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Current State of the Model *Shasthya Shebikas* of BRAC: A Quick Exploration of the 'Pilot Project for SS Sustainability'

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INTRODUCTION

Inspired by the Primary Health Care (PHC) concept of Alma-Ata and the bare-foot doctors of Mao's China, the Essential Health Care (EHC)[1] services of BRAC evolved over time from its experiences of working with the poor for improving their health and well-being (Hadi and Ahmed 2005, Karim *et al.* 1994, Islam *et al.* 1991). It provides the building blocks with which the larger BRAC Health Programme (BHP) is built, and contributes to the mitigation of income-erosion effect of illness and vulnerability of the poor households. For sustainability, the EHC programme is embedded in BRAC's microfinance programme.

The nucleus of BRAC's EHC is the *Shasthya Shebika* (SS) who are the front-line workers of BHP (Ahmed 2008). They provide a cost-effective bridge between the community they serve and the PHC level facilities of formal health systems, though they are not part of it. They receive basic training on PHC (with additional, need-based programme-specific training for DOTS, community-based ARI or MNCH as and when necessary)[2] and backed by regular monthly refresher training. During household visits, they disseminate health and nutrition messages including family planning and immunization, motivate for installing tubewells and sanitary latrines, provide pregnancy-related care and treatment for some common illnesses, identify TB suspects and sells health commodities. The SS supposedly works on voluntary basis but earns some income from sale of health commodities and medicine (around Tk. 300-500 per month depending on activity). Currently, BHP has about 80,000 SS actively providing service to >90 million people. The success of micro-credit programme as a health intervention tool is extensively documented. The continuing need of this kind of generic Community Health Workers (CHW) that BRAC propagates is emphasized in the literature, in the context of shortage of human resources for health (HRH) in low income countries (LICs) (Standing and Chowdhury 2008).

In the eighties and the nineties, when the EHC/SS model was being developed, the scenario in the rural areas was quite different compared to the beginning of the 21st century. In the 1980s, the economy was only beginning to gain momentum after the liberation war and natural disasters, and mobility and opportunities for rural women were limited. Besides involvement in the family planning programme of the government, large-scale employment of women in income-earning activities at the grassroots level was virtually absent. To work as a community health provider and earn a modest sum of money was quite rewarding for rural women at that time besides social recognition, prestige, etc. However, the scenario has changed over time and income-earning opportunities have increased for rural women in different sectors (ready-made garments RMG, poultry, non-agricultural activities sponsored by the non-governmental organizations, etc.). The opportunity cost of being involved in low-return activity like SSs, has also increased. Demographic and its associated health transition with emergence of new conditions such as non-communicable diseases, and consumer preference for qualified doctor, are making the traditional model irrelevant.

[1] Health and nutrition education, safe water and sanitation, child immunization and Vitamin A supplementation, FP and pregnancy care, basic curative care for common illnesses at cost prices (or free of charge if unable to pay), DOTS, malaria and ARI prevention and control.

[2] On maternal and child health and nutrition, immunization, family planning, water and sanitation, communicable disease control, and basic curative care for common illnesses.

Besides, improved literacy and mobility have widened the horizon for these women. These have led to a system loss of around 15-20% of the *Shebikas* dropout annually despite adherence of recruitment criteria, introducing performance-based incentives, and diversifying the product basket. So, the challenge now is how can BRAC/BHP maintain her motivation and retention in an era of increasing opportunities for poor women? BRAC has been actively engaged in addressing this issue and craft out a model of next generation SSs in recent times (Special meeting report 20 Dec. 2010).

MODEL *SHASTHYA SHEBIKA*: A PILOT PROJECT FOR THE SUSTAINABILITY OF SSs

BHP has initiated a pilot experiment to develop an improved cadre of SS (model SS) from the existing *shebikas*, based on their performance throughout the year. The model SS should, in addition to the usual criteria for a SS (known resident of the community and acceptable to them, married with children aged >2 years, preferably with some literacy knowledge and numeracy skills), be literate and own a grocery shop from where she can operate. Besides performing her routine job as an SS, a model SS will give some time to the shop to sell BRAC health products. The revolving fund is increased from regular loan of Tk. 200 to 2,000 by which she is supposed to buy health products from BRAC and repay by monthly installment of Tk. 200 only. The pilot experiment started in 35 different branches of the *Manoshi* project in urban slum areas of Dhaka city since July 2010.

RATIONALE

The pilot project has been running for more than four months (as of Nov. 2010). BHP is thinking of scaling up the pilot in additional areas. Before expansion, it is imperative to understand how the current model SSs are doing, whether the project is in the process of achieving its stated objectives, the perception of the clients/consumers regarding the model SSs and their shops, and the perception of the supervisors about the activities of the model SSs. The proposed study aims to document the process of the activities of the model SSs and build knowledge base for informed decision-making by the programme practitioners

OBJECTIVES

General

This study aims to have process documentation of the pilot project for the sustainability of model SS and comparing with regular SSs.

Specific

To have information on the

- Socio-demographic and employment characteristics of the model SS; activities of the model SS in terms of routine (household visits) and new responsibilities (attending the shops),
- Performance of the model SSs; their perception of their new role, and their satisfaction and aspirations related to the new role,

- Perception of the community (clients/consumers), family members including spouse, and supervisors (SK, PO, BM) regarding the model SSs and their shops, and
- Comparing the model SSs' performance with a sample of regular SS in the *Manoshi* programme.

METHODS

All the 35 branches from the five areas (Jatrabari, Dhanmondi, Gulshan, Mirpur, Uttara) where the pilot project started in July 2010 were included in the study. A mini-survey was done to elicit socio-demographic and employment characteristics of all model SSs (n=35), their experiences of running the shops (n=28), their performance-related information, and perceptions of the community about the shop, and the available services. A total of 125 consumers/clients who received services from the shop at least once since the start of the shop were included. The SS registers were used to know about pregnancy identification and delivery records.

In-depth interview of a number of randomly selected model SSs (n=15) were done to document their perceptions and experiences of the new role, experiences with accounting and inventory management, and opportunities and challenges, satisfaction, aspirations, etc. In-depth interviews of 15 randomly selected POs were also done to document the performance of model SSs in both field and shops, and relevant issues. To compare, 15 randomly selected regular SSs were interviewed on the same issues. Data were collected during 5-23 December 2010.

TOOLS

Data were collected through face-to-face interview using semi-structured questionnaire. The questionnaire was pre-tested in areas outside our sample and revised and updated accordingly. The quantitative information was supplemented by 15 in-depth interviews of model SS, regular SS and POs respectively using guidelines/check-lists. Through the quantitative questionnaire the following information were collected:

1) Socioeconomic and demographic characteristics of the model SS;
2) Background characteristics;
3) Model SSs experiences of running the shops;
4) Perceptions of community people about the shop run by model SS;
5) Awareness of the community people about the activities of the SS.

ETHICAL ISSUES

The study was reviewed and approved by the Internal Review and Publication Committee (IRPC) of the Research and Evaluation Division (RED) of BRAC. All respondents were informed about the purpose of the study and verbal consent was obtained before commencing interviews. All information was kept anonymous and confidential.

DATA MANAGEMENT AND ANALYSIS

The completed questionnaire was scrutinized in the field by the supervisors for any inconsistency and incompleteness, and additional interview done if needed. Data entry and cleaning was done under the supervision of the investigator. Data analysis was done by SPSS version 16.0. Content analysis of qualitative data was done for summarizing the main themes.

RESULTS

Table 1. Socioeconomic and demographic characteristics of the model *Shasthya shebikas* (N=35)

	%	N
Age (years)		
25-30	29	10
31-40	54	19
41-50	17	6
Currently married	91	32
Have <5 children	14	5
Can't read and write	20	7
Husband's occupation		
Private service	11	4
Self-employment	34	12
Small business	37	13
Others	17	6
HH income per month (mean taka)	13,511	
Sources of household's income		
Husband's income	40	31
Children's income	9	7
Self income	42	33
Others	9	7
HH Expenditure per month (mean taka)	9,611	
Categories of expenses		
House rent	69	24
Children's education	23	8
Treatment expenditures	6	2
HH expenditure	3	1

Socio-demographic characteristics

Majority of the respondents (54%) belonged to the age group 31-40 years. Around 91% of them were currently married and 14% had under-five children. Sixteen percent of the model SSs could not read and write. Their husbands were mostly involved in small business (37%), and other self-employment activities (34%). Their reported mean household income per month was around Tk. 13,000. Model SSs contribution to household income was about 42%. Their reported mean household expenditure per month was around Tk. 9,611, with 69% of it as house rent (Table 1).

Table 2. Background characteristics of the model *Shasthya shebikas* (n=35)

	%	n
Previously engaged in income-earning job	86	30
Currently engaged in income-earning job (besides model SS)	54	19
Motivational factors to become an SS		
Family member	10	50
BRAC member	58	30
Self initiative	23	12
Social awareness	10	5
Perceived reason for being selected as model SS		
Good performance	31	21
More medicine selling records	16	11
Well-known in the community	19	13
Already owned a shop	7	5
Selected by SK	7	5
Received training	4	3
General meeting for Model SS selection	3	2
More delivery records	3	2
More pregnancy identification	3	2
First SS in the area	3	2
More incentives received	2	1
No small children	2	1
Benefited for being a model SS	94	33
Nature of benefit		
Financial solvency	37	28
Social popularity	35	26
More knowledge gained	21	16
ID card	1	1
Reading glass	1	1
More service to community people	1	1
More revolving funds	1	1
Social security	1	1
Satisfaction with current status	74	26
Reasons for dissatisfaction		
More work, less money	21	3
More income needed	14	2
Reading glass not available	14	2
Less training facilities	14	2
Misbehavior from community people	7	1
Abuse	7	1
Less development	7	1
No promotion	7	1
BP machine and thermometer	7	1

Majority of the model SSs were previously engaged in different income-earning activities (86%) while 54% of them are currently involved in some other income-earning activities other than shebika work (Table 2). In most of the instances, they were motivated by BRAC staff to become an SS (58%). However, they mentioned good performance (31%), medicine selling records (16%) and popularity in the community (19%) to be the most common reasons for which they were selected as model SS. A model SS said,

"SK apa, PO apa/bhai and BM apa/bhai decided to select me as a model SS based on my performance for the last few years, I owned a shop, I had better contact in the community, etc."

Figure 1. Self hygiene of a model SS at 2 pm

Ninety-four percent of the model SSs thought that they benefitted from being selected as model SS such as financial solvency (37%), social popularity (35%), and access to privileged knowledge (21%), etc. Seventy-four percent of them were satisfied with their current status while others were not for reasons such as 'more work, less money', need for more income and training (14% each), misbehavior of community people (7%), etc.

Experiences with shops

Informal interaction with programme people reveals that one of the main criteria for selecting a model SS was that she should posses a grocery shop of her own or the family. However, this was not mandatory. We found that 20% did not possess any shop (Table 3). Sixty-three percent of the model SSs keep the shops open for the whole day and about 56% used to close the shops at night. When their shops were closed, they attended their clients either from the stores at home (45%) or by re-opening the shop (34%). Some of the SSs provide door-to-door service such as delivering required medicine. A 50 years old SS said,

"When I am not at home my daughter keeps the name of the person and later I deliver required medicine at their home."

Their husbands and other family members help them run the shop in most cases (husbands 39%, sons 27%). Sixty-three percent of the model SSs maintains a stock register for their daily sales at the shop. Fourteen percent faced problems in running the shops such as eve-teasing (9%). Some of them took it as a challenge and avoided the comments (6%), others used to run their shops with the help of their sons. When asked how to improve the operation of the shops, they suggested adding more varieties of medicines (34%), increasing the size of the revolving fund (29%) and advancing a large one-time loan (e.g., Tk. 1 lac) (6%).

Table 3. Experiences of the model *Shasthya shebikas* on shops (n=35)

	%	n
Does not possess a shop	20	7
Shop opening hours		
Whole day	63	22
Morning/afternoon	17	6
Time of closing the shop		
At night	55.2	16
At noon	20.7	6
During HH visit	3.4	1
Cloth selling	3.4	1
Whole day	3.4	1
Once in a while	3.4	1
Service given to community people during closing hour		
Asks to come later	6.9	2
From stores at home	44.8	13
Opens the shop and provides service	34.5	10
Others	13.7	4
Person attending shop while the SS is away		
Husband	39	13
Son	27	9
Sister/daughter	12	4
Brother	6	2
In-laws	9	3
Others	6	2
Keeps daily sales register	63	22
Felt needs for the improvement of the shop		
Varieties of medicine	34	18
Increasing the revolving fund	29	16
Add other health products	11	6
Cosmetics/fridge	8	4
1 lakh Tk. for shop build up	6	3
Nothing else	2	1
Problems faced being a female shopkeeper	14	5
Nature of problems faced		
More hard work	3	1
Eve-teasing/ harassment	9	3
BRAC is not well accepted by some people	3	1
Solutions to problems faced		
Son runs the shop	3	1
Husband talks with the seniors in the community	3	1
More facilities	3	1
Avoiding comments	6	2

Perception of the community about the shops

Around 60% of the community people were aware about the shop of the model SSs and its opening and closing time (Table 4). A small proportion could mention the name of the products available in the shops such as medicine (28%), BRAC health products (15%), tea/betel leaf/*biri* (17%), etc. Around 26% said that the model SS provided their required stuff from home while the shop was closed and 6% said that they were asked to come later. Around 47% could say 'who runs the shop during the absence of the model SS'. Eighteen percent of the people thought that their household visits were compromised due to the running of the shop. More than 47% reported that they have seen signboards (about the model SS) in front of their house.

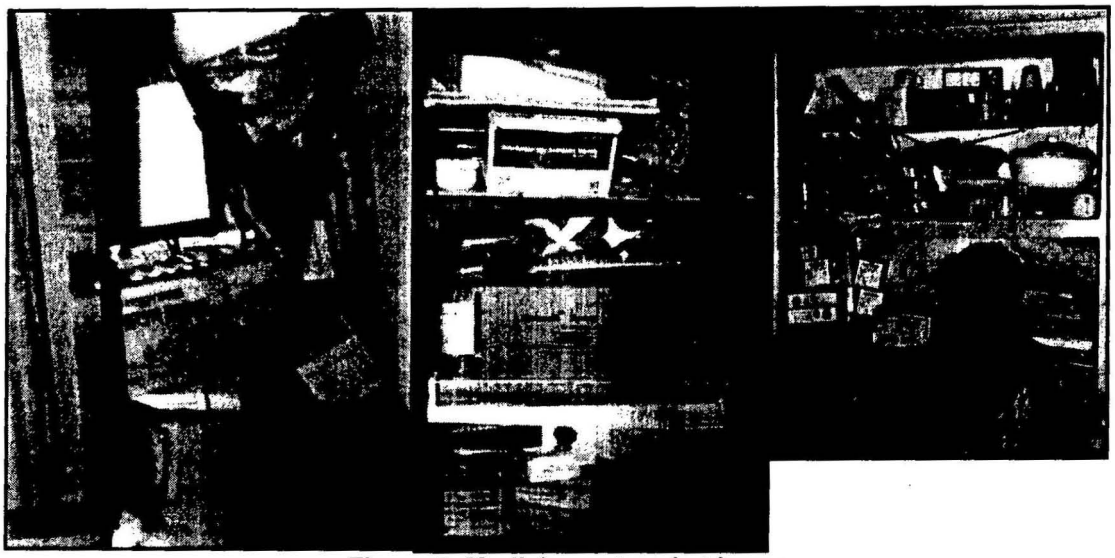

Figure 2. Medicines stored at home

Table 4. Perceptions of community about the shop run by the model *Shasthya shebika*

	%	n
Knows about model SS's shop	61.1	77
Available products at her shop?		
Medicine	27.8	54
BRAC health products	14.9	29
Tea/betel leaf/biri	16.5	32
Daily HH products	19.1	37
Bread/banana/biscuit	14.9	29
Don't know	1	2
Others	5.6	11
Opening hours		
Whole day	49.2	62
Morning/afternoon	2.4	3
Don't know	3.2	4
What is done when shop is closed		
Given from home	25.4	32
Asked to come later	6.3	8
Given from shop (after opening)	2.4	3
Communicate through mobile phone	2.4	3
Others	6.4	8
Don't know	1.6	2
Thinks HH visit is interrupted due to shop	18.3	23
Person who runs the shop in her absence		
Husband	46.5	47
Son	37.6	38
Brother	6.9	7
Signboard in front her shop/house	47.6	60

Table 5. Awareness of the community people about the activities of the model *Shasthya shebika*

	%	N
HH visit per month		
None	9.5	12
Once	11.9	15
>Once	76.2	96
Everyday	9.5	12
Always	1.6	2
After conceiving	0.8	1
Usual time of visit		
Morning	56.8	104
Afternoon	37.7	69
Others	4.9	9
Activities while visited		
Pregnancy identification	39.8	107
ANC/PNC	39.4	106
TB patient identification	7.1	19
Health forum	5.6	15
FP advice	2.6	7
Other	4.0	11
Don't know	1.5	4
Ever visited SS's house	59.5	75
Thinks her as an expert in treating 10 common illnesses	69.8	88

PERCEPTION OF THE COMMUNITY ABOUT THE ACTIVITIES OF THE MODEL SSs

Seventy-six percent of the community people surveyed said that the model SS visited them regularly at home more than once a month (Table 5). They usually visit households in the morning (57%) and sometimes in the afternoon (38%). They mostly do pregnancy identification (40%) and antenatal care/postnatal care (ANC/PNC) (39%). According to the Programme Organizers (POs),

Figure 3. Husband helping running the shop

"Since the SS are given incentives for pregnancy identification and pregnancy-related services they are more interested to identify pregnant mothers rather giving family planning advice...this would increase the population size... so, if we think in broad spectrum we can say that they should be involved minimally in identifying pregnant mothers."

Findings from qualitative exploration reveal that the SSs make home visits regularly (sometimes more than once a day) if there is a pregnant women in the household; once the delivery is over, they hardly visit them. One SS said,

"Now I am well-known in my community, so it is not needed to visit households every day, my mobile number is kept with them, when required they call me or they come to my shop."

Around 60% of the community people interviewed were found to have visited their *shebika's* home, and the same proportion thought of the SS as expert in treating the 10 common illnesses.

Table 6. Performance characteristics of the model *Shasthya shebikas* (N=35)

	%	N
Household (HH) under supervision		
<200	20	7
201-300	31.4	11
301-400	20	7
401-500	5.7	2
501-600	17.1	6
601-700	2.9	1
701-800	2.9	1
Time of HH visit		
Morning	50	27
Afternoon	44.4	24
Whenever time is available	1.9	1
At night	3.7	2
HH visits interrupted for attending shop	8.6	3
Time spent for HH visit		
15 mins	48.6	17
30 mins	37.1	13
10 mins	8.6	3
≥ 1 hour	6.8	21
Pregnancy referral	80	28
TB patient under her supervision	60	21
Expectation from BRAC		
Monthly/Festive bonus	40.6	26
More increment	18.8	12
Self health check up and service for treatment	7.8	5
ID card	6.3	4
More training	4.7	3
BRAC should provide more medicine	4.7	3
Improved umbrella and bag	3.1	2
Increased amount of loan	3.1	2
Others Job security	11.2	7

PERFORMANCE CHARACTERISTICS

According to the model SSs, their catchment areas i.e., households supervised varies from <200 to 800 households (Table 6). Qualitative findings reveal that when there were some inactive SSs, the others have to take the brunt of their works. These model SSs reported that they usually spent 15 minutes (49%) to 30 minutes (37%) for a household visit. Eighty percent of them reported to have referred pregnant women when needed. Sixty percent had TB patients under their supervision. These *shebikas* expected monthly/festival bonus (41%) and increment in remuneration (19%) from BRAC. Some asked for cellular phone bills as they have to call the SKs and report safe delivery and sometimes they need to contact with hospitals for referral. They wanted a regular nurse/paramedic at the delivery centre so that they do not have to go

to different hospitals for trivial things as most of the time these hospitals were not cordial. One model SS said,

> *"We would not have to face this sort of ill-behaviours from the hospital staff, if BRAC could own a hospital itself or at least a healthcare centre with some modern facilities."*

They mentioned of low monthly salary and lack of job security as reasons for dropout. They said,

> *"It sometimes discouraged us from doing the work when a pregnant woman goes to other place for the delivery. This makes us helpless and all our efforts of the last 8 months just go in vein and ultimately we are defeated from the incentives."*

The SS said, as people asked for better brand medicines, it would be better if BRAC could provide those:

> *"These days there are lots of drug stores, so people know the names of different pharmaceutical companies--- they ask for specific brand names...we know BRAC has limitations, still it would be better if BRAC can provide us with some other kinds of medicines too."*

Interestingly, many of them expect healthcare service for themselves from BRAC. One of them said,

> *"BRAC exists because of these shebikas, but they do not provide any benefit for us, no healthcare service for us. Once when I asked for supporting me for a surgery, they asked me to take loan from them. If I could take loan then why would I go to BRAC for work?"*

The POs who supervise the model SSs opined that more training (on pregnancy and delivery, neonatal care) and a fixed monthly remuneration would be helpful to retain them. Also, increasing the amount of incentives for bringing the pregnant women to delivery centres, and neonatal care could help.

Case study

One of the *shebikas* (52) has been working at BRAC for the last one year. She has been residing permanently in her locality for a long time. She just became widow in recent days. She has got 3 children. Her eldest son works in a garment factory, another one lives in Kuwait and works there, and both of their wives works for tailoring. Her only daughter got married recently. She has been working as a birth attendant for almost 23 years; she got the training from 'Red Crescent' during 1973-74 (according to her statement). Besides she also works for bathing dead bodies. She thinks these are humanitarian works. But if she works under BRAC she has an obligation - a boundary - a fixed HH which is sometimes bothering.

She supervises small number of HHs, only 72. So her income is also small. Though this gives her less stress but income is almost nil. She got Tk. 500 max in a month. During her entire period of work as an SS, she has been given less number of HHs, so that gives her less number of pregnant women too. For example, she identified 3 pregnancies last month, among them one was referred to Dhaka Medical College Hospital.

She visits the HH only in the afternoon. It takes her a week to complete all the 72 HHs. She mainly identifies pregnancies and gives care to new born babies.

She thinks those who are active, selling more medicines, young, owns shop and can harmonize better, are selected as model SS. She is aged, works less and straight forward in speech. So, undoubtedly she cannot become a model SS. She can hardly sell medicines of Tk. 200. So, she is also not interested to become a model SS.

She attends the SS refreshers regularly. There she makes mistakes sometimes while demonstrating to others. And she complained that she gets scolded because of this.

She is thinking of leaving her activities as an SS. Since she has been assigned to less number of HHs, her income is less. There is no monthly salary facility from BRAC, neither any option for health care check up.

SUMMARY OF KEY FINDINGS

- Currently, the main differentiating element between the two types of SSs is the size of the RLF. This should be changed; the model SSs should be an improved version of the regular SSs. The selection criteria for model SS (as found in the MSS training manual) was not strictly followed (e.g., at least have ≥5 years of schooling, a shop, enough free time for household visits, running shops, etc.); majority were motivated by BRAC staff. Fifty-four percent are also engaged in a second income-earning activity other than model SS activity.
- Daily household visits is compromised due to time required for running the shops (18% of the service receivers think so, 21% reported none or only one visit in the past month; only 9% of the SSs think it to be disrupting); substantial help received from family members (mainly husband or son); only 63% keep daily

sales registers (self-reported). The variation in catchment HHs for a model SS should be minimized as far as possible.

- Little time given for activities other than pregnancy identification and ANC/PNC. One example is family planning advice; 70% of the service receivers interviewed perceived them as experts on treating ten common illnesses.
- There is a felt need among the model SSs to expand the medicine and healthcare product baskets (and the revolving loan fund) so as to better serve their community and increase their income; they expect fixed monthly remuneration including other incentives such as festival bonus, free health check-up, treatment for self, more training, etc.

CONCLUSIONS

The programme is on the right track but needs some refinement and re-designing for better performance in the scaling-up phase.

RECOMMENDATIONS

Based upon the above findings, the following recommendations are made for the scaling-up phase:

- Follow the selection criteria for model SSs as meticulously as possible; the literacy and the children criteria need special attention for maintenance of stock and sales registers, and enough free time for doing enhanced activities. Better to avoid women with existing income-earning activity as it shortens time for doing other activities (e.g., running shops). The criteria should be transparent and objective, not subjective!
- Family members are playing important roles in running the shop-based model. A second person from the family of the model SS (husband, son or other) can be involved in the programme formally and trained along with the SS in matters such as maintain registers, responding to client's demand to services when the SS is away, etc. This will increase ownership by the family and secure assistance from family members.
- The criteria of having a shop should be strictly followed. Otherwise it will be the usual existing model and may not serve programme's purpose of installing the model SSs. They may be developed as health resource person (for PHC) in the slum community with a static facility which is backed by a big NGO and its infrastructure (will increase credibility of the model SSs)
- The basket of medicine may be expanded and the amount of RLF may be increased depending upon needs and capacity to use. Additional monetary (such as a basic minimum fixed remuneration, incentives as per activity and not outcome at the SS level like death of the newborn, etc.) and non-monetary incentives (arranging to formally embed the SS with shop in the slum, etc.) should be explored to improve retention.
- A congenial, win-win relationship should be developed between the SSs and the delivery centres (DC) so that the SSs are motivated to operate keeping the DC in confidence. This is necessary for increased credibility of the DCs (for referral etc.) in the slum community.

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