A documentation on BRAC's *Shastho shebika*

Exploring the possibilities of institutionalisation

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Executive summary

Introduction

Shastho shebikas (SS) are health cadres, selected from BRAC's Village Organisations (VO). They are the nucleus of BRAC health programmes and are trained in preventative, promotive and curative aspects of health. As the frontline work force, their role and functions in BRAC health programmes are enormous. BRAC health programmes cover approximately thirty-five million people by mobilising these *shastho shebikas.* BRAC has been using the SS since 1977, and several studies have been done so far on different aspects relevant to the SS. The present study has made an effort to document the present situation of SS using various primary and secondary sources. Concurrently the study tried to explore the possibilities of institutionalise the activities of SSs in the community.

Methodology

The study was conducted in Sadar Thana of Sherpur region by using a number of qualitative methods to describe the prevailing scenario regarding the situation of the SSs. Data collected took place during mid April to end of May 2000 from different primary and secondary sources. Results of previous studies conducted to explore different issues related to *shastho shebika* were used as secondary sources. Different qualitative techniques were utilised to collect information from primary sources. These were semi-structured interviews, focus group discussions and key informant interviews. The study population was comprised of the *SSs* of BRAC's health programmes in the study area. The informants were mainly selected through convenient sampling techniques. The male villagers were also included in the study. Village elite, husbands of *SSs,* aged women, VO leaders, programme personnel etc. were regarded as key informants.

Findings

The study revealed that the SSs became involved in the activities due to a variety of reasons. The SSs considered it as a source of profitable income, access to medicine and knowledge and a prestigious job. Peer pressure also appeared as a significant factor in the study to become an SS. In assessing skills and performance of the SSs it was noted that the retention of knowledge of SSs was high. Most of them could identify common

diseases like the common cold, amoebic dysentery, and pneumonia and were able to manage these cases correctly. Regarding ARI management the SSs were able to produce the desired outcome in identifying and treating pneumonia in children at the community level. Due to familiarity and good relationships with the villagers, the SSs were useful in increasing the adherence to tuberculosis treatment. However there was an obvious relationship between regular and adequate supervision and quality of performance of SSs in their various activities.

Their participation in various BRAC activities combined with household duties meant that SSs were undoubtedly overburdened. However, they were happy as they could earn an income and social prestige through their activities. The SSs reported that in present days they could carry out their health activities along with household chores together as they did not visit house to house to the same extent as they used to do before. The present study revealed that family members and husbands of the SSs were supportive of their activities as they recognised it as a source of income. However, an implicit complaint regarding care for husbands was noted in the study.

Due to multiple reasons such as lack of profitability, workload, lack of sociocultural acceptance SSs were found to discontinue their activities. Drop out rate of SSs hampered programme activities and sometimes caused financial loss. The study also identified factors like economic, social and access to skill and knowledge which motivated SSs to continue their work. Indeed, satisfaction of SSs, from their popularity and position in the society sometimes went beyond the importance of their income capacity.

Most of the SSs perceived themselves as a crucial component for the success of BRAC health programmes. Without them BRAC would undoubtedly encounter several difficulties in working with the community. In the study, SSs expressed their confidence to continue with their activities if BRAC withdrew the support. However, they were unwilling to leave BRAC as they felt emotionally attached.

It was evident from the study that in due course acceptance of SSs in the community gradually increased. In addition to women, adolescent girls and men in the community also consulted SSs during various illnesses. The increasing acceptability of SSs indicated that the activities of SSs were more or less institutionalised in the community. As a pattern of norms and behaviours had been established between SSs and the people in the community.

Conclusion

In conclusion the study suggested undertaking a further research on the cost effectiveness of SSs and their economic contribution in order to estimate the market value of their services to the community and to BRAC's health programmes. It will provide a detailed view on the situation of SSs.

Introduction

Community health workers can generally be defined as local inhabitants given a limited amount of training to provide specific basic health and nutritional service to the members of their surrounding community. They are expected to remain in their home village or neighbourhood and usually only work part-time as health workers (Berman et al. 1987). They are the key human resource for successful implementation of comprehensive primary health care programmes (Islam 1992). The BRAC health programmes address health, population and nutrition issues with particular focus on women and children by mobilising around 25,000 voluntary community health workers locally known as *shastho shebika* (BRAC 1999).

As frontline work force *shastho shebikas* (SS) are the core of BRAC health programmes. They are trained in preventative, promotive and curative aspects of health. Most of the SSs are illiterate women, aged between 25-35 years and are members of BRAC's Village Organisations (VO). They are selected by the other VO members and trained by BRAC staff for 15-30 days on health and population. Each SS covers 150 to 200 households including her own VO members and provides services for family planning, sanitation and water supply, immunisation, acute respiratory infection, tuberculosis, nutrition, reproductive health, treatment of common diseases and community health education (Islam et al. 1999). The SSs also provide assistance to government health workers in order to organise and operate satellite clinics, EPI centres and in distributing vitamin A capsules (BRAC 1995). They are not paid but retain a small profit from the sale of medicines prescribed for common diseases (Chowdhury et al. 1997).

Background

In 1973 on the basis of the "barefoot doctors" concept in China, BRAC trained a few paramedics in its Sulla project. They were recruited from middle and lower middle class society. They were trained to provide basic health care in their own village under the supervision of medical doctors. BRAC also tried to develop a health insurance system with a minimum premium raised by the villagers. During harvesting period, the villagers paid the premium in kind. However, the programme was not sustainable mainly for two

reasons. First, most of the paramedics left BRAC and became quacks. Secondly, the programme was not able to reach the target population. From this experience and due to changes in BRAC's approach to its target group, it was decided to train one health worker per 700 to 900 people to provide basic health care to villagers.

From 1977 to 1990 in its Manikganj integrated project, BRAC selected one *shastho shebok/shebika* (SS), preferably female from each village. So far, 285 females and males from the target group have been selected to provide basic health care to the community (Islam 1992). Later on BRAC changed its strategy and only female members from BRAC's VO were selected as SSs. The selection criteria requires the SS to be married and have children, to be well motivated for community development, to be sincere about their responsibilities (Islam 1992).

From 1992, SSs started to deliver family planning services to villagers. The use of slab-latrines among VO members were promoted by the SSs who acted as an intermediary in selling the product. At the beginning, SSs did not receive any remuneration from community members. This resulting frequent loss of interest and high dropout rates. As a solution, BRAC introduced a cost recovery mechanism through which SSs would be able to receive financial benefits from their services (BRAC 1993).

However the role and function of SSs in BRAC health programmes are enormous as the elements of health programmes are implemented by them (Afsana et al. 1998, Khan et al 1998). Apart from attending VO and issue based meeting SSs assist the Program Organisers (PO) in organising Antenatal Care Centres (ANCC), Satellite Clinics (SC) and EPI sessions, and also are involved in motivational work and in distributing contraceptives among eligible couples. Due to SSs' role and activities the incidences of diarrhoea and tuberculosis have been reduced to a great extent in villages and people's awareness of safe water and latrine use is also found to have increased (Afsana et al. 1998). SSs play a major role in raising the sale of contraceptives among villagers. They sell contraceptives on credit and villagers think that the quality of contraceptives sold by them are better (Ali et al. 1994).

Since SSs are a crucial core element of BRAC's health programmes, it is important to explore their present situation and the possibilities of institutionalise their activities in the community to promote greater sustainability. The present study was undertaken with this interest in mind.

Objectives

The study was initiated with two broad objectives:

- To document the present situation of the SSs in BRAC health programmes; and
- To explore the possibilities of institutionalise SSs' activities in the community.

The specific objectives of the study were to:

1. Understand the process of becoming an SS.
2. Assess skill and performance of SSs.
3. Measure community acceptance of SSs.
4. Solicit the perception of SSs about their role in BRAC health programmes.
5. Assess the workload of SSs.
6. Understand the situation of SSs' dropout.
7. Elicit the attitude of husbands and other family members towards their work.
8. Understand the factors that motivate SSs to work.
9. Examine sustainability of SSs without BRAC support.

Methodology

The study was conducted in Sadar Thana of Sherpur region by using a number of qualitative methods to describe the prevailing scenario regarding the situation of SSs. It was a descriptive study by nature, which involved the systematic collection, and presentation of data to provide a clear picture of a particular situation (Hardon et al. 1995).

Data collection techniques

Data collection took place during mid April to end of May 2000 from different primary and secondary sources. Results of previous studies conducted to explore various issues related to *shastho shebika* were used as secondary sources. Other literature on Community Health Workers (CHW) were also reviewed in the study.

Different qualitative techniques were utilised to collect information from primary source. These were semi-structured interviews, focus group discussions and key informant interviews. These different data collection techniques were more or less complementary to one another. Triangulation of various techniques and sources was done to maximise the validity and reliability of data and to reduce the chance of biases. During data collection, the context or the setting was always taken into consideration. Checklists were followed for semi-structured and key informant interview as well as focus group discussions.

Study population and sampling

The study population was comprised of the *shastho shebikas* of BRAC health programmes in the study area. The informants were mainly selected through convenient sampling techniques. The focus group discussions were carried out with male villagers and the number of participants was selected based on their availability. Village elite, husbands of *shashtho shebikas*, aged women, Village Organisation (VO) leaders, programme personnel etc. were regarded as the key informants in the study. However, according to the requirement of the study, any person could serve as a key informant, but she/he should be knowledgeable and communicative.

Data processing and analysis

The data was processed and analysed manually. Data processing included coding of different themes, compilation of data under different themes, comparison of the facts and relations between themes.

Limitation

The study was conducted in a selected area of BRAC health programmes. As such the study results can not necessarily be generalised. Nevertheless the study would be able to provide an impression about the situation of SSs in BRAC health programmes.

Findings

Becoming an SS

There are a number of selection criteria from programme point of view for becoming an SS. The SSs are usually selected by mutual understanding between VO members of BRAC's Rural Development Programme (RDP) and representatives of BRAC (Islam 1992). All SSs are active group members of the RDP. The selection process begins with Program Organisers (PO) asking VO members to suggest names of prospective SSs during VO meetings. After the nomination another selection is made at a general meeting in the area office. However, the final selection interview is made at the regional office. The selection is done based on certain criteria such as, 25 to 35 years old, married, youngest child's age above five years, socially acceptable, eager to work, preferably educated and not living near a local health care facility or big *bazaar* (Khan et al. 1998).

From SSs perspective, there were various reasons for becoming an SS. They considered it as a source of earning a profitable income. Some wanted to be an SS in order to have access to medicine and help make people aware of contraception, immunisation and health and hygiene practices towards children and neighbours. Besides, the activities of SSs were regarded as prestigious; giving medicine was associated with name and fame (Khan et al. 1998).

Peer pressure was also appeared to be a significant factor in the discussion to become an SS. Often VO members asked one particular woman to be an SS. For instance, Rokeya a VO leader stated:

We requested Saleha to become a shebika in our village. She did not have much work in her household and her house was situated in a convenient place so that everybody could go there. Initially she was hesitant that her family may not allow her to work as a shebika. We convinced her that for the benefit of the other villagers and us she should become a doctor of the village. Then I informed the manager about the matter and he organised a meeting for the final selection. Presently she is realising that along with the villagers she is also receiving benefits from her activities.

Sometimes BRAC personnel were found to motivate a particular VO member suitable for becoming an SS. Hena was such an example. She stated:

One day BRAC Apa came to suggest that I should become a shebika. She explained that if I become a shebika of the village, the villagers would benefit from my activities. I would be able to provide advice and the necessary medicine during children's diarrhoea and other general diseases. This would increase my status and prestige in the long run. Then I thought about it myself and realised that if I became a shebika my learning would not only help the villagers, my family members would also be benefited. Everybody of my surrounding would be able to seek advice regarding health and medicine; thus, the overall environment (poribesh) ultimately would improve. I also considered my training of shebika would become an asset like land.

Some of the SSs mentioned that primarily they wanted to be an SS because they considered it to be a salaried job. Nobody eliminated this misunderstanding at the beginning. During training when it became clear to them that they would not receive any regular salary, they were in a dilemma as to whether continue. Afterwards considering certain factors like being able to serve the people, access to knowledge and prestige, they decided to continue with their activities. However, other SSs opined that it was clear to

them from the beginning that they would not receive any regular salary for their activities.

Skill and performance

Different studies revealed the level of skill and performance of SSs. Studies indicated that the retention of knowledge was high amongst SSs (Islam et al 1994, Islam et al. 1995, Islam 2000). A study found that 90% of SSs could identify common diseases like common cold, amoebic dysentery, pneumonia and over 80% of them managed these cases correctly (Islam et al. 1994). Another study showed that 88% of SSs knew the major symptoms of tuberculosis and over 98% knew the treatment regimen for tuberculosis. Similar level of knowledge were also found for other health components (Islam et al. 1995).

In assessing skills and performance of SSs regarding ARI management a study (Hadi 1999) demonstrated that SSs were able to produce the desired outcomes in identifying and treating pneumonia in children at the community level. According to the study the performance of SS in identifying pneumonia cases was high. The overall proportion of agreement between SSs and research physicians in diagnosing (89%) and treating (87.2%) sick children, including prescribing antibiotics (89.3%) in the case of pneumonia, appeared to be reasonably high (Table 1).

The performance of SSs in pneumonia management was largely influenced by the training and supervision system of ARI control programme. Table 1 shows that the correct diagnosis of pneumonia was significantly higher among SSs who received basic training (90.8%) than who did not (86.1%). Similarly regular and adequate supervision by para-professionals significantly improved the performance of SSs in diagnosing pneumonia. The number of supervisory contacts were positively associated with the performance of SSs.

The length of experience had no association with the quality of performance of SSs. It was apparent that SSs performed poorly with the length of experience in ARI control

programme. One possible reason of such poor performance could be that earlier recruits were relatively older and relatively less educated. They were thus less attentive in diagnosing and treating pneumonia than new entrants.

Table 1. Factors affecting diagnosis and treatment of pneumonia by SSs.

Factors	Diagnosis	*P*	Treatment	P	Antibiotic	P
All	89.0		87.2		89.3	
Health volunteer						
Basic training		<0.01		<0.01		ns
Not received	86.1		84.0		84.6	
Received	90.8		89.2		92.8	
Supervision		<0.01		<0.01		ns
Irregular	77.7		74.6		80.6	
Adequate	93.4		91.8		92.9	
Number of supervisions		ns		ns		<0.05
0 - 1	86.3		85.9		91.3	
2 - 3	89.1		87.1		91.2	
4 – 6	92.2		89.0		57.1[α]	
Experiences (years)		<0.01		<0.05		ns
<4	93.5		92.6		95.8	
4 - <6	90.3		86.8		83.3	
6+	86.3		85.2		90.2	

Source: Hadi, A 1999.

[α] Number of cases is too small

Several studies analysed the performance and skill level of SSs in tuberculosis control (Islam et al. 1999, Chowdhury et al. 1997, Islam 2000). Studies indicated that SSs could easily find symptomatic patients as they were from the same community and knew each other. Often, there was also a good relationship between patients and SSs as the community people were involved in selecting SSs and trusted them being one of their own. Thus patients felt more comfortable in dealing with SSs than they would with some one from outside the village. Patients could also interact with SSs without much disruption to their daily chores. Especially as all SSs were women, they were well placed to assist female patients. Such convenient situational factors enhanced the adherence to tuberculosis treatment (Islam et al. 1999, Chowdhury et al. 1997, Islam 2000). In BRAC areas the majority of people were aware of tuberculosis and treatments available through SSs.

Regarding the measurement of tuberculosis diagnosis and treatment one study (Islam 2000) revealed that in the study area a total of 186 patients were successfully identified by SSs as having tuberculosis between July 1996 and June 1997. Of them 91.4% were sputum positive, 7.0% were sputum negative and the remaining 1.6% were extra-pulmonary patients. Out of the positive patients 87.1% were new sputum positive and 12.9% were previously treated patients. Regarding the treatment outcomes of the new sputum positive patients, 85.6% were cured, 9.5% died and 2.0% failed in treatment and the remaining 2.7% defaulted. Of the previously treated patients 72.7% were cured, 9.1% completed treatment, 13.6% died and 4.6% were referred to other facilities.

The community were also satisfied with SSs' performance and had reliance on their skills. According to them SSs were skilled as qualified doctors in managing illness situations. SSs were also confident enough about their own skills. In this regard during group discussion they stated that "*We are sure that we do our job properly. We practice what we have learn without any mistake.*"

Community acceptance

Community acceptance is a prerequisite for the success of any programme launched for the community. An earlier study on community acceptance of SSs showed that 58% of VO members and 40% of non-VO members received curative treatments from SSs. Various reasons were given for non-acceptance in studies like BRAC medicine was not free of charge and expensive, medicine was not sold on credit and not always available. Indeed, most of the time people were not willing to pay for BRAC medicine because they thought BRAC received it free from the government. Sometimes they also thought that the quality of medicine was not good enough (Islam 1991, Khan et al. 1998).

Regarding acceptance of SSs, one study indicated that there was a dilemma in the community that SSs were not doctors but delivered health care services. People wanted to go to an educated health care provider rather than an uneducated one. Besides, people did not want to buy medicine from SSs because there were too many doctors and pharmacists in the nearby bazaar. (Khan et al 1998). However, the status of SSs had been gradually improved. Although some neighbours, especially the well off opposed their activities, they were respected presently as *a dakter* for providing treatment of TB and some other common diseases. The community was gradually beginning to accept SSs at large (Afsana et al. 1998).

SSs were in great demand as service providers to rural women. They were found to seek contraceptive methods and treatment for their children to SSs. The women were also comfortable in consulting SSs for their reproductive health problems, as they felt shy seeking these services from the local bazaar from male providers (Khan et al. 1998, Mahbub and Ahmed 1997). In a study in RDP-EHC area a change in women's health seeking behaviour was observed following the introduction of SSs in the community. As medicine for ten diseases were easily available through SSs, the women tended to use these medicines more than traditional medicines which they used to take before (Mahbub and Ahmed 1997).

Adolescent girls also presently consulted SSs for problems related to their reproductive organs. SSs reported that most of the time adolescent girls visited them for problems like white discharge, which they could not talk to the other women, as social stigma attached with it. Unmarried adolescent girls relied on SSs and talked frankly to them.

The study noted that men in the community were gradually accepting SSs. As they mentioned during a focus group discussion:

> *The villagers have started to go to shebika for four/five years. Usually the women in the village consult them during an illness. The men rarely consulted them in the beginning but for two years they have started to seek advice and medicine from them. In the past, we did not have any trust in them. We thought how could these illiterate women be able to perform a doctor's job! This was useless (abol tabol). These women came out from their houses just for chatting (betira ghor theke ber hoise shodho golpo korar joinoya). Later on, we have found out that they talked to the women on important issues. They are working for the well-being of the community. Besides their medicine is effective. Our trust was gradually established in them. They are now playing an immense role in the community. Nevertheless, the women feel more at ease in talking about their problems than us. Sometimes we feel awkward speaking about our health problems to shebikas and they also feel awkward on listening to us. Still, if we get benefit from her in our illness condition, we have to go.*

According to the SSs, at the initial stage they encountered resistance. As one of the SSs stated:

> *People did not pay any heed to us. They did not even allow us to enter their house. The young men teased us on the way. They thought our medicine was false. Sometimes they challenged our treatment. Once I gave histacin (anti allergic medicine) to a woman who had itching and*

afterwards I gave same medicine to her daughter-in-law for cold. Then one man from their house aggressively told me to go away. He told other people that I was a cheater and I was providing medicine without any knowledge as I gave the same medicine for two different diseases. He asked for my licence to practise as shastho shebika. I showed them my bag and said that that was my licence. At that time, fortunately a young educated man was passing by. On seeing the crowd he stopped and asked about the matter. After listening to the whole account, he said that I was correct.

The other SSs admitted that every one of them faced such experiences at the beginning. However, as the bag provided from BRAC was regarded as a licence for practice and a symbol of status, it became valuable to the legitimacy of SSs. They were always found to carry the bag with them even though they went for social visits to their relatives and friends' houses. Almost every SS reported that they lied to the villagers, saying that they received a regular salary of TK. 1000 to 1500 from BRAC as this increased their status and social acceptance.

Thus, SSs adopted different strategies to increase their acceptance in the community. While visiting door to door they often helped the women in doing household chores, so that they could at least convince them to listen to them. Presently according to the SSs the situation was reversed:

People come to our place if we do not go to them for two/three days. They come to call us for advice and medicine whenever they need to late at night or early in the morning. We used to help them do their household chores before. Now they help us, so that we get some leisure from our household activities and can listen to their problems.

Workload

Management of household activities is considered to be the primary role of a woman in the predominantly rural and agricultural society of Bangladesh. Micro level studies have shown that the rural women in Bangladesh spent 56 hours a week in different types of activities (Khuda 1982). Given the situation of women in rural society the lives of SSs were severely constrained by the burden of their triple roles – reproduction, production and community management (Afsana et al. 1998). Various studies have revealed that due to participation in different BRAC activities along with performing household duties, SSs were overburdened (Islam 1991, Afsana et al. 1998, Khan et al. 1998).

Among the health related activities SSs participated in health forums, cluster meetings, visiting clients' house and visiting area offices to collect medicine. They assisted POs in organising ante-natal care centres (ANCC), EPI and Growth Monitoring (GM) sessions, and were also involved in motivational work and in distributing contraceptives among the eligible couples. During their free time, the SSs maintain contact with the family welfare assistance (FWAs) of the government family planning programme in order to collect pills and condoms (Afsana et al. 1998).

The most important work of SSs was the supervision of TB patients. SSs visited TB patients every alternate day during the first two months of treatment to inject TB drugs and every week for the rest of the treatment period to provide oral medicine. Most of SSs were found to attend 1-4 patients for injections and 1-7 patients for oral medications. Moreover, SSs were found to collect sputum from suspected and identified TB patients, and to bring the sputum for laboratory tests (Afsana et al. 1998).

In addition to health related activities SSs attended VO and issue based meetings. They also attended a half-day monthly refresher's course in the area office. According to a study for the weekly VO meetings, SSs spent 1-2 hours. In previous days Gram Committee (GC) meeting were held after VO meeting were continued for half to one hour and if GC and issue-based meeting were organised in the afternoon it take 2-2.5 hours for all the members to arrive. Besides, SSs used to attend all the *Mohila Shova*

(MS) meetings within their supervision areas, and every month at least spent 15 hours in the MS meetings (Afsana et al. 1998). However, GC and MS meetings had presently been rescinded. Nevertheless, on average SSs spent more than an hour daily in holding several meetings. Apart from all this, SSs spent a large amount of time travelling to and from BRAC offices. Due to a lack of money they were not able to buy all the medicines required for a month. BRAC staff were also found to suggest medicines collections weekly due to lack of availability (Islam 1991).

In performing these activities they not only used their free time of household chores but also their active working hours. With all these works, they practically had no free time. According to the study results, SSs on their meeting or other activity days started the day much earlier. Before going out, they tried to finish their household chores very swiftly. Under such circumstances if they failed to finish their work, they left it for their daughters or mother-in-law. Thus, excessive involvement of SSs caused inconvenience for themselves as well as their family members'. By the end of the day with this double, treble and often quadruple workload the SSs would become exhausted and fatigued (Afsana et al. 1998, Islam 1991).

Workload of SSs created several difficulties in their lives. It often limited their subsistence and other income earning activities, which in turn created food insecurity and financial loss for the family. Especially, childcare appeared as a genuine problem for SSs as they had a very little time for childcare. Even when a child was ill, they could not cancel their meetings or end their tasks (Afsana et al. 1998).

However in the present study SSs reported that their workload had been a little reduced as presently they did not need to visiting house to house. Due to their familiarity people rather consulted them in their house. Therefore, along with household chores they were able to continue their health activities. Nevertheless they stated –"*though visiting house to house is little reduced than before but whilst carrying out the household chores people come to us and we have to talk to them (manush ashley aao chaoo korai lage). Still we have peace of mind now that our status has changed in the community.*"

Dropout

The terms "trained" and "active" in the available literature indicate that drop out of SSs might be occurring. "Trained" refers to those SSs who received foundation or basic training. "Active" means those SSs who received training and are currently working and have participated in two consecutive refreshers. Drop out refers to those SSs who after participating in the basic training and two consecutive refresher training stopped working as an SS, do not make household visits, or no longer take part in health forums (Khan et al. 1998).

Dropout of SSs can be considered as a loss of resources as BRAC health programmes expend significant resources to recruit, train and supervise SSs. According to a study on drop out of SSs, the drop out rate in the study area was 44%. It was found that in the study area the drop out rate was as high as in the particular region of Mymensingh it was 31%, and it was 32% for overall essential health care (EHC) programme (Table 1). The study revealed that among 50 SSs of the study area, 28 were active. In the whole region of Mymensingh 174 SSs were trained, and 121 of them were active. In EHC programme 11285 SSs were trained nationally and only 7740 SSs were active (Khan et al. 1998).

Table 2. Profile of SS dropout in RDP-EHC.

Duration of programme	Trained SS	Active SS	Dropout rate (%)
Fulbaria (area) 3 years	50	28	44%
Mymensingh (region) 5 years	174	121	31%
EHC (national) 10 years	11, 285	7, 740	32%

Source: Khan et al. 1998.

The studies revealed that due to multiple reasons SSs often discontinued their work (Afsana et al. 1998, Islam 1994, Khan et al. 1998). One of the main reasons for this was a lack of profitability. Many dropouts mentioned that they did not earn much profit from selling medicine and people often bought medicine on credit purchase basis, which later would become difficult to recover. Sometimes people in the community were unwilling to buy medicine from an SS as they preferred to buy cheaper medicine from local shops.

According to SSs people were reluctant to pay for BRAC medicine. They perceived BRAC received those free from the government. With so much effort needed for the dropout SSs were unwilling to continue without a salary. However, the other active SSs pointed out that those who dropped out were basically idle. They explained:

> *They did not give much effort to selling medicine. They did not visit the households of the village regularly and behaved badly with the community people. Hence people stopped coming to them for medicine. When patients come to us we cordially receive them and talk in a soft manner. Doctors should always be soft to their patients, then patients will come to them.*

The drop out SSs stated that their work demanded a greater time and attention than they had anticipated or were willing to invest. They had household chores, they had to look after their children and some of them were involved in multiple activities i.e. VO leader, government *shetchsa shebika*. Thus they had not counted on spending so much time on this voluntary work (Khan et al. 1998). The community people reported that the husband of SSs beginning to disapprove of their work as it took up a lot of their time.

Due to certain socio-cultural reasons some dropout SSs were uncomfortable in doing their work. According to them the work of SSs was not compatible with the image of village wife. Going house to house was not socio-culturally accepted for the village wife (Khan et al. 1998). Some of the active SSs also reported that they would not be able to continue their activities if their husbands did not help them. Initially their husbands

accompanied them while visiting households as they were uncomfortable going their own, and they did not always know the way well.

Although BRAC health programmes anticipated drop out and had a strategy to overcome it, the effects of SS dropouts have been immense. In a study, BRAC staff expressed that their activities were hampered due to dropout rates. The entire workload would fall on Programme Assistants (PA). The achievement of targets for each component of EHC was hampered as well. Dropout of family planning (FP) client occurred and medicine, sanitary latrine and tubewell sales fell below set target. As it was difficult to inform the rural community without SSs, the motivation and mobilisation process became very slow. Due to a lack of motivation and mobilisation the EPI facilitation programme was hampered. Health forums were not held properly and attendance fell. Besides, drop out of an SS put extra pressure on the VO leader as she was usually asked to take over the SSs' responsibilities.

Another effect was the costs incurred by the BRAC health programme and the SS. It was calculated in a study that BRAC's EHC programme spent a minimum of TK 1049 per SS. This cost included salary of the staff, food cost and the cost of training materials. As the study area had 22 dropouts, the financial loss was a minimum of TK. 23078 to BRAC (Khan et al 1998).

Husbands' attitudes

The husbands of SSs had more or less positive attitude towards their activities as it was considered a source of income earning and an esteemed job. According to the SSs their husbands initially had a different attitude towards their work. They did not like them visiting house to house and talking to people. Sometimes they used to mock their activities and prevent them from doing their work, as they were not getting a salary. Subsequently, when they realised that their wives had started to earn money and were able to meet some of their daily small necessities, they stopped trying to prevent them from doing their work. However, some of the SSs stated that from the very beginning,

their husbands were supportive as their activities were considered to promote the well-being of the community.

The male in the community opined:

> *Why should the husbands raise an objection because it is a source of income for the household? The women also do not bother about their husbands' permission. They decide on their own to work as a shebika. Sometimes it is found that the shebikas do not wait to serve meal to their husbands. They just cook and go for households visit. The poor husbands have to take the meal on their own.*

Key informants reported that husbands were often found to scold their wives as their meals and other things were not always kept ready. In such situations other VO members would often come forward to persuade husbands not to behave in this way as their wives' work benefited the community.

Benefits and motivating factors

Describing benefits of SSs' activities which act as motivating factors to continue their work, one key informant stated:

> *Despite facing hard times in the beginning, shebikas continued their activities with the hope of some economic benefits. They thought that they would get economic solvency from their earning. Gradually the environment has changed and people have started to accept them. Nowadays their suggestions are given importance and people call them by dakterni (female doctor). They are proud of this which motivated them to continue their work. They believe that along with some income earning, this achieved status is also a benefit of their activities.*

The SSs shared similar opinion about the benefits of their activities. As one SS, Selina said:

> *The earning from shebika activities has assisted me to become economically independent. From this earning I meet the expenditure of my children's education and other necessities. Once I even managed to run my family on this income when my husband was bedridden due to an accident. Indeed a good shebika can earn at least fifty Taka per day. The income is even higher if she visits house to house. Thus, a good shebika can earn 1000 to 1200 Taka a month.*

In addition to economic benefits, social prestige was another gain of *shebika* activities. The SSs expressed that people were happier with their services than with those of qualified doctors. They felt honoured when people addressed them as "*dakarni*" and they thought this was the real value of their activities. They stated:

> *People spend so much money to become a doctor. They have to study a lot as well. We, the illiterate women, perform a doctor's job and provide medicine to the villagers. This increases our prestige and honour. Even the rich people come to consult us. The people in the community suggest us to stand for election.* _____

The SSs considered the knowledge and skill they had gained as a benefit. They stated that through their acquired knowledge they were able to increase awareness of the community people which contributed to the improvement of the overall environment. They could also use their skill and knowledge in treating their own children, therefore they did not need to go to a doctor as before. The SSs also said that they felt delighted when a patient got recover by using their medicine. Indeed a combination of all of these factors motivated them to continue their work as an SS.

Perceived role in BRAC programme

An effort was made to explore *shastho shebikas'* perceptions about their role in BRAC health programmes. Two different perspectives were noted in this regard. Most of the SSs believed that they were vital for BRAC health programme as without them BRAC would encounter several difficulties with working in the community. One of them clarified:

> *BRAC people would not be able to reach the villagers without us. Nobody would even talk to them properly. How could they find TB patients and pregnant women on their own! Since we are in the centre of BRAC activities and village life, the villagers take medicine from us. We sell medicine on behalf of BRAC, we send patients to BRAC's hospitals. We make villagers aware of sanitary latrines. These all are useful for BRAC, yet we also get profit from these activities (aigula bracer joinnoya jemon dorker temon amadero ete kichu ashe).*

However, an opposite view was also found among some of the *shastho shebikas:*

> *We are not that useful for BRAC. BRAC could work in the village without us; they would not encounter any difficulties. The other apas and bhais (BRAC staff) have come from different places. They do not belong to our area but people talk to them and listen to them. Therefore, they did not need us to do this type of activities. It is their generosity that has provided this opportunity to poor women to become involved in this income earning activities.*

Sustainability without BRAC

According to a study (Islam 1992) about 85% of the SSs anticipated continuing their activities if BRAC withdraw. Yet some of them wanted to receive proper training on

management in order to avoid possible problems. A few of them mentioned that they would seek assistance from government health staff and organise a committee.

The present study revealed that most of the SSs in the study area were confident enough to continue their activities if BRAC withdrew the support. As they thought they gained enough skill to carry out their activities without BRAC's support. One of them explained:

> *BRAC will not be able to take what we have learnt from BRAC's training. We will use our learning. Our identity is already established in the community. People visit us for medicine and advice. If we do not get further support from BRAC, we will be able to buy medicine on our own and sell them to the villagers. But we will not leave BRAC, even if BRAC leaves us. For many years now we have been working with BRAC without any salary. We have earned very small amounts of money (chaair ana aat ana poisha), still we have kept the relation with BRAC. So why should BRAC leave us!*

Some of the *shastho shebika* believed that they required additional training to continue their activities independently. According to them:

> *If we do not have BRAC support in the future, socially we will not face any difficulties. The villagers are already familiar with our activities as an SS. They will keep on coming to us for medicine and advice. But we will have problems in buying medicine on our own from the market.*

People in the community opined that the SSs would not be able to work independently without BRAC's support. The villagers would not value their activities without BRAC's identity. However, they might visit them for taking advice regarding the management of illnesses. Still due to a lack of money and skill, SSs would not be in a position to buy

medicine on their own. They would need to develop their skills more to work independently without supervision from BRAC.

Discussion and conclusion

The *shastho shebikas* (SS) are the health cadres, selected from Village Organisations (VO) of BRAC. They are the nucleus of BRAC health programmes and are trained in preventative, promotive and curative aspects of health. As the frontline work force, their role and functions in BRAC health programmes are enormous. The programme covers approximately thirty-five million people by mobilising these *shastho shebikas* (BRAC 1999). BRAC has been using SS since 1977. Several studies have been done so far on different aspects related to SS. The present study made an effort to document the current situation of SSs from different primary and secondary sources. Concurrently the study tried to explore the possibilities of institutionalise SSs' activities in the community.

The study revealed the various reasons for a BRAC member becoming an SS. The SSs considered the position to be a source of profitable income, access to medicine and knowledge and a prestigious job. Peer pressure also appeared to be a significant factor in the decision to become an SS. In assessing skill and performance of SSs it was noted that the retention of knowledge SSs was high. Most of them could identify common diseases like the common cold, amoebic dysentery and pneumonia and. They were also able to manage these cases correctly. Regarding ARI management SSs could produce the desired outcome in identifying and treating pneumonia in children at the community level. Due to familiarity and a good relationship with villagers, SSs were useful in enhancing adherence to tuberculosis treatment. However there was a clear relationship between regular and adequate supervision of SSs and the quality of their performance in their various activities.

Due to participation in a variety of BRAC activities along with performing household duties SSs were undoubtedly overburden. However, SSs were happy as they could earn an income and gain social prestige through their activities. SSs reported that they could often carry out their health activities alongside their household chores at home.

Nowadays their workload was a little relieved as they did not have to visit house to house to the extent they did before. However, an analysis of women's workload revealed that women involved in development interventions usually reallocate their surplus time from domestic work to other types of work such as economic and social development work etc. They also cope with the situation by developing a household support system (Sabri 2000). The present study revealed that the family members and husbands of the SSs were supportive to their activities as they took it as a source of income earning. Although an implicit complaint about not taking care of the husbands enough was noted in the study.

In identifying the factors which motivate SSs to work the study found that economic and social reasons were important, as well as access to skills and knowledge. The study showed that in the view of SSs, the satisfaction of their popularity and position in society, often went beyond the importance of their income earning capacity.

Most of the SSs perceived themselves as an important component for the success of BRAC health programme. They believed that without them BRAC would encounter several difficulties in working with the community. In the study, SSs expressed their confidence to continue their activities if BRAC withdrew support. However, they themselves were unwilling to leave BRAC as they felt emotionally attached.

The study revealed that in due course the acceptance of SSs in the community gradually increased. In addition to women, adolescent girls and men in the community also consulted SSs during illnesses. The increasing acceptability of the SSs indicated that their activities were more or less institutionalised in the community. As a pattern of norms and behaviours had been established between SSs and the people in the community. An institution usually implies forms of standardise action or behaviour linked to a set of complex and interdependent norms and roles and applying this to a relatively large proportion of people within a society (Smith 1988).

This study mainly focused on the social aspects which provide a partial view of the situation of SSs. An estimation of the market value of the SSs' services to community

and to BRAC's health programme is required to measure the cost effectiveness of SSs. To gather a clear picture on the cost effectiveness of SSs and their economic contribution A study can be conducted which will include all direct and indirect cost. It may be possible to see by comparing two situations, where the one health programme operates with SSs and the other without them. However, as all of BRAC's health programme areas have SSs working as community motivators. It would be difficult to find the comparison area. It may, therefore, better to compare BRAC health programmes with other NGO(s) running similar health programmes.

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