The Story Behind The *Shasthyo Shebika* Dropouts

(Training and Retaining *Shasthyo Shebika*: Reasons for Staff Turnover)

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BANGLA SUMMARY

স্বাস্থ্য সেবিকার কাজ ছেড়ে দেয়ার কারণসমূহ

সুহেলা হক খান, এ এম আর চৌধুরী, ফজলুল করিম, মিলন কান্তি বড়ুয়া*

১৯৭২ সালে ব্র্যাকের স্বাস্থ্য কর্মসূচী শুরু হয়, যার একটি অংশ RDPতে অন্তর্ভুক্ত হয় ১৯৯১ সালে। এই অংশটি ১৯৯৬ সালে এসেনশাল হেলথ কেয়ার (EHC) নামে আত্মপ্রকাশ করে। স্বাস্থ্য সেবিকারা (SS) RDP-EHCর একটি প্রধান উপাদান । SSরা হলো গ্রাম্য সমাজ সেবক-কর্মী যারা EHC-র বিভিন্ন সেবা প্রদান করে থাকে। প্রতিটি SS প্রশিক্ষণে অংশগ্রহণ করে এবং যে কোন প্রশিক্ষণ কর্মসূচীতেই কিছু ষ্টাফ চলে যায় (staff turnover) । ফুলবাড়িয়াতে এ পর্যন্ত মোট ৫০ জন SS কে প্রশিক্ষণ দেয়া হয়েছে, যার মধ্যে ২৮ জন এখনও কাজ করছে। দেখা গেছে ফুলবাড়িয়াতে EHC কর্মসূচী থেকে SS ত্যাগের (dropout) হার ৪৪%, ময়মনসিংহ অঞ্চলে ৩১%, এবং RDP-EHCর জাতীয় SS ত্যাগের হার ৩২% । ফুলবাড়িয়ার এই হার RDP-EHCর আঞ্চলিক এবং জাতীয় হারের প্রায় দেড়গুন। RDP-EHC কর্মসূচী এসব SSদের নিয়োগ, প্রশিক্ষণ এবং তত্ত্বাবধানের জন্য অর্থ/সম্পদ ব্যয় করে। এসব চলে যাওয়া SS হারানো সম্পদের প্রতীক।

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* Summary of the RED research report titled "The story behind the *Shasthyo Shebika dropouts*," by Suhaila H. Khan et. al., April 1997. 50p (Summarized in Bangla by Suhaila H. Khan).

এই সমীক্ষার উদ্দেশ্য ছিল অনুসন্ধান করে সনাক্ত করা যে কি কারণে SSরা RDP-EHC কর্মসূচী ত্যাগ করে, এবং RDP-EHC কর্মসূচীতে এই ত্যাগের প্রভাব কি। এটি একটি rural case study/সমীক্ষা ফুলবাড়িয়া-ময়মনসিংহে। এ সমীক্ষায় অর্ন্তভূক্ত করা হয় ১০ জন SS যারা গত তিন বছরের মধ্যে কর্মসূচী ত্যাগ করে চলে গেছে । এ সমীক্ষায় যে বিষয়গুলো বিবেচনা করে হয়েছে সেগুলো হলো: SSএর বয়স, বৈবাহিক অবস্থা, জীবিত সন্তানের সংখ্যা, পরিবারের সদস্যসংখ্যা, শিক্ষা, পেশা, ব্র্যাক সদস্যপদ, EHC কর্মসূচী ত্যাগ করার কারণ, এবং EHC কর্মসূচীর উপর এই ত্যাগের প্রভাব । ১৯৯৬ এর ডিসেম্বর মাসে এ সমীক্ষার তথ্য সংগ্রহ করা হয়।

SSরা যে সকল কারণে এই কাজটি বাদ দেয় তা হলো: সময়ের স্বল্পতা (ছোট বাচ্চা দেখাশুনার জন্য ও সংসারের অন্যান্য কাজে বেশী সময় ব্যয়), ঔষধ বিক্রি করে পর্যাপ্ত "লাভ" না হওয়া (SSরা মাসে ১০০-৩০০ টাকা আয় করে এই কাজ থেকে), অন্যান্য কাজে "লাভ" বেশী (e.g. পশুপালন, সরকারী স্বেচ্ছা সেবিকা হওয়া), অল্প "লাভের" জন্য অতিরিক্ত পরিশ্রম করতে হয়, ঔষধ বিক্রির জন্য পর্যাপ্ত ক্রেতা না পাওয়া, ঔষধ কেনার প্রতি ক্রেতার অনীহা, এবং এ কাজ পরিবারের অপছন্দ।

EHC কর্মীরা কর্মসূচীর উপর SS ত্যাগের প্রভাব সম্পর্কে বলেন যে, SSরা কর্মসূচী ত্যাগ করার ফলে অভীষ্ঠ লক্ষ্য অর্জিত হয় না যেমন, ঔষধ, স্বাস্থ্য সম্মত পায়খানা এবং চাপকল বিক্রি কমে যায়, পরিবার পরিকল্পনা গ্রহনকারীদের সংখ্যা কমে যায়, সরকারী সেবা (EPI & SC services) গ্রহণে সমাজকে উদ্বুদ্ধ করা হ্রাস পায়। কর্মসূচী ত্যাগের আরেকটি প্রভাব হচ্ছে RDP-EHC র ব্যয়। একটি এরিয়াতে EHCর চারজন কর্মী থাকে (১ জন ম্যানেজার, ১ জন SPO এবং ২জন PA)। এরা স্বাস্থ্য সেবিকাদের নিয়োগ, প্রশিক্ষণ এবং তত্ত্বাবধান করেন। দেখা গেছে যে, একজন SS এর পেছনে EHC ন্যূনতম ১,০৪৯ টাকা ব্যয় করে (যদি প্রত্যেক SS

বেসিক/মৌলিক প্রশিক্ষণ গ্রহণ করে, তারপর ১মাস কাজ করে, এবং তারপর ১টি refresher's প্রশিক্ষণে অংশগ্রহণ করে)। এই ব্যয়ের মধ্যে আছে ব্র্যাক কর্মীর বেতন, SS এর খাদ্যবাবদ খরচ, এবং প্রশিক্ষণ উপকরণ বাবদ ব্যয়। ফুলবাড়িয়া থেকে ২২ জন SS চলে যাওয়ায় সেখানে মোট ক্ষতি ন্যূনতপক্ষে ২৩,০৭৮ টাকা (যদি সবাই পূর্বে উল্লেখিত কর্মগুলোতে অংশগ্রহণ করে; এতে দুটি ব্যয় ধরা হয়নি -- overhead ব্যয় ও ব্র্যাক কর্মী দ্বারা SS কাজের তত্ত্বাবধানের ব্যয়)। এই কাজ করার জন্য SSএর opportunity ব্যায় হয় ৬৪০ টাকা, যা তার মাসিক আয়ের কমপক্ষে দ্বিগুন।

যেসব SS রা কর্মসূচী ত্যাগ করে চলে গেছে তাদের বর্ণনা থেকে কিছু বিষয় বের হয় যেমন, কাজটি যে স্বেচ্ছাসেবামূলক তা নিয়ে প্রশ্ন, ব্র্যাকের সেবার দাম বেশী, বাড়ীতে SSএর সময়ের অধিক চাহিদা, SSএর জনপ্রিয়তা, SSদের বাছাইয়ের মানদণ্ড, কর্মসূচী নির্দেশনার অভাব, SSরা ডাক্তার নয়, মহিলা জনিত এবং অন্যান্য বিষয়। সেবিকা চলে যাওয়া EHC ফুলবাড়িয়ার জন্য যেমন তাৎপর্য বহন করে তেমনি অন্যান্য ব্র্যাক এলাকার স্বাস্থ্য কর্মসূচী এবং দেশী-বিদেশী একই প্রকার স্বাস্থ্য কর্মসূচীর জন্যও তাৎপর্য বহন করে। সেবিকা চলে যাওয়ার পিছনে যে সব কারণ সনাক্ত করা হয়েছে সেগুলো RDP-EHCর অন্যান্য এলাকার জন্য প্রযোজ্য (generalizable) না হলেও এগুলো ত্যাগের সম্ভাব্য কারণ এবং প্রভাবের উপর আলোকপাত করে। তবে, RDP-EHC তার সেবা প্রদানের জন্য একটি সাধারণ পদ্ধতি ব্যবহার করে এবং একটি বড় নমুনায়নের মাধ্যমে বিভিন্ন RDP-EHC এলাকাতে সমীক্ষা চালানো হলে প্রাপ্ত তথ্য আরো সর্বজনীন হবে।

RDP-EHC কর্মসূচী কর্তৃপক্ষের জন্য তাৎপর্য: সুনির্দিষ্ট সুপারিশের জন্য আরো বড় নমুনার সমীক্ষার প্রয়োজন। সেজন্য, এই সমীক্ষা কর্মসূচী কর্তৃপক্ষের জন্য কিছু পরামর্শ/প্রস্তাব দিবে যা EHC কর্তৃপক্ষের কাজে আসতে

পারে। এগুলো হচ্ছে: প্রশিক্ষার্থী বাছাই করার সময় RDP-EHCর উচিৎ তার বিদ্যমান গাইডলাইনে দৃঢ়ভাবে অবিচল থাকা (e.g. গ্রুপ সদস্য নয় এমন লোক বাছাই না করা, বাজারের কাছে কর্মএলাকা এমন SS বাছাই না করা), যাদের বয়স ৩০-৪০ বছর এমন SS বাছাই করা, যে সব মহিলা বিভিন্ন ধরণের কাজে সম্পৃক্ত তাদের বাছাই না করা (অথবা তাদের package of activities করতে দেয়া), ৪ কি.মি. ব্যাসের কর্মএলাকায় শুধু একজন SS বাছাই করা, ব্র্যাক কর্মীদের আরো সৌজন্যমূলক ব্যবহার করা এবং SS প্রশিক্ষণের সময় বিশেষভাবে উল্লেখ করা যে SS দের প্রাথমিক কাজ হবে স্বেচ্ছাসেবিকার ও তারপর বিক্রেতার।

RED-EHC একটি সম্ভাবনাময় এবং দ্রুত বর্ধনশীল কর্মসূচী যা বিরাট অবদান রাখছে "ক্ষুদ্র ঋণ ও স্বাস্থ্য" কে বাস্তবে পরিনত করতে। সেজন্য এখন আরো বেশী করে প্রয়োজন বর্তমান কর্মসূচীর মূল্যায়ন করে প্রয়োজনীয় সংশোধন করা,যাতে এর কর্ম আরো আকর্ষণীয় ও কার্যকরী হয়।

ABSTRACT

Essential Health Care (EHC) is a component of the multifaceted BRAC health programme, whose core element is its *Shasthyo Shebikas* (SS) or rural community health worker-volunteers. Each SS participated in training and as with any training activity there was some staff turnover. Fulbaria area dropout was 44%, Mymensingh region 31%, and RDP-EHC national dropout was 32%. Since RDP-EHC expends resources to recruit, train, and supervise the SS, dropout SS represent lost resources. *The study objectives* were to explore and identify the reasons why the SS drop out of the RDP-EHC programme, and to explore whether and how these dropouts affect the RDP-EHC programme. This was a rural case study in Fulbaria-Mymensingh comprising of 10 SS who dropped out of RDP-EHC. *Data collection* was done during December 1996 with open ended guidelines.

The SS *discontinued* their work because of lack of time (e.g. more time spent looking after small children and doing household chores), not much "profit" earned from selling medicine, more "profit" earned from other activities, too much effort spent for too little "profit", and family did not approve of the work. *The effect of the SS dropouts* on the RDP-EHC programme was decreased achievement of targets (e.g. fewer medicine, sanitary latrine and tubewell sales), more FP client dropout, decreased mobilization of the community for the utilization of GoB services. Another effect was the cost to RDP-EHC, which was a minimum of Tk. 1,049 per SS. For these activities an SS's opportunity cost amounted to Tk. 640, which was at least twice more than her monthly income from SS activities.

Some issues raised were: question of voluntarism, BRAC dearer, demand on SS time at home, SS popularity, selection criterion of SS, SS "not a doc", and gender. Dropouts have implications not only for EHC Fulbaria but also for other BRAC health programmes and other national and international programmes. Although the reasons identified are not generalizable for other RDP-EHC areas they provide some insight into the possible causes of the dropouts and its effects.

Suggestions for programme management function are: RDP-EHC should strictly adhere to its existing guidelines when selecting the trainees, select SS between age 30 - 40 years, do not select women who are involved with multiple other activities (or have them do a package of activities), do not select more than one SS in a working radius of 4 km, BRAC personnel should try to be more courteous with the SS, and EHC should highlight during the SS training that the SS's first and foremost primary role will be that of a volunteer worker's, and then that of a salesperson's.

EXECUTIVE SUMMARY

BRAC health programme started in 1972, and a component of this was incorporated into RDP in 1991. This component emerged as Essential Health Care (EHC) in 1996. One of RDP-EHC's core elements is its *Shasthyo Shebikas*. These are rural community health workers/volunteers who help deliver the different EHC services. Each SS was recruited and participated in training. As with any training activity there was some staff turnover. In Fulbaria a total of 50 SS have so far been trained, of whom 28 were still considered to be "active". Fulbaria area dropout was calculated to be 44%, Mymensingh region 31%, and RDP-EHC national dropout 32%. It was calculated that Fulbaria had one and a half fold higher dropouts than the regional and national figures! Yet, EHC programme expends significant resources to recruit, train, and supervise the SS. Thus, dropout SS represent lost resources.

The study objectives were to explore and identify the reasons why the SS drop out of the RDP-EHC programme, and to explore whether and how these dropouts affect the RDP-EHC programme. The *study* was *designed* as a qualitative rural case study in Fulbaria-Mymensingh. *The study population* comprised of 10 SS who dropped out of the RDP-EHC programme within the last three years. *The variables* considered for the dropout SS were: age, marital status, parity, family size, education, occupation, BRAC membership, reasons for dropout, and effects of dropout on the EHC programme. *Data* was *collected* during December 1996 with open ended guidelines.

The dropout SS mentioned multiple *reasons for discontinuing* this work, such as, lack of time (due to more time spent looking after little children and doing household chores), not much "profit" earned from selling medicine (SS earn Tk.100-300 per month from this activity), more "profit" earned from other activities (e.g. livestock, poultry, GoB *Shetchsa Shebika*), too much effort spent for too little "profit", could not find enough customers to sell medicine to, people were reluctant to buy medicine, and family did not approve of the work.

The effects of the SS dropouts on the RDP-EHC programme, as mentioned by the EHC personnel, was decreased achievement of targets, such as, fewer medicine, sanitary latrine and tubewell sales, more FP client dropout, decreased motivation and mobilization for the utilization of GoB services (EPI and SC). Another effect was the cost to RDP-EHC. The minimum resources

spent by EHC in one area were four personnel, that is, 1 AM, 1 SPO, and 2 PAs to recruit, train, and supervise the training and subsequent work of the SS. It was calculated that EHC spent a minimum of Tk. 1,049 per SS (if each SS participated in a basic training, then worked for one month, and went to one refresher's training). This cost included salary, food cost, and the cost of training materials. Since Fulbaria had 22 dropouts, total financial loss was a minimum of Tk. 23,078 (if all had participated in the activities mentioned above which did not include the overhead costs or the training/supervision of EHC personnel). If an SS participated in these activities her total opportunity cost amounted to Tk. 640. This opportunity cost was at least twice more than her monthly income from SS activities.

The stories narrated by the dropout SSs gave rise to some issues, such as, question of voluntarism, BRAC dearer, demand on SS time at home, SS popularity, selection criterion of SS (nonVO member, age, multiple activities), lack of programme direction, SS "not a doc", gender issues, and other reasons. Dropouts have implications not only for EHC Fulbaria but also for other BRAC health programmes and other national and international programmes. Although the reasons identified are not generalizable for other RDP-EHC areas they provide some insight into the possible causes of the dropouts and its effects. Nevertheless, RDP-EHC does use a general formula for executing its services, and only a study with a larger sample size in different areas of RDP-EHC will enable the findings to become generalizable.

Implications for RDP-EHC management function: For specific recommendations a study with larger sample size is required. Thus, this study gives suggestions which may be useful for programme management function. These are: RDP-EHC should strictly adhere to its existing guidelines when selecting the trainees (do not select non-VO members, do not select SS whose working area will be near a bazaar), select SS between age 30 - 40 years, do not select women who are involved with multiple other activities (or have them do a package of activities), do not select more than one SS in a working radius of 4 km, BRAC personnel should try to be more courteous with the SS, and EHC should highlight during the SS training that the SS's first and foremost primary role will be that of a volunteer worker's, and then that of a salesperson's.

The RDP-EHC Programme is a promising and fast growing programme which contributes greatly to make the myth of 'microcredit and health' a reality. Thus, it is even more prudent to evaluate the

various aspects of the current programme and make appropriate adjustments to enhance its activities.

INTRODUCTION

The Essential Health Care (EHC) programme is a component of the multifaceted BRAC health programme, whose core element is its *Shasthyo Shebikas* (SS) or rural community health workers/volunteers. Each SS participated in training and as with any training activity there was some staff turnover. Since RDP-EHC expends resources to recruit, train, and supervise the SS, dropout SS represent lost resources and may effect the programme by delaying in achievement of its targets. Currently RDP-EHC utilizes a total of 7,740 SS and of those 28 were in Fulbaria. The Fulbaria SS presently cover 6,000 households (population about 30,000). Each SS was recruited from the community and participated in a training that lasted for 15 days. In addition each SS attended one refresher's training of a day's duration each month.

Rationale of the study: Of the few studies available on SS activities the SS were usually mentioned using the two terms '*trained*' and '*active*', and the numbers differed for the two categories (Ali et al. 1994). From such statement it was evident that SS dropouts might be occurring. Also, a strategy used by the RDP-EHC was as follows: SS training was given in one area in two groups. If SS dropout continued then a third and final training was given to recruit new SS. In Fulbaria a total of 50 SS have so far been trained in three years, of whom 28 were still considered to be active. Total trained SS and active SS in Mymensingh region were 174 and 121 respectively. For the entire RDP-EHC programme ~~the number of trained and active SS were 11,285 and 7,740 respectively. Fulbaria area dropout was~~ calculated to be 44%, Mymensingh region was 31%, and RDP-EHC national dropout was 32%. Thus, it was observed from the numbers available for area, region and national dropouts that Fulbaria had a one and a half (1.4) fold more dropout than the Mymensingh region and the national figure. This was a good rationale for the study being done in Fulbaria-Mymensingh.

The objectives of the study were to explore and identify the reasons why the SS drop out of the RDP-EHC programme, and to explore whether and how these dropouts affect the RDP-EHC programme.

Background of RDP-EHC: BRAC health programme started in 1972, and a component of this was incorporated into RDP in 1991. This component emerged as Essential Health Care (EHC) in 1996. The RDP-EHC programme engages in preventive health activities but realizes that such work cannot be achieved overnight as people have to be first made aware of the proper health behaviour. Thus, curative services related to preventable diseases were added to the programme objectives. The RDP-EHC programme consists of water and sanitation, immunization, health and nutrition education, family planning (FP), and basic curative services (BRAC, 1995).

SS job description: The SS sell medicine; diagnose, treat, and give health education on diseases such as, diarrhoea, dysentery, fever, common cold, anaemia, worm infection, gastric ulcer, allergic reaction, scabies, and ring worm infection. SS also refer patients to nearby health facilities. Total monthly working days for each SS are 20. The SS also sell contraceptives, sanitary latrines, tubewells, vegetable seeds, and give health education, and motivation and mobilization regarding the five components of EHC. Furthermore, the SS go on follow up visits in the afternoon and encourage pregnant women to utilize government facilities. Moreover, the SS are involved in attending their daily household chores, VO activities, establish liaison with government workers, prepare monthly progress reports and send it to area office.

SS selection/recruitment: Most of the SS are aged 25 - 35 years, illiterate, and from poor households. They are not paid a salary but they retain a small profit from the sale of medicine and

from the sale of sanitary latrines and tubewells. Credit Programme Assistants (PA) initially ask VO (village organization) members to suggest names of prospective SS during VO meetings. The credit-PA refers these names to the EHC-PA, and the EHC-PA nominates them as SS's. Then at a general meeting of POs (Programme Organizer) and PAs at the area office where another selection is made; lastly, the regional office makes the final selection-interview based on the following criterion: socially acceptable, age 25 - 35 years, married, youngest child's age above 5 years, eager to work, preferably educated, and not living near a local health care facility/big *bazaar* (EHC, 1996). The selected SS trainees are required to leave their homes from morning till evening for the duration of the training. They usually leave their children at home during this training period.

SS training: Foundation/basic training lasting 16 days, 4 days per week, at the area or regional office. Then refresher's training of a day's duration given every month for 2 years at the area or regional office.

METHODOLOGY

- ***Study design:*** This was a rural case study taking the SS who dropped out as study units.
- ***Study area:*** This consisted of the RDP-EHC working area in Fulbaria-Mymensingh.
- ***Study unit:*** This comprised of 10 SS who dropped out of the RDP-EHC programme over the last three years, and who had worked for a duration of 3 months to 3 years. These dropouts were identified and selected from the refresher's register kept at the area office.
- ***Variables:*** The variables considered for SS were: age, marital status, parity, family size, education, occupation, BRAC membership, and reasons of dropout for the SS. The effects of dropout on the EHC programme were also considered.

- ***Study Implementation plan:*** Data was collected by the principal researcher using an open ended interview technique. Each interview took about 45 minutes. The interviews were conducted at the houses of the respondents either in the morning or in the afternoon. There were no refusals. As this was a qualitative study no "substantive" statistical analysis was done, mostly the reasons why the SS dropped out of the programme and its effect on the programme were explored and identified from the collected data.
- ***Time frame:*** The study was conducted from November 1996 to February 1997, with data collection during December 1996.
- ***Definitions used in this study:*** The term "trained" means those SS who received foundation/basic training. The term "active" means those SS who are still working or those who participated in two consecutive refresher's training and daily visit fifteen households and take part in two health forums per month. The term "dropout" means those SS who stopped working as an SS, and who do not make house visits or take part in health forums anymore, after participating in the basic training and two consecutive refresher's trainings.

FINDINGS

Socio-economic demographic characteristics of the respondents: The socio-economic demographic characteristics of the respondents (dropout SS) are given below. Their **ages** ranged between 25-55 years, averaging 39 years. **Marital status** was as follows: seven were married, two were widowed, one was divorced. The **number of living children** per woman ranged between 1-6, average being 3.4. **Education** ranged between nil to Class Five, average being Class Three. **BRAC membership** was as follows: eight were VO members, one was a non-VO member, while another was an ex-VO member.

Reasons for SS dropout: The dropout SS mentioned multiple reasons for discontinuing this work, such as, lack of time due to more time spent looking after little children, lack of time from doing household chores, not much "profit" earned from selling medicine, more "profit" earned from other activities, too much effort spent for too little "profit", could not find enough customers to sell medicine to, target set by office too high to be achieved, unwillingness to do this work without a salary, people kept buying medicine on credit purchase basis, people were reluctant to buy medicine because their perception was that BRAC got the medicine free themselves, availability of cheaper medicine at the local *bazaar* was cheaper, preference for buying medicine from local shops, people wanted the medicine free, having to buy medicine every month, people's preference for going to a doctor for treatment, hampered other VO work, family disliked the work, socially unacceptable for a woman to do this work, discourteous BRAC officers, and illness. The reasons of the SS dropout became apparent through the stories narrated by them, which are also given in tabular form in relation to their age and duration of work in the annexure.

Case 1: The story of Sufia

Sufia was a 35 year old married woman from the village Fulbaria, with four living children, the eldest being eighteen years and the youngest one and a half years old. The total number of her family members were 6, i.e. six people ate at the same kitchen. She had studied in the *madrasa*, the local religious school, upto the *Kaida*. **She was not a VO member**, and as such her current credit status was nil and she had never participated in any other RDP activities. She became an SS two years ago and received one month's training on children's diseases, latrines and tubewells. Her motivation for becoming an SS had been two fold: one, she wanted to do some work for children, and two, she wanted to have a "profitable"[i] income source for herself. When asked why she stopped working as a SS after less than a year's involvement she replied, "*I was ill when expecting a child so I stopped then. Now I do not go because my child is young. Also my SS work caused difficulty in completing the household chores. Moreover, profit from this work was not much. So I quit.*" According to one of the PAs this SS was so poor that as soon as she got hold of any cash she used it to buy food, as she did not have access to any cash at all.

Case 2: The story of Anowara Begum

Anowara Begum of Fulbaria-West Para was a 35 year old married woman with four living children. Her family consisted of six members. She had studied upto Class 4 in a government primary school. Her main occupation was sewing and she owned her own sewing machine/business. **She was an ex-VO member**. She had been a VO member for five years and gave up the membership two years ago. When she was a VO member she took part in various RDP activities, such as, credit, sewing, vegetable gardening, etc. Her current credit status was nil. Anowara became a SS three years ago because she wanted to earn an income and access to medicine. She received a 15 day training for this SS work. She remained an SS for less than one year because the profit earned from this work was not enough for her to stay on. She could not get by with the profit earned. Furthermore, she could not find enough customers to sell her medicine to. In fact she used to earn more from her tailoring business. She also mentioned quite succinctly that she did not know enough people to whom she could have gone, and that there were only so many times her neighbours could buy medicine from her!

Case 3: The story of Ayesha Khatun

Ayesha Khatun of Fulbaria South Para, was a 28 year old married woman with two living children. Her family consisted of four members. She had studied upto Class 5 in a government school. This was the only respondent who mentioned her husband's name spontaneously. She owned her three *katha vita*. Her main occupation was selling paddy rice. She had recently started working as a government *Shetchsa Shebika*. She had been a VO-member for twelve years and participated in various RDP activities which included: a recently borrowed Tk. 5,000 from RDP, training in sewing; bought and sold goats with loans; poultry activities (for which she received a three-day training). She became an SS two years ago because she wanted to get by with the "profit" earned from SS activities. She received a forty-day basic training, followed by one-day refresher's training each month. She worked for less than three months as an SS before she quit. She stopped going to the refresher's training because she was embarrassed as she could not sell medicine. Her other reasons for quitting were as follows: it was difficult to work on her own because she had other household chores to complete; she could not sell medicine because people went to the *bazaar* to seek treatment and buy medicine when they became ill. Furthermore, BRAC office gave the SS some set targets to be achieved in one month (e.g. 10 packets of oral contraceptive pills, 10 packets of condoms, 5 injections, 2 ligations, 1 Copper-T) which were too high to be successfully achieved every month. Now she would not do the SS work even if BRAC paid her because no one wanted to buy BRAC medicine. She also complained that BRAC medicine was more expensive than those available in the local *market/bazaar*. For example, a 200 ml bottle of Syrup Ferocyn cost Tk. 25 in the local pharmacies and BRAC charged Tk. 35 for that very same medicine. Ayesha opined that she would rather work as a government *Shetchsa Shebika* because she was given Tk 90 for a three day training, and afterwards every month she received Tk. 30 from the government. Ayesha hoped to become a Family Welfare Assistant (FWA) one day, as she could earn a lot more. *"Someday I will become an FWA myself"*, was her last comment.

Case 4: The story of Lutfannahar

Lutfunnahar was a 25 year old married woman with one living child. Her family consisted of three members. She had studied upto Class 5 in a government school. She had been a VO member for eight years. Her main income source was from RDP activities. Her current credit status amounted to Tk. 3,000. She invested this loan in a fisheries project for which she had received one-day's training. She had worked as an SS for two and a half years before quitting. She received a sixteen-day training on the SS work which had included the identification of sign/symptoms and treatment of certain illnesses. She became an SS to help the poor of the country. She had also thought that she would earn a lot and make big profits from this work, because the BRAC *apas* had told her so. She gave up the work because she earned little profit after walking around all day leaving her household chores unattended. After walking so much a profit of Tk.1 was not worth it and not enough to get by. Furthermore, people were reluctant to buy the medicine saying either that BRAC medicine was not good or that it was more expensive or that BRAC got the medicine free so why should they pay for it. This woman opined that this type of work could not be done without a salary. Moreover, her husband used to get angry because she went off locking the door and he would come home from work and not be able to get inside. Thus, he asked her to stop working.

Case 5: The story of Jeleka

Jeleka of Kushmail, was a 42 year old married woman with four living children. Her family consisted of seven members who ate at the same kitchen. She had studied upto Class 5. She had been a VO member for two years. Her husband and son were also VO members. She was also the centre leader of her VO. She owned 10 *katha* of land including the *vita*. Her current credit status was Tk. 6,000 which was being invested by her husband and son. As a VO member she participated in credit, livestock, and vegetable gardening activities. She became an SS two years ago but left after working for less than a year. She had received a sixteen-day training for the SS work which had consisted of education in medicine, sanitary latrine and tubewells. She took part in the training because initially she had wanted to do the work, and make a "profit" from it. Jeleka gave the following reasons for leaving her work as an SS: people did not want to buy medicine from her as they thought the government gave this medicine free and they were unwilling to pay for such 'free' medicine; also people kept buying the medicine on 'credit purchase' basis; furthermore, people preferred to buy medicine from the village doctors available in the nearby *bazaar* and not from her, a mere SS.

Case 6: The story of Jamela Khatun

Jamela Khatun of Valukjan West Para, was a 39 year old divorcee who had no children. She had studied in the *madrasa*, the local religious school, and finished the Quran. She had been a VO member for ten years. Her RDP activities included using credit for poultry (for which she received three-day's training). She had used a portion of her loan to buy food, and the rest she invested in buying a goat. According to her current credit status she owed RDP Tk. 1,000. She became an SS and remained so for less than six months. In the entire time that she had been an SS she never tried to sell any sanitary latrines or tubewells because she did not consider the work important or profitable enough. She became an SS because: to earn a profitable living from selling medicine, to make people aware so that people could take the Maya pill and stop having babies, and to inform and motivate mothers into accepting the injection for prevention of measles in children. When asked why she had quit the SS work her responses were: there was not much buying and selling of medicine, profit was little from selling medicine, and there were two village doctors practicing in the nearby market and everyone preferred them as these doctors gave the same diagnosis as MBBS doctors.

Case 7: The story of Zebunnessa

Zebunnessa of village Fulbaria Baati Para, was a 38 year old married woman with four living children. Her family consisted of six members. She had studied upto Class 5. She was a full-time housewife now that her son earned enough for the entire family as a bakery shop assistant in Mymensingh. She owned five decimals of land. She had been a VO member for seven years and participated in various RDP activities which included using credit for vegetable gardening, and small business of selling banana and rice. But she had not taken any loans during the last one year and was not actively involved with any RDP activities anymore even though she continued to retain her VO membership. Zebunnessa had begun the SS work because she wanted to know about the health aspects and hygiene of her own children and neighbours, and also to earn something from such activities. She had received a sixteen-day training for the SS work, which consisted of education on FP (temporary methods -- pills, condom, injections, copper T, ligation, **Norplant**; permanent methods – ligation), medicine – Histacin for fever, Metronid for dysentery. She worked as an SS for three years but gave it up because: she did not like leaving her children on their own as they were small and got into mischief when left on their own; this work hampered performing the other work she did for RDP credit; she should not go out because she was a village wife/*bou*; she was afraid of going about the village on her own as she did not know the way well; if she went too far people there would tell her to give the medicine free or else they would not take it; people said that these were hospital medicine which BRAC got free and so were unwilling to pay for them; people also opined that since BRAC had bought this medicine from the local pharmacy they would rather get the medicine there and not from an SS. **Interestingly enough the principal researcher found this dropout SS at the BRAC office buying medicine because she wanted to keep some medicine with her as emergency supplies; also she said that it was easier for her to achieve the targets now that she was not under pressure from the EHC programme.**

Case 8: The story of Rabeya

Rabeya was a 55 year old widow with six living children. Her family consisted of four members who ate at the same kitchen, her son being the main provider. She was illiterate. She had been a VO member for fourteen years and had participated in RDP activities for thirteen years, such as, credit, poultry, vegetables, etc., but not anymore. According to her current credit status she had a house loan of Tk. 5,000. She had received a one month training as SS for selling medicine. She worked as an SS for three years and then quit because her sons did not like it. Her other reasons for quitting were: she had to buy medicine every month; she could not find enough time to go to the BRAC office; the BRAC officers were very young, some were mere children, yet they used extremely rude and insulting language which even village elders would not use. Also people wanted to buy medicine from a doctor who was educated, but an SS was an uneducated doctor so people did not want to buy medicine from her. Rabeya had initially started the SS work because she had thought that she could do it but in reality could not; furthermore, her expertise as a *Kabiraj/Sharsi* was far more profitable, e.g. if selling BRAC medicine brought a "profit" of Tk.20, *Sharsi* practice would bring at least 4/5 seers of rice or Tk. 200-300!

Case 9: The story of Feroza

Feroza of village Nishchintopur, was a 38 year old married woman with three living children. Her family consisted of five members. She had studied upto Class 4. She had been a VO member for five and a half years and was involved with various RDP activities during that time. She was also the centre leader of her VO. Her current credit status was TK. 11,000, which also included a house loan, credit and vegetable gardening activities. She received a sixteen-day training for the SS work. Her work as an SS had included selling medicine, sanitary latrines and tubewells. Initially she had started the SS work because: if she or anyone in the village got ill there would be an advantage in knowing all this health information, also she would earn name and fame if she gave treatments for such illnesses; furthermore, she wanted to make money. She worked as an SS for one and a half years and then quit. Her reasons for quitting were: profit from selling medicine was not much and barely enough for her to get by; also she had low blood pressure so she gave it up. (She was the poorest of the dropouts, even the mud house she owned was extremely dilapidated and broken down in many places.)

Case 10: The story of Sakhina

Sakhina of village Baaliaan West Para, was a 55 year old widow with six living children. She was did not go to any kind of school but could sign her name. Her main income was from the earnings as a *dai*, an untrained midwife. She had been a VO member for four years and participated in various RDP activities such as, credit, poultry (for which she had received a three-day training), and small business of selling rice. She was an SS for two years (receiving 17 day's training) and quit four months ago. Sakhina had started working as an SS because she had thought that she might get a salary and earn an income; the then health PA had also suggested the very same and so she had joined. She quit because: she did not make much "profit" from selling the medicine; "profit" from selling medicine was not enough to get by as her sons did not feed her and she had to fend for herself. Another reason she mentioned towards the end of the interview was that because she could not do the work properly the BRAC officers used to misbehave with her which she did not appreciate. Sakhina opined that any work had to be done by two people together, that is community work should be a joint collaboration of both EHC and community. "So much harsh words I did not like. So I quit!"

Effects of the SS dropouts on the RDP-EHC programme: Effects on the RDP-EHC Fulbaria programme were identified by the Programme Assistants (PA) and Area Manager (AM) as follows:

- Hampered PA activities as entire work load fell on PAs,
- Hampered achievement of the target of each component in the different RDP-EHC activities,
- Medicine, sanitary latrine and tubewell sales fell below set target,
- There were more FP client dropouts.
- Motivation and mobilization process slowed down as it was difficult to inform the rural community about various EHC activities,
- EPI programme was hampered as parents were not able to be motivated or mobilized,
- Health Forums were not held properly and attendance at Health Forums fell,
- When an SS quit, the Centre Leader of her VO was asked to take on the SS's responsibilities to fill the gap. This strategy of using the VO by EHC to continue SS work is unlikely to be effective as these women were unmotivated to begin with and in the long run would not put much effort to the work. This also puts extra pressure on the Centre Leader and may affect her other RDP activities.

All the responses above are based on hearsay and the perception of the AM and PAs of Fulbaria area. One concrete evidence may be the difference in the set target and the achieved numbers because the two numbers were different.

Dropout rate: In Fulbaria a total of 50 SS have so far been trained in three years, of whom 28 were "active". This made the dropout to be 44%. This percentage should be considered very high for any programme, and even more so for a programme that relies heavily upon its community volunteer-workers. Mymensingh region dropout was 30.45%, and RDP-EHC national dropout was 31.41%. Thus, it was observed from the numbers available that Fulbaria area dropout was one and a half times higher than Mymensingh region and the RDP-EHC national figure[iii]. There were different types of dropouts, such as, some SS dropped out after only a few months and there were those who did so after years of service[iv]

Another effect was the financial and economic costs incurred by the RDP-EHC and the SS. The minimum resources used in one EHC area were four personnel (i.e. 1 AM, 2 PAs, 1 Programme

Organizer) to recruit, train, and supervise the training and subsequent work of the SS. Using the minimum wage scale for both EHC personnel and SS it was calculated that EHC programme invests a minimum of Tk. 1,049 per SS (if the SS participated in a basic training, then worked for one month, and then went to a refresher's training). This cost included the salary of the personnel, the cost of food for trainees, the cost of training materials, and other costs. This expenditure of Tk. 1,049 was a loss for EHC per SS if they work just for one month including a basic and a refresher's training. Since there were 22 dropouts in Fulbaria, the minimum financial loss to EHC from these dropouts was Tk. 23,078 (for a basic training, one month of work, and a refresher's training). These numbers would be higher if the overhead costs, the training of the EHC personnel, and the supervision of the area office personnel were also included. These were lost resources. If an SS participated in basic training, then worked for one month, and then went to one refresher's training her opportunity cost amounted to Tk. 640. Opportunity costs included training and other SS activities. The following gives a breakdown of the costs per SS:

Table 1: Breakdown of the costs in *Taka*.

	Basic training	**Refresher training**	**Supervise 1 month**	**Total**
Financial Cost to EHC				
Salary	189	07	156	**352**
Food	288	18	00	**306**
Trng. mat.	151	00	00	**151**
Other	240	00	00	**240**
Total	**868**	**25**	**156**	1,049
Opportunity Cost	**Basic training**	**Refresher training**	**Activities 1 month**	**Total**
to SS	320	20	300	640

(SS activities include health forums, follow ups, house visits, visit government EPI & SC centres.)

Yet an SS earned Tk. 100-300 on average, which made the economic cost at least twice more than the financial gain, which was a reason behind the dropouts (e.g. *"too much effort for too little profit"*).

To recover the Tk. 1,049, EHC should ensure that the SS work for at least 10.5 months and returns to EHC a minimum of Tk. 100 per month, and if SS returned Tk. 300 per month then at least 3.5 months work is enough to recover the initial costs. But the dropout SS had indicated that their earning did not always range between Tk. 100 - 300.

DISCUSSION

Some critical issues were raised which are discussed below.

Question of voluntarism or role played by SS: was raised. All ex-SS, regardless of age or duration of activity, mentioned the issue of "profitability" at some point during the interviews as one of the chief reasons for both joining and quitting the SS work. The ex-SS did not consider the work as voluntary which was quite evident from their responses, '*Profit from selling medicine was not good or enough*'; '*Too much labour spent for too little profit*'; '*This type of work could not be done without a salary*'; '*I earned more from other activities*'. SS mentioned specifically that since VO work, *Shetchsa Shebika* work, etc. were more "profitable" they would rather invest their time and efforts into those activities than those of an SS. This puts a question to the voluntary role of the SS, as a philosophy behind the incorporation of the SS within RDP-EHC that rural women could be motivated and trained into doing community health work voluntarily.

The above also questioned the role played by SS. There seems to be some confusion regarding the role played by SS in delivering the services. RDP-EHC perceives them as volunteer workers, but the SS perceive themselves as salespersons aiming to make a profit. This is evident from the reasons given by them as three reasons were related to "profit", such as, '*not much profit earned*'. '*more profit*

earned from other activities', and 'too much effort spent for too little profit'. RDP-EHC should address this problem in perception because it has led to a gap between programmers and SS.

The PAs were enquired what the dropout SS said about BRAC after quitting. The PAs answered that the ex-SS said selling BRAC medicine was not "profitable", and thus they would not do that work anymore. Two issues actually arose through this statement, which were: one, voluntarism was not a motivation for joining the SS cadre, and two, interestingly enough neither the PAs nor the SS mentioned selling sanitary latrine, tubewell or contraceptive, as profitable or non-profitable spontaneously at all. This may indicate momentary forgetfulness or the fact that they did not give much importance to this vital part of the EHC preventive health activity.

Implication for management function: It should be highlighted during the SS training that the SS's first and foremost primary role will be that of a volunteer worker's, and then that of a salesperson's. Also the BRAC personnel had given these women an inflated (no precise amount mentioned by anyone) idea of the "profit" they would be making but reality was far more difficult than anticipated. May be this difficulty should be addressed more explicitly before training.

BRAC dearer: Eight respondents mentioned why the community were reluctant to buy medicine from an SS. These were:

a) To both the provider (SS) and the consumer (villager) BRAC medicine was perceived to be more expensive than those available in pharmacies or shops located in the nearby *bazaar* and that *bazaar* medicine was cheaper. This problem had also arisen due to the less than honest dealings of the local shops where thev dilute liquid medicine or sell half of tablets at half the price to the illiterate villagers. To have prevented this programmers should have done a market research in the area before introducing certain curative services.

b) People were unwilling to pay for medicine they thought that BRAC got free from the government, such as the local *Thana* Health Complex.

c) People said that BRAC medicine was not good enough.

Implication for management function: Do not to select an SS whose working area will be near a big *bazaar* or *Thana* Health Complex.

Selection of the SS:

"Non-VO": According to programme guideline one of the selection criteria for being selected as SS trainee is to be a VO member. Yet one of the dropouts, Sufia (Case 1) was a non-VO member (but her mother-in-law was a VO member). She had even less incentive for doing this kind of voluntary community health work than the others. Another dropout, Anowara (Case 2) was an ex-VO member.

"Age": Jeleka (Case 5) was 42, and Rabeya (Case 3) was 55, and Sakhina (Case 10) was 55 years old, and none met the "age" selection criterion.. When the age and the duration of work were analyzed it was found that either the SS dropped out after working less than one year or they dropped out after working for two years. SS dropped out if they had four or more children as they needed extra time to be looked after. This issue is further expounded in "demand on SS time at home".

"Multiple activities": SS also dropped out if they were involved with multiple BRAC activities. e.g. VO membership and activities related to that. This issue is further expounded in the next issue "demand on SS time at home".

Implication for management function: (1) Select SS between age 30 - 40 years; (2) Select SS who do not have more than two young children. as age of children was an issue; (3) Do not select non-VO members for SS training.

Demand on SS time at home: The SS work demanded a greater time and attention than the SS had anticipated or willing to invest. They had other household work, their work pertaining to VO membership, work as a centre leader, government *Shetchsa Shebika* work, the work of a mother, wife, and so forth, evident from some responses, *"Children were young and needed looking after"*; *"the SS's work hampered daily household chores and vice versa"*. They all mentioned that VO work and *Shetchsa Shebika* work were more "profitable" and they would rather invest their time and effort into those activities than those of an SS's. SS work involved participating in health forums, house visit of clients, and visit area office to collect medicine; all these totalled on average 15 working days per month per SS. These ex-SS had not counted on spending so much time on this voluntary work for such little "profit" just from the goodness of their hearts.

Implication for management function: Do not select SS who are already involved with multiple other BRAC activities (or have them do a package of activities).

SS's popularity - SS not in much demand: The SS were known in their immediate community/village, but their acceptability and popularity was not yet fully known. The issue here is rather one of "**acceptability/credibility**" and not of "**known or unknown-ness**". Whether **SS are in much demand or not** is related to their popularity. There was a demand for services rendered by them, particularly for female FP/contraceptive methods because rural women were shy about seeking these services from the local *bazaar* and from a male provider. There was also a demand for the services provided for diarrhoea and dysentery, specially for children.

Furthermore, this issue relates to their not finding enough customers to sell their services to. The SS could not find enough customers to sell medicine to. 2 ex-SS Sufia (Case 4) and Lutfunnahar (Case 5) both complained of lack of customers. These 2 SS had competed for the same customers from the

same programme! The distance between the houses of the two ex-SS were 2 kilometres, and both houses were a five minute walk from the main road. Half of this main road was *pucca* and the other half was partially brick layered. Moreover, people wanted to utilize the BRAC services but they are not willing to pay for services rendered, *"People kept buying the medicine on 'credit purchase' basis and it was difficult to collect the money after selling the medicine"*.

Implication for management function: Do not select more than one SS from the same working area within a radius of 4 km.

SS "not a doc": This seemed to be quite a dilemma in the community where the SS lived and worked. People wanted to go to an educated health care provider rather than an uneducated one. One reason may be that time elapsed since SS training has not been long enough. If more time had elapsed more people would have learned about the SS and accepted their services, that is, the more the time elapses the more their acceptability may increase. On the other hand people were willing to avail themselves of the services of the traditional healers even though they were also uneducated. The dynamics behind this should be explored further. However, one positive attitude shines through this pessimism is that an awareness has been successfully created among the village folk that education can teach some things better and give more beneficial results, e.g. the case of the educated doctor versus the uneducated SS, *"People did not want to buy medicine from the SS because there were too many 'doctors' and pharmacies in the nearby bazaar, and people would rather take medicine from an educated doctor than an uneducated SS"*.

Lack of programme direction: Dropout due to reasons directly related to BRAC personnel were mentioned by only those SS who were above the age of 35 and had worked for more than a year. The reason for this may be that this group of ex-SS were less inhibited and had more confidence in

themselves, or they had little to lose from being so forthright and confrontational, *"BRAC officers were discourteous, and used harsh and insulting words because I did not work up to their expectations. So I quit"*.

Implication for management function: BRAC personnel should be more courteous with SS, after all the SSs are the nucleus of the EHC programme. It is difficult and trying when a programme falls behind in target achievement but programmers should try to understand the causes behind the problems without resorting to rudeness. It may also be possible that targets set were unrealistic.

Gender/Social Issue: Some SS were still reluctant to come out of their houses unless and until they absolutely had to. A handful of SS still believed that going house to house was not a socio-culturally accepted thing. It is something a "*village wife*" should not do. This was a culturally ingrained perception evidenced through the following comments, *"SS was a 'village wife' and so she should not go about openly in such a manner"; "I was afraid of going to villages on my own as I did not know the way well"; " Family members (husband/son) did not approve of such work"*. A handful of women were uncomfortable doing this work for the above reasons, even though none mentioned any snide remarks being made at them personally or their work.

Access to medicine and health information:

- Some ex-SS had joined the EHC health cadre to get access to medicine. This was a strong and important enough incentive for them to have stayed on participating in a rigorous training schedule and then the consequent job.
- Some ex-SS joined the health cadre to get access to information which they thought might be beneficial to her family. This indicates that there was a demand for information in the rural areas which EHC is fulfilling in its limited capacity. And as soon as that need for gathering information

was over the SS quit the volunteer work. This was also an important enough incentive for them to stay on working in a rigorous job for some years.

CONCLUSION

SS dropouts have programmatic implications which are not just confined to the arena of RDP-EHC or even BRAC, but for other national and international health programmes using community volunteer-worker health cadres.

Implications for the Fulbaria area RDP-EHC programme: EHC-SS dropout in Fulbaria was found to be one and a half times higher than the regional and the national rates. Fulbaria area dropout was calculated to be 44%, Mymensingh region was 31%, and RDP-EHC national dropout was 32%. A trained SS who drops out represents lost resources. The effect of the dropouts was in terms of delayed or decreased achievement of targets (e.g. less medicine. sanitary latrine and tubewell sales; more FP client dropout; decreased motivation and mobilization for the utilization of various BRAC and government health services). Another effect was the cost to the RDP-EHC, which was a minimum of Tk. 1,049 per SS.

Implications for the BRAC health programmes (RDP-EHC and HPD): The findings of Fulbaria area are not generalizable for other areas, however, they offer some insight into the possible causes of SS dropout and its effects. Also RDP-EHC uses a general formula for executing its services. Thus, the Fulbaria findings may be used in other areas of RDP-EHC and HPD if such problems exist. Only a study with a larger sample and in different areas will enable the findings to be generalizable. Also an

in-depth study on the costs of dropouts should be undertaken to determine the price of the dropouts for the RDP-EHC programme including the cost of replacement.

Implications for other national and international organizations: There are other Bangladeshi non-governmental and governmental organizations, and international organizations, who have various types of community health care programmes, employing community health workers-volunteers. Such programmes can utilize the findings of this study to modify their own strategy on training and staff development since no programme can claim to a 0% dropout rate.

Recommendations to management: This study offers some suggestions/recommendations which might be useful to the management. These are:

- RDP-EHC should strictly adhere to its existing guidelines when selecting SS trainees

  ⇒ Do not select non-VO members for SS work.

  ⇒ Do not select SS whose working area will be near a local *bazaar* or hospital.

- Select SS between ages 30 - 40 years.
- Do not select women who are involved with multiple other activities (or have them do a package of activities).
- Do not select more than one SS from within a radius of 4 km of the same working area.
- BRAC personnel should try to be more courteous in their dealings with the SS.
- It should be highlighted during the SS training that their first and foremost primary role will be that of a volunteer worker's, and then that of a salesperson's.

The RDP-EHC programme is a promising and fast growing programme, and it was prudent to evaluate some aspects of the programme, and make appropriate and timely adjustments to enhance its effectiveness.

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ENDNOTES

[i] The respondents used the term "profit", which actually means the margin or return from the sale of medicine. EHC buys the medicine at an institutional margin from respective pharmaceuticals. Then EHC increases the price by 2% before letting the SS buy them. This 2% is kept by EHC as service charge. Then EHC gives the MRP rate to the SS and SS then sell the medicine to community at the MRP rate. On average SS get a margin of 25% from the sales.

[ii] *Shetchsa Shebika*: These are female community health workers recruited and trained by the government of Bangladesh. The *Shetchsa Shebikas* assist the FWA and FWV to carry out their various work, such as mobilizing and motivating into using EPI services, satellite clinics, distribution of contraceptives. For this work they receive Tk. 30 per month from the government.

[a] Formula used: (trained - active) / trained

* Profile of EHC-SS:	**Active SS**	**Trained SS**	**Dropout Percentage**
Total RDP-EHC	7,740	11,285	32%
Mymensingh (region)	121	174	31%
Fulbaria (area)	28	50	44%

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Annexure

Annexure 1: The distribution of the responses of the dropout SS interviewed at Fulbaria.

	Duration of work ≤ 1 yr	Duration of work > 1 yr
Age ≤ 35 yrs	**N = 2** • avg age of SS: 35 ↔ • avg # of child per SS: 4.0 ↔ • more time spent looking after little children • more time spent doing household chores ↔ • not much "profit" from selling medicine • more "profit" from other activities, e.g. sewing • couldn't find enough customers to sell med. ↔ • didn't know her way in the village well enough • was ill when pregnant	**N = 2** • avg age of SS: 26.5 • avg # of child per SS: 1.5 • had to do other household chores • too much effort for too little "profit" • difficult to work on her own • people didn't want to buy BRAC medicine, e excuses given were: it was more expensive, medicine not good, BRAC got medicine free then why should people pay for it; people pr to get medicine from the *bazaar* • target set too high by BRAC • husband did not like the SS work
Age > 35 yrs	**N= 2** • avg age of SS: 40.5 ↔ • avg # of child per SS: 2.0 ↔ • BRAC got medicine free from govt so why should people buy from SS ↔ • people would rather go to a 'doc' than an SS • village docs give the same diagnosis as MBBS docs so people go to them • too many doctors work nearby • people buy medicine on 'credit purchase' basi • not much buying & selling of medicine • "profit" little from selling medicine	**N = 4** • avg age: 46.5 • avg # of child per SS: 4.75 • children were little • hampered other VO work • BRAC got medicine free from the govt so wh should people pay for it • people prefer to go to educated doctor than a an uneducated SS • BRAC buys medicine from pharmacies & people would rather go there to buy medicin • had to buy medicine every month • more "profit" from other activities • "profit" not good/enough • did not find time to go to BRAC office • BRAC officers misbehaved/were rude • sons did not like it • was ill with low blood pressure • afraid to go to villages on her own • housewife should not walk about in the open in the village in this manner

N = 10

Annesure 2: The distribution of the total SS dropout in Fulbaria.

	Duration of work ≤ 1 yr	Duration of work > 1 yr
Age ≤ 35 yrs	7	5
Age > 35 yrs	5	5

Usually women do not work as day labourers in Mymensingh, but when they do they earn 40 - 80 Tk per day.