remains uneven and rural populations continue to face shortages of qualified healthcare professionals, understanding who provides the first point of care is essential for planning effective health services. The study by Mondal et al. in this issue of the journal offers valuable insight into healthcare-seeking behavior and prescribing practices among patients admitted to a tertiary hospital.

Like many developing nations, the informal sector provides the bulk of health care, particularly for the poor.1 Formal sector mostly with the public sector and a small proportion in the NGO sector. The formal sector providers included physicians, paraprofessionals and midwives. Informal healthcare providers were dominated by Traditional Birth Attendants (TBAs, with or without training), followed by traditional healers, Village Doctors, and homeopaths. Informal health care providers are a heterogeneous group of providers with differences in type of training, regulatory frameworks, and services provided, local governments tend to think of providers outside the formal sector as one group with little knowledge on the size and utilization of this sector.[4]The findings in Mondal et al. demonstrate that nearly half of the patients initially sought care from informal healthcare providers, while only a small minority accessed government primary healthcare facilities as their first point of contact. These observations are not entirely surprising. Informal providers have long occupied a significant place in the healthcare landscape of Bangladesh and many other low- and middle-income countries. They are accessible, affordable, and often available beyond conventional working hours and their close integration within local communities makes them a natural first choice, particularly for rural populations.

One of the most important observations of the study relates to antibiotic use. More than one-quarter of patients received antibiotics before presenting them to the tertiary hospital. Although registered physicians prescribed the largest proportion of antibiotics, informal healthcare providers and pharmacy-based providers together accounted for a substantial share of antibiotic prescribing. This finding has significant implications for antimicrobial stewardship efforts in Bangladesh.

There are three principal reasons for using Informal health care providers: convenience, affordability, and social and cultural effects. Compared to either the public or formal private sectors, Informal health care providers have flexible working hours and are likely to be open at all hours, more likely to have medicines in stock, generally geographically closer, and offer more rapid service. IPs may also accept in-kind payment when patients have no cash, A study in Bangladesh found that the median cost of treatment of visiting a formal physician was five and fifteen times higher compared to visiting a village doctor or traditional healer, respectively.3 However, other evidence from Bangladesh suggests that even when illnesses are serious enough to require multiple visits, IPs remain substantially cheaper than their formal counterparts.3 There is a gap in the healthcare need and available services from qualified providers. The authorities responsible for the public health system are aware of this issue and have failed to regulate the informal sector. It is important therefore, to acknowledge the important role of informal healthcare providers and promote mechanisms to engage with them to provide quality healthcare services to the communities.

However, the continued reliance on informal healthcare providers raises important concerns. While these

providers often fill a critical service gap, many lack standardized medical training and operate outside formal regulatory systems. Consequently, clinical decision-making may not always be guided by evidence-based practice or established treatment guidelines. The challenge for policymakers is therefore not merely to acknowledge the existence of informal providers but to address the structural deficiencies that make them indispensable to large segments of the population.

The findings reported by Mondal et al. should therefore be viewed not merely as a description of healthcare-seeking behavior but as an important policy signal. They remind us that healthcare utilization patterns are shaped by accessibility, affordability, trust, and system performance. Strengthening primary care, improving access to qualified healthcare professionals, enhancing regulatory oversight of medicine dispensing, and promoting rational antibiotic use should become national priorities

The formal healthcare facilities in the rural areas are inadequate for serving the population in their catchment areas. As health service is one of the constitutional rights of the citizen of Bangladesh, the nation must work to find ways to meet its obligation. It needs long term vision and commitment to create adequate number of physicians, nurses and other formally trained healthcare professionals to meet the needs of the people of rural areas of Bangladesh. In the meantime, we need innovative programs that engage both public and private healthcare providers as well as informal healthcare providers to ensure quality healthcare services for the rural people in general and the poor in particular.

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