Impact of BRAC on community health networks: A Village Study

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ABSTRACT

Mere health service provision may be unable to bring about the desired impacts on health outcomes. Such outcome impact is mediated by changes in health seeking behavior underpinned by changes in health knowledge, attitude and practice---variables which are socially embedded and transmitted through networks. BRAC, the largest national NGO in the world, in an effort to provide cost-effective and mass scale essential health service coverage in rural areas, makes use of locally recruited community health workers--*shasthya shebikas*.

This study attempts to describe the health network in a village where the *shebika* has been working for many years. It has tried to assess the past health network in the village and how the introduction of a *shebika* has influenced this network. It also examines the power and influence of the *shebikas* in a village, and how this influence has changed over time. The study finds that far from polarising the village between members and non-members the *shebikas* are actually consulted by a range of people. Thus it can be said that the health network in the village, which is dominated by the *shebikas* have created an inclusive health network of different NGO and non-NGO members. After ten years of BRAC's Mainstream Health Programme in the study village we found that the *shebikas* reached a large and inclusive group transcending social and wealth categories. This is even more encouraging in view of the fact that the *shebikas* come from the lowest wealth category. Though only six percent of the households did not visit any health practitioner at all, they were noted to include some of the poorest in the village, suffering from exclusion from multiple networks. Future research should explore the pathways through which such exclusions happen and the general interlinkages between health and other socio-economic networks.

EXECUTIVE SUMMARY

The overall objective of this study is to identify changes in community health networking relationships due to BRAC intervention. The study aimed to understand whether BRAC's ongoing commitment to poverty alleviation, through an equal distribution of knowledge and power in the society, has been effective in the health field. The study exploring power distribution within a village required in-depth study using qualitative methods.

This study attempts to describe the health network in a village where the s*hasthya shebika* have been working for many years. It has tried to assess the past health network in the village and how the introduction of *shebika* has influenced this network. It was hoped that by doing this the current and future role of *shebika* could be better understood in promoting not just the physical well-being of villagers but also their social well-being.

The study also attempted to answer some crucial questions about the role of BRAC's Mainstream Health Programmes and the introduction of the *shebika*. Have they been able to usurp the past discriminatory health networks in the village and replace it with a more inclusive one that is not biased towards the rich against the poor, towards men against women, towards BRAC-members against non-members?

The study shows that far from polarising the village between members and non-members the *shebika* is actually consulted by a range of people. Thus, it can be said that the health network in the village, which is dominated by *shebika* has created an inclusive health network of different NGO and non-NGO members. After 10 years of BRAC's Mainstream Health Programme in the study village it was found that the *shebika* reaches a large and inclusive group which transgresses social and wealth categories.

INTRODUCTION

Nanda (1987) describes 'networks' as a useful way to study social organisation in complex societies. Community networks place an emphasis on links between individual actors who share a part of their lives with other individuals in various situations. The emphasis is less on closed kin-based or corporate groups. Therefore, community health networks can be said to be the social organisation of health in a village.

The rural power structure in Bangladesh, as in many other societies, is organised to control the movements and even behaviour of villagers. Kleiman (1980) refers to the clinical consultation as a transaction which occurs between two parties who are separated by differences in power. This can be both social and symbolic power. It includes power-differentials based on social class, ethnicity, age or gender.

In many villages BRAC has introduced certain 'factors and resources'[1] to change this rural health power which divides clients from providers and concentrates health power to the wealthier segment of society. These health resources have included training and introduced a community health worker known as *shasthya shebika* to the village. Through human and skill development training, supplying materials, social mobilisation and raising motivation levels BRAC challenges the existing traditional and non-trained health power structure. The demand is for a share of that power to the *shebika*, who is usually a woman from a poor household.

Afsana et al. (2000) observed that poor rural women and the majority of traditional birth attendants belonged to a similar socioeconomic class. Mutual respect and familiarity with one another created a good horizontal relationship between them. This was found to be lacking in rural women's relationship with biomedical practitioners. Poor rural women and the *shasthya shebika*, however, share a similar horizontal relationship. This strongly suggests that the re-allocation of health power to include the *shebika* can help to extend this power to her clients through mutual respect which they share.

[1] Nanda (1987) refers to certain 'factors and resources' which can influence networks.

Studies carried out so far on networking relationships in BRAC villages have focussed largely on the role of village organisation (VO) members and the *shasthya shebikas* in these networks. A village level outlook analysing network relationships existing between BRAC and non-BRAC members and the change over time is a relatively new area of research.

Begum et al. (1998) incorporated this village level outlook in comparing health, social and economic network relationships in a village before and after BRAC intervention in Matlab upazila*. The study found that the number of female leaders (i.e. women that were consulted by individuals or families with regard to their social, economic or health problems) within the networks increased over the study time (1991-1995), with the exception of those in the health network. In 1991, no female leaders were mentioned in the economic network. However, in 1995 the same number of female and male leaders were found in this category. The study discovered BRAC VO members and NFPE teachers to be in leadership positions in the economic and social village networks. It was concluded that BRAC intervention had to impact on network relationship, and empowered women within these community networks. However, the study found that the impact on health networks was minimal, with only a few women maintaining leadership position.

Ahmed et al. (1998) found an increased use of qualified allopathic practitioners by BRAC member households compared to other NGO-members and non-members. This was explained as possibly due to both an increased proportion of household income available for expenditure on health and an indirect effect of health education and other Essential Health Care (EHC) inputs of RDP (which motivated them to seek 'modern medicine'). The study also discovered that 20% of ill persons did not seek any treatment at all, and 6-8% relied on home remedies. Two reasons for this were postulated: either they were not sick enough or they were not able to access health care of any sort.

Chowdhury et al. (1992) found that with the advancement of time, use of allopathic medicine was increasing. The highest allopathic treatment was recorded in the control study area followed by BRAC RDP intervention area, where BRAC health programmes were not included. The study also found that in the RDP intervention area prevalence of diarrhoea, and child mortality rate were higher, and EPI coverage was lower than in the control area. The study suggested that only RDP intervention, without health programme inputs, was not enough for considerable improvement in health status.

Similarly, in a survey carried out in an area where BRAC had been working for three years, Chowdhury et al. (1995) found very little benefits, if any, for members of BRAC's village health committees. The health network leadership was found to be in the hands of the wealthy and the elites. Immediate tangible benefits from BRAC were limited within this short time frame.

Afsana et al. (1998) found that BRAC had been successful in changing women's status, particularly that of the *shasthya shebikas*', by raising their position in society. The *shebikas* are now respected as doctors, particularly for their role in the treatment of TB and other common diseases.

The Study

This study forms part of the village level research component of the Third Impact Assessment Study (IAS-III) of BRAC's Development Programme (BDP). The previous two impact assessment studies focussed on the household and national levels. The IAS team decided that to understand whether BRAC's ongoing commitment to poverty alleviation through a more equal distribution of knowledge and power in society has been effective in the health field it was important to complement IAS-III with a village level focus. It is only through in-depth explorations at this level that dynamics of local level power can be probed into and re-distribution of power can be assessed. It was agreed that

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* Upazila is the lowest level of government administration.

a smaller research team would be formed to provide a more in-depth exploration of this using both qualitative and quantitative methods.

The study aimed to understand the nature and extent of the health network existing in the study village. Its focus was in understanding whether, through the introduction of BRAC's *shasthya shebika* (who belongs to the lowest wealth category), new networking relationships within the village have been created which transgress social and wealth boundaries. It also aimed to assess whether BRAC has merely succeeded in replacing social and wealth boundaries with those favouring BRAC members against non-BRAC members, or NGO members against non-NGO members. The findings from this exploratory study can then be used to measure impact in other fields including economic and social networking relationships.

The overall objective of this study is to identify changes in community health networking relationships due to BRAC intervention. The specific objectives include:

1) Identifying changes in health networking relationships between BRAC health providers and villagers (including both BRAC and non-BRAC members);

2) Identifying changes in health networking relationships between different wealth categories; and

3) Identifying changes in health seeking behaviour.

METHODOLOGY

The very nature of the study problem – exploring power distribution within a village – required in-depth study using qualitative methods. Information on individual health links between providers and clients needed to be gathered carefully through house-to-house and in-depth interviews. Participatory research techniques: Focus Group Discussions (FGD), Wealth Ranking, Time Line, and Social Mapping were used for this study.

Sampling

Programme impact at village level is a relatively new area of research. There is little existing research in this area. As such, determining an appropriate methodology was a difficult and challenging task. The study was conducted in a village in *Sadar upazila* of Jamalpur district according to the following criteria:

- Presence of *shasthya shebika* for more than five years;
- An active *shasthya shebika;* and
- Presence of alternative health options.

It is assumed that it took at least five years to get impact of any development programme. This study was conducted in a village where the same *shasthya shebika* has been working for over 10 years. BRAC Development Programme (BDP) has provided health services to this village since 1990. The study was also carried out in an area where the *shebika* is known to be very active, thus the potential for change could be assessed. An area with other practising health providers was chosen to assess the changing nature of the village health network and compare the status of health providers. Four other health providers were identified in the village.

As the study looked at network relationship at village level both male and female residents of the village comprised the study population. The study sample also consisted of all health providers. In-depth interviews were carried out with two *kabiraj* one is faith healer and another one herbalist, one homeopath, one unqualified pharmacist and

BRAC's *shasthya shebika*. Two focus group discussions (FGD) were held with above 50 years old men and women groups in the village. House-to-house interviews were conducted with the 96 client households, and 30 households outside the health network. Separate interviews were also conducted with current clients of *shebika*.

Data collection and analysis

Data were collected during October 2000 - February 2001. A selection of participatory research techniques was used. Wealth ranking exercise was carried out with villagers to define and determine the different socioeconomic groups within the study village. A timeline was also constructed to trace the various health inputs affecting the village. The timeline was used to gather a clear picture of the situation before BRAC's health inputs were introduced. FGDs were held with above 50 years old men and women groups in the village to assess the health service and behaviour of villagers before BRAC's RDP health intervention. At the beginning of data collection, social mapping was conducted to identify the households and to obtain a general picture of the village.

All current health providers were then identified. In-depth interviews were carried out with all providers. Each listed the names of all their clients, within the study village, who had visited them for treatment or health advice in the preceding year. This information was then cross-checked by home visits to all the listed clients. Non-clients were also approached through house-to-house visits to understand their health-seeking behaviour and their relation to the health network present in the village. The *shasthya shebika's* present clients were asked about their previous health-seeking behaviour to understand who they used to consult before BRAC intervention. This, along with the FGDs, gave us a clear idea of the past health network in the village.

Indicators in the study included network links between villagers in different wealth categories, and NGO membership including health links between providers and villagers.

Limitations

The study was conducted in one particular village in Bangladesh, where the *shasthya shebika* is very active in the community. In other areas the *shebika* may have differing involvement with community members. The findings from this study should therefore be used as a guide to possible impact at the village level. However, the study suggests that the *shebika* is placed in a unique position to bring about change through community networking relationship.

The study has also relied on villagers recalling the health scenario of 10 years ago to compare it with today's situation. Relapses in memory or inaccuracy should not be ruled out.

Village profile

Rupshi village in Jamalpur district consists of 162 households. It is located 16 km away from Jamalpur *sadar,* and 7 km from the main road. There is a private college in the village for both girls and boys, which started in the year 2000. It also has one NFPE[2] school, with three cycles of graduates. Another NFPE school is based in a neighbouring village, and has completed further three cycles. The nearest high school and primary school are 0.5 km away.

Rupshi also has a Family Welfare Centre (FWC), which has been running for 15 years. FWC is a union-based facility, and its location in Rupshi indicates the central significance of the village. Its services include ante-natal check-up, immunisation as well as treatment for children and mothers. There is also a nutrition centre in the neighbouring village which has been running for two years. It is part of BINP (Bangladesh Integrated Nutrition Programme) and is being implemented with assistance from BRAC. Services include growth monitoring of under-two children, supplementation for newly wed

[2] Non-formal Primary Education – these schools are run by BRAC Education Programme. Classes usually consist of 33 students and teachers are recruited from the local area. The curriculum and learning material is produced by BEP.

women, pregnant and lactating women and under-two children, as well as education related to health and nutrition.

The *haat* and *bazaar*[3] can both be found half a km from Rupshi. The *haat* sits twice a week. There are eight allopathic and two homeopathic pharmacies in this *bazaar*. The village has access to two rice mills in the *bazaar*. The nearest bank is situated eight km away. Thirty-four percent of households have access to electricity, which is also used in irrigation. The agricultural crops produced include rice, wheat, jute, mustard and vegetables (e.g. potatoes and pumpkin). Occupations for men include farming, vegetable selling, rickshaw/van driving, running shops, and some salaried jobs. For women occupations include paddy husking, *kantha* stitching, vegetable growing, chicken rearing, sericulture and domestic help. Wages for men in the agricultural sector varies from three meals a day plus 40 taka or wage in kind, to 60-70 taka plus three meals a day during the peak season.

The level of school enrolment for children between the ages of 5–15 years was found quite high. Ninety-eight percent of both boys and girls in this age group attended schools. Fifty-five percent of the households were also found to have their own tube-wells (this included one government tube-well), and 54% owned slab latrines.

Three wealth categories were recorded in the village (where 1 is the richest and 3 the poorest) as follows, out of a total of 162 households:

Category 1: 21 households (13%)
Category 2: 45 households (28%)
Category 3: 96 households (59%)

NGOs currently working in Rupshi include the Grameen Bank, Ansar VDP and BRAC. Fifty-two percent of the households have at least one member registered with one of the

[3] The *haat* is a market which usually sits once a week, and sells fresh vegetables, fish and meat. The *bazaar* is a permanent shopping area.

above NGOs. Within this group BRAC holds 23% of the members, Grameen Bank 13%, Ansar VDP 9%, and overlapping households amount to 7%.

Grameen Bank inputs

Grameen Bank started its work in Rupshi village eight years ago in December 1992. Types of loans given include general loan, seasonal loan, housing loan, cow-rearing and share-cropping loans. In addition, loans for four sanitary latrines were also disbursed.

Ansar Village Defence Party (VDP) inputs

Ansar VDP is an organisation founded in 1976. It works in three local *paras* which include Rupshi. Villagers, in addition to becoming members, can also become shareholders of this organisation. Ansar VDP's microfinance programme began in 1997. It has given over 200 loans in its working areas amounting to 10 Lac taka. The loan size varies from 5,000 to 15,000 taka, which can only be used for income generating activities. These activities include chicken and duck rearing, cow rearing, engineering workshop, clothes business, rickshaw and tempo. Ansar VDP also gets involved in mending local roads, personal conflict resolution, and raising awareness of family planning.

BRAC inputs

BRAC extended rural development activities in Rupshi in 1990 with two village organisations (VO) - one male and one female. Now there exists one female VO only. The programmes include general loans, housing loans, loan for tube-wells and latrines, loans for non-farm activities, fisheries, poultry, poultry for nutrition, sericulture, cow rearing, vegetable growing, trees, legal education, legal aid, health centre, IGVGD (income generation for vulnerable group development), agriculture and paddy husking, non-formal primary education, and BRAC mainstream health programme (BMHP). BMHP provides a selective combination of basic health interventions linked to rural development. The essential package of health services is delivered mainly through 32,152 village health volunteers called *shasthya shebika* (BRAC 1999). The *shebikas* are usually selected by mutual understanding between VO members of BDP and representatives of

BRAC (Islam 1992). Most of the *shebikas* are selected from BRAC VO members aged between 25-35 years who are married with a child not younger than five years, socially acceptable by the community, and eager to work (Mahbub, 2000). Educated women are preferred who do not live near a local health care facility (Khan *et. al.* 1998). The *shebikas* are trained by BRAC staff for 15-30 days. Each *shebika* covers 150 to 200 households including her own VO members and provides preventive, promotive and curative health services (Mahbub, 2000). This includes selling medicines and temporary family planning methods, provision of latrines and tube-wells for safe water and sanitation, health and nutrition education, HIV/AIDS awareness in the community and mobilisation for immunisation (Karim *et al.* 1994). Under EHC programme, VO members are provided with an annual health check-up that monitors weight, blood pressure, pulse rate, level of anaemia, and the presence of diseases like jaundice, diabetes, etc. (BRAC 1999).

FINDINGS

Past health network

Ten years ago in the study village there were four *kabiraj*, one homeopath and one pharmacist. Three of the *kabiraj* have passed away and the other one still practices. Villagers informed that a new *kabiraj* began (K2) practising after the BRAC intervention. The pharmacist used to distribute medicine from his house. He opened a pharmacy in the *bazaar* in 1993 which he still runs. The homeopath's clients steadily decreased as new health providers began practising in the village. He is now retired. A new homeopath began practising in 1992. The Family Welfare Centre (FWC) opened in 1986. Initially villagers received treatment for child and maternal illnesses. However, it has gradually become inactive. Villagers informed us that both the medical assistant and family welfare visitor lived in the district town and did not come regularly. They also mentioned that medicine was not always available from the FWC due to shortage.

Villagers recalled that the four *kabiraj* were the most frequented health providers in the past. They estimated that 50% of the village clients sought medicine and advice from them. In their view the other 50% was divided equally between the homeopath and the pharmacist.

During informal interviews the existing *kabiraj* 1, the pharmacist and the homeopath stated that they now have less clients than before. *Kabiraj* 1 claimed that this was because the number of health practitioners in the village had increased. The pharmacist, who provides allopathic medicines, named the *shebika* and her house-to-house visits as the main reason why his clients from the village had decreased. The homeopath claimed that he did not have as many clients in the village as before because he no longer provides treatment from his *bari*. He currently sits in the *bazaar*, which is the second furthest one from the study village.

House-to-house visits with current clients of the *shebika* were conducted to discover who they used to seek advice and treatment before the *shebika* was trained. It was found that

the majority of her clients (58%) used to go to the pharmacist. The second largest group (24%) used to visit one of the village *kabiraj*. Ten percent went to Jamalpur hospital and 8% used to go to the homeopath (Table 1,Figure 1). This shows that a third of the *shebika's* current clients used to rely on non-allopathic medicine.

Table 1: Past health-seeking behaviour of *shasthya shebika's* clients.

Health service providers	No. of clients
Pharmacist	42 (58)
Kabiraj	17 (24)
Jamalpur Hospital	7 (10)
Homeopath	6 (8)
Total	**72 (100)**

Numbers in parentheses indicate percentage

Figure 1 is a sociogram of the past health links[4] of the *shasthya shebika's* current clients (i.e. who her current clients used to seek advice and treatment before she was trained). The one circular row of numbers in the sociogram each represent a household in the study village. The arrows emanating from the four boxes represent a link between the household and the provider. It can be seen that all households have links with a provider.

Present health network

Background of health providers

Of the five health providers present in the village the *shasthya shebika* was the only female. She was also the youngest (33 years) followed by the homeopath (37 years). She belonged to the lowest wealth group (i.e. category C) along with both the *kabiraj*, whereas the pharmacist and the homeopath were from category A. The *shebika* was found to wield the largest health links, with a number greater than that of all the other four providers combined. She was associated with 72 health links out of 128. The Homeopath had the second largest number of health links, and *kabiraj* 2 was found to have the least (see Table 2 and Figure 2).

[4]'Health links' refers to the direct relationship between providers and clients. This includes advice and remedies given my providers to clients on health matters. From regular consultation a relationship is developed between providers and clients; we refer to this as a health link.

Figure 2 visualises the present health links through a sociogram. The two rows of numbers on the outside each represent a household in the study village. The arrows emanating from the five boxes represent a link between the household and the provider. It can be seen that some households have links with more than one provider (e.g. household no. 63, 65, 66). This indicates that they regularly consult different practitioners.

Table 2: Background of health providers and their links.

Type of Provider	Age in years	Sex	Wealth category	Actual links	NGO membership
Kabiraj 2 (herbalist)	60	Male	C	03	-
Kabiraj 1 (faith healer)	45	Male	C	11	BRAC
Pharmacist	50	Male	A	15	-
Homeopath	37	Male	A	27	-
Shasthya shebika	33	Female	C	72	BRAC

An interesting inter-provider relationship was found, which showed that the relationships between providers did not necessarily need to be viewed in a competitive manner. The *shebika* explained that about three or four years ago one the *kabiraj* 2 came to her house and asked for medication. He explained the symptoms and she gave him some medicine. Thus, he visited her a few more times. At some point she realised that the medicine was not for him rather he was selling it outside the village. At first she worried about whether she any of the symptoms as the information had obviously been second hand. She did not know whether she should continue to give him medicine. However, *kabiraj* 2 explained the situation to her and persuaded her to continue giving him medicine. She insisted though that he was careful about listening to the symptoms and explaining them correctly to her, as well as following-up the patients. This non-competitive inter-provider relationship is important to highlight as it shows that the *shebika's* health links are, in fact, more extensive than has been recorded through the actual link number in Table 2.

Fig 1: Past health networking links between providers and shasthya shebika's current clients.

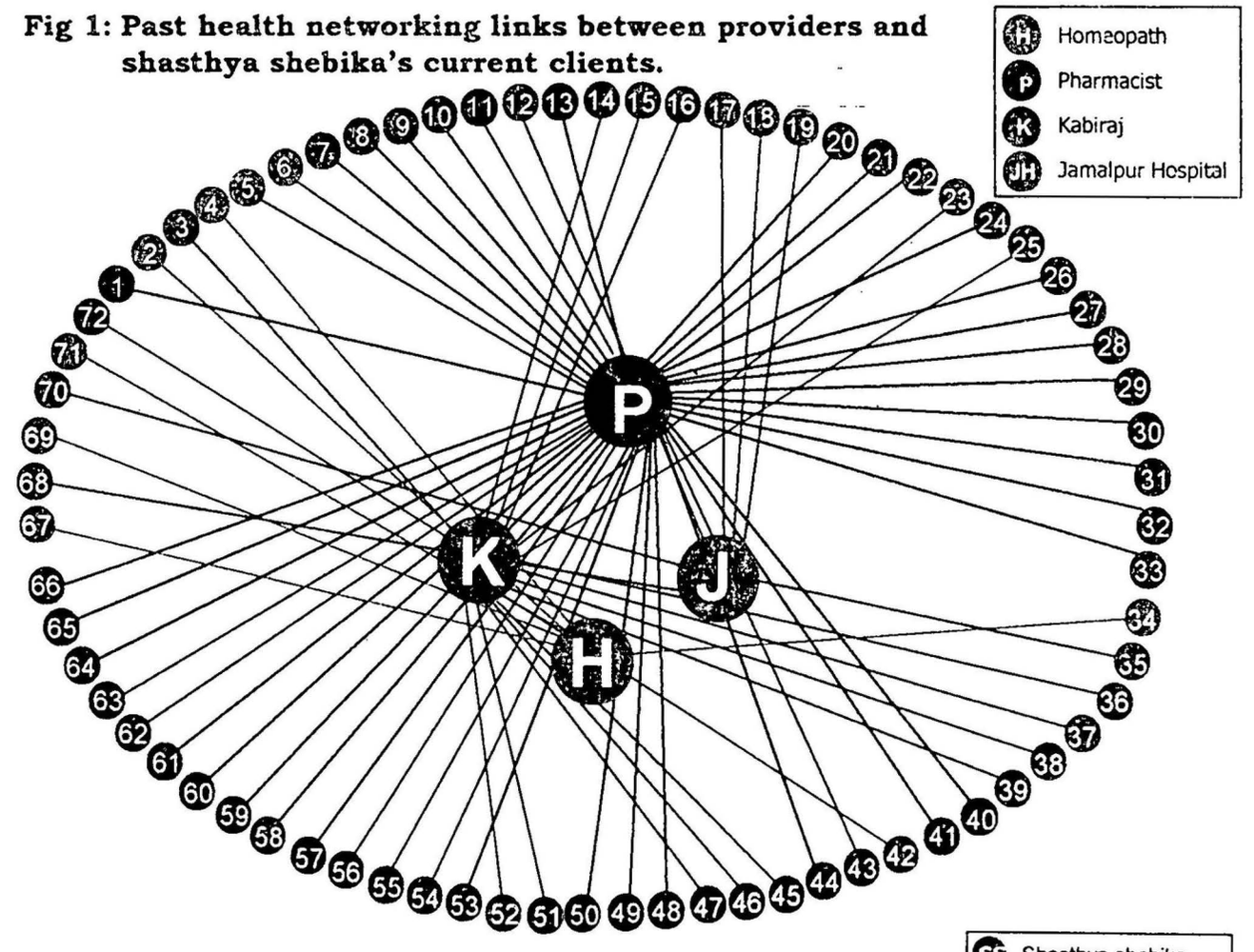
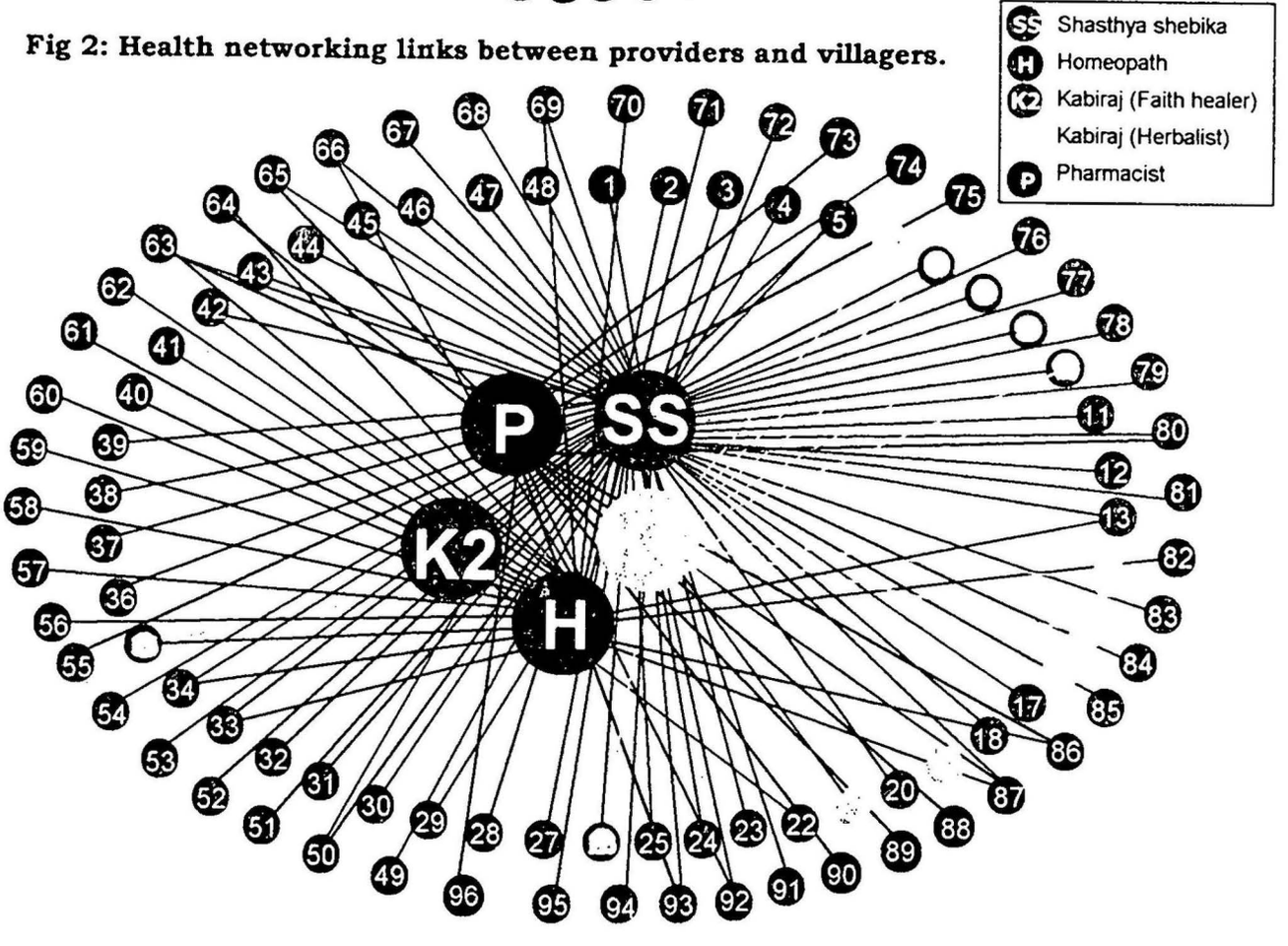


Fig 2: Health networking links between providers and villagers.



NGO membership of clients

The study found that the *shebika's* services were not just limited to BRAC members. Fifty-three percent of all BRAC members were found to consult the *shebika*. This figure coincides with findings from another study (Islam et al. 1994), which looked at five different areas in Manikganj where the *shebikas* had been working for over 13 years. It was reported that an average of 59% of BRAC members consulted the *shebika* in these areas. Interestingly, the present study found an even higher consultation rate for Grameen Bank and Ansar VDP members (60% and 65% respectively). The majority of non-NGO members (56%) also consulted the *shebika*. The study further revealed that 42% of BRAC members sought non-allopathic medicine, while it was 27% for non-BRAC members (i.e., Grameen Bank, VDP and non-NGO members).

Table 3: NGO membership status of clients.

Health Service providers	BRAC	GB	VDP	BRAC & VDP	BRAC & VDP & GB	No involvement	No. of actual links
Kabiraj 2 (herbalist)	2 (6)	0	0	0	0	1 (2)	3 (2)
Kabiraj 1 (faith healer)	5 (15)	1 (6)	1 (10)	1 (14)	0	3 (5)	11 (9)
Pharmacist	2 (6)	3 (18)	0	0	0	10 (17)	15 (12)
Homeopath	7 (21)	2 (12)	3 (30)	2 (29)	1 (50)	12 (20)	27 (21)
Shasthya shebika	17 (52)	11 (65)	6 (60)	4 (57)	1 (50)	33 (56)	72 (56)
Total	**33 (100)**	**17 (100)**	**10 (100)**	**7 (100)**	**2 (100)**	**59 (100)**	**128 (100)**

Numbers in parenthesis indicate percentages

Wealth category of clients

All health providers, with the exception of *shasthya shebika*, maintained health links predominantly with members from their own wealth category. Both the *kabiraj* (herbalist and faith healer) belonging to the poorest group, i.e. category C, and their clients from wealth categories B and C. The pharmacist and homeopath, belonging to the richest group, i.e. category A, served the largest group of category A clients (a combined 75%), whereas they served 31% and 19% of the clients from category B and C respectively. On

the other hand, the *shebika*, despite belonging to the poorest wealth group, was consulted by 25% of the wealthiest clients. She also served the majority of clients in wealth categories B and C.

Table 4: Wealth category of clients.

Health service providers	Category A	Category B	Category C	No. of actual links
Kabiraj 2 (herbalist)	0	0	3 (4)	**3**
Kabiraj 1 (faith healer)	0	2 (6)	9 (13)	**11**
Pharmacist	5 (21)	4 (11)	6 (9)	**15**
Homeopath	13 (54)	7 (20)	7 (10)	**27**
Shasthya shebika	6 (25)	22 (63)	44 (64)	**72**
No. of actual links	**24 (100)**	**35 (100)**	**69 (100)**	**128**

Numbers in parenthesis indicate percentages

Households outside health network

Out of 162 households in the village, 61 37.7% were not named as clients by providers (this is minus the five provider households). Due to time constraints 30 of these households were randomly selected and house-to-house visits were carried out. Three households stated that they did not visit any health practitioner. This group belonged to category C of the wealth groups. They did not seek treatment due to lack of money as reported. They said *Allah* (God) would take care of them. The other 27 households mentioned 47 links between them. Table 5 shows the health-seeking behaviour of these 27 households. The majority of the links were to the *bazaar*, *shasthyo shebika* and homeopath (a combined 82% of links). However, these visits by households were rare and less frequent, therefore they were not mentioned by the health providers and were not included within the health network.

Table 5: Health-seeking behaviour of households outside health network.

Source of Treatment	No. of actual Links	NGO involvement			
		BRAC	GB	VDP	No involvement
Jamalpur *sadar bazaar*	2 (4)	0	0	0	2 (8)
Nearest *bazaar*	19 (38)	2 (22)	4 (57)	1 (20)	12 (46)
Shasthya shebika	12 (24)	3 (33)	2 (29)	1(20)	6 (23)
Pharmacist	4 (8)	1 (11)	0	2 (40)	1 (4)
Homeopath	10 (20)	3 (33)	1 (14)	1 (20)	5 (19)
Total	**47 (100)**	**9 (100)**	**7 (100)**	**5 (100)**	**26 (100)**

Numbers in parenthesis indicate percentages

A profile of the 61 households outside the health network was compiled. Table 6 shows that 67% of these households belonged to the lowest wealth category, followed by 31% in Category B. Despite the majority of these households belonging to the poorest group it was found that they were also non-NGO members (61%). It was discovered that BRAC-member households constituted the lowest percentage of NGO-member households outside the network.

Table 6: Status of all households outside health network.

Wealth category:	
A	1 (2%)
B	19 (31%)
C	41 (67%)
NGO involvement:	
BRAC	6 (10%)
Grameen Bank	8 (13%)
VDP	9 (15%)
BRAC/VDP	1 (2%)
Non-Involvement	37 (61%)

DISCUSSION

This study has attempted to answer some crucial questions about the role of BRAC's Essential Health Care services and the introduction of the *shasthya shebika*. Had they been able to usurp the past discriminatory health networks in the village and replace it with a more inclusive one that is not biased towards the rich against the poor, towards men against women, towards BRAC-members against non-members?

The study found that the *shebika* does indeed reach BRAC as well as non-BRAC members, poor as well as rich households, both men and women. Fifty-three percent of BRAC members (including overlapping members with Grameen Bank and Ansar VDP) regularly visit the *shebika*. However, it was found that an even greater percentage of Grameen Bank and Ansar VDP members visit her (60% and 65% respectively) as well as 56% of the households not involved with any NGO. This shows that far from polarising the village members and non-members the *shebika* is actually consulted by a range of people. Thus, it can be said that the health network in the village, which is dominated by the *shebika* (who accounts for 72 health links out of 128), has created an inclusive health network of different NGO and non-NGO members.

Unlike the other health providers in the village, the *shebika* was also found to reach clients from all wealth categories, despite being a woman and belonging to the lowest wealth group herself. This is an important discovery as it means that through the training of *shebika* BRAC has not only been able to transfer knowledge to a woman belonging to a poor household, but also a certain degree of power at the village level. This power comes with the acknowledgement of her position from the different wealth groups, and the fact that the wealthier households consult her.

The study has also raised a few issues. It was discovered that 42% of BRAC members currently seek non-allopathic treatment. This percentage was found to be higher than for non-BRAC and non-NGO members. This highlights the need for greater awareness raising of allopathic medicine amongst BRAC members. This finding contradicts Ahmed et al.'s (1998) study which discovered an increased use of allopathic medicine by BRAC

members compared to non-members due to the motivation received from BRAC's EHC programme. However, this study found that 32% of the *shebika's* current clients used to seek non-allopathic treatment before the *shebika* was trained. This shows that she has been able to convert many villagers to allopathic medicine.

The study shows that the *shebika* is approachable to women. Her system of payment in kind and the fact that she is also a fellow village woman has made it convenient for other women to seek treatment. The women were also comfortable in consulting the *shebika* for their reproductive health problems as they were often embarrassed to seek these services from male providers (Mahbub et al. 1997, Khan et al. 1998). Mahbub (2000) found that adolescent girls also consulted the *shebika* for their reproductive health problems. Many adolescent girls visited the *shebika* for problems related to white discharge, which they were not able to approach other women due to social stigma attached to many of these reproductive health problems.

The study identified 38% of the households in the village to be outside the health network, and 67% of these to be from the poorest wealth group. Although the *shebika* has been able to reach villagers from across the different wealth categories this substantial percentage in group C indicates that her reach is not complete. However, it was found that BRAC-member households constituted the lowest percentage of NGO-member households outside the network.

After spending a few days working in the village it came to our attention that there were certain areas of the village which the *shebika* did not visit as often. She did not feel welcome in certain *baris*. We realised that in the study village there was a division between certain households. It is our understanding that some of the households not within the network links belong to those *baris* which the *shebika* does not have good relations with. It was also noted that many households which were further away from where the *shebika* lives were also outside the network links. This finding shows the importance of introducing *shebikas* who are accepted by villagers and have regular contact with them even if in a social context.

Conclusion

This study describes the health network in a village where the *shasthya shebika* has been working for many years. It has tried to assess the past health network in the village and how the introduction of a *shebika* has influenced this network. It was hoped that by doing this the current and future role of the *shebika* could be better understood in promoting not just the physical well-being of villagers but also their social well-being.

The *shebika* in the study village was chosen for this study because she was known to be very active. However, it has been found that despite the creation of a large health network there are still issues which she has not been able to overcome, such as reaching the households outside the health network and the BRAC-members who seek non-allopathic medicine.

However, she has been able to bring about much positive change in the village health network. By giving training to a poor woman as a *shasthya shebika* BRAC has attempted to re-distribute knowledge, power and access to resources at the village level. The study found that poor families now have greater access to allopathic medicine, especially the women. The *shebika* was originally introduced to provide medication and health care advice to poor families, however, after 10 years of work it was found that her services reached a larger and more inclusive group which transgresses social and wealth categories.

This study has been exploratory in nature. It is hoped that the results from this work can be used to help future studies on network relations in not just health but also in the social and economic spheres.

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