

TAKING HEALTHCARE WHERE THE COMMUNITY IS: THE STORY OF THE *Shasthya Sebikas* OF BRAC IN BANGLADESH

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ABSTRACT

To mitigate the income-erosion effect of illness and vulnerability of the poor households, BRAC, an indigenous Bangladeshi NGO, integrates Essential Health Care (EHC) activities with its microcredit-based poverty-alleviation interventions. The EHC delivers preventive and basic curative health services to the villagers through *Shasthya Sebika* (SS) who is the community health worker selected from among the village-based women's credit group members who is willing to provide voluntary services, and acceptable to the community she serves. The SSs receive four weeks basic residential training backed up by regular monthly refreshers. For specific programmes such as DOTS, community-based ARI, or safe motherhood, the SSs are given additional training. Each SS covers around 250 households, and she makes at least once a month visit to the households. During these visits, they disseminate health, nutrition and family planning messages, motivate to install tube-wells and sanitary latrines, identify and register pregnancy cases, identify TB suspects for sputum examination, provide treatment for common illnesses and sell health commodities. The SSs work on voluntary basis but earn some income from the sale of health commodities. Meticulous selection, training, supportive supervision, functional referral linkage and performance-based incentives are key factors responsible for the sustenance of the model till date.

Key Words: Community Health workers, BRAC, Bangladesh.

I. INTRODUCTION

Of all the risks that the poor households encounter, health 'shocks' probably pose the greatest threat to their lives and livelihoods. This have been shown empirically in diverse settings such as India [1], Vietnam [2], Tajikistan [3] or elsewhere [4] — including Bangladesh [5]. This happens due to income-erosion effect of illness through loss of income, catastrophic health expenditures, and potentially irreversible crisis coping mechanisms that involve asset and savings depletion [6,7]. Cost burdens of healthcare may deter or delay healthcare utilization or promote use of less effective healthcare sources or practices, particularly by the poor [8], proving the 'inverse care law' [9,10]. Thus, enhancing poor people's ability to access acceptable level of health care at low-cost has a potential poverty-alleviating effect.

BRAC, an indigenous Bangladeshi NGO (for more information, please visit <http://www.brac.net>) realises the potential high impact that health services can have in reducing the vulnerability of

the poor households. Towards this end, it integrates Essential Health Care (EHC) services in its microcredit-based poverty-alleviation interventions for delivery of basic curative and preventive health services to the villagers [11]. The front-line worker of BRAC's health programme is the *Shasthya Sebika*, SS (meaning a woman who provides basic healthcare services in the community) who forms the core of its EHC services. They are trained on basic preventive, promotive and curative health care which is backed up by regular monthly refresher training. They provide a cost-effective [12,13] bridge between the communities they serve and the primary health care (PHC) level facilities of formal Health Systems, though they are not part of it. Currently, BHP has about 70,000 SS actively providing services to about 90+ million people in the rural areas of Bangladesh. The success of micro-credit programs as a health intervention tool is extensively documented in the literature [14,15,16,17]. Below, we describe the story of the *Shasthya Sebikas*— the BRAC model of sustainable community health workers including its problems and prospects.

II. THE STORY OF THE *Shasthya Sebikas*

From VO member to *Shasthya Sebika*

The SS is recruited from among the currently active village-based BRAC credit and development group called Village Organisation (VO) members. The VO is formed by women from poor households (households having ≤ 50 decimals of land and selling manual labour) in the village and it extends small loans to members for income-generating activities. The process of selection of the SS begins with BRAC Programme Organiser (PO) asking for names of prospective candidates from the group members [18]. The members discuss among themselves and mutually nominate a person. Sometimes peer pressure or motivation by the PO may persuade a VO member to accept the nomination. A general meeting is held in the BRAC local office to ratify this nomination and finally, the prospective candidate has to undergo a selection interview in the BRAC regional office. To become a SS, the woman has to be ≥ 25 years of age, married having children not below two years, few years of schooling, willing to provide voluntary services and acceptable to the community they serve. Preferably, they should not be living near a local health facility or big *bazaar* to avoid competition, and extend basic health coverage to places far away from any health facility [19].

After recruitment, they receive a three weeks residential training in one of BRAC's Regional Offices across the country [18,11]. Training is given on maternal and child health and nutrition, immunization, family planning, water and sanitation, communicable disease control, and basic curative care for some common illnesses (e.g., common cold and cough, diarrhoea, anaemia, worm infestation, scabies etc.). For specific programmes such as DOTS (Directly Observed Treatment for TB, Short course), community-based ARI, or safe-motherhood interventions, the SSs are given additional training as and when necessary. The catchments area of each SS consists of around 250 households (in intensive programme areas, this may be reduced to 150 households) and she usually visits 15 households daily, thus making at least once a month visit of the households. She is expected to spend around two hours each day for the household visits, six days a week.

During these visits she disseminates health and nutrition messages, motivates for adopting family planning and seek child immunization, and mobilizes for tube-well and sanitary latrine installation. She also identifies pregnancy and TB suspects, provides treatment for common illnesses, and sells health commodities produced by BRAC. She maintains a register of all the patient she treats with description of illness and treatment given, and also quantity of different products sold. The SS is initially given a fixed revolving fund for buying essential medicines and health commodities from BRAC at cost price which is then sold at a mark-up price to the consumers and the difference is kept by her as incentive. For illnesses beyond her capacity to treat or manage, she refers the patient to nearest health facilities, either in the public or private sector including BRAC health facilities where present.

Keeping track of what and how well they are doing: Supervision and refresher training

The provision of services by the SSs is strengthened by 'the involvement, support and supervision of the *Shasthya Kormis* (SKs)' who are paid health workers of BRAC with minimum ten years of schooling [11]. Each SK looks after the activities of ten SSs. The SK makes field visits three days a week during which time she reviews the activities of the SS with respect to different services such as DOTS treatment, FP and EPI motivation and mobilization, maintenance of registers etc. and helps her to solve the problems encountered while delivering SS duties.

The SSs of a particular area are brought once in a month into the BRAC field office in a day-long refresher training which is conducted by the Programme Organizer, Health (PO (Health)). S/He is also responsible for all health programme activities occurring in the catchments area of the field office and supervises the SSs and the SKs. The SK and the PO (Health) work under the overall supervision of a medical doctor in an area. In the session, problems faced during service provision by the SS as well as those observed by the SKs during field visits are discussed, followed by probable solutions. Also, this forum is used for discussion of new health and nutrition issues, making work-plan for the next month, and accounting activities related to sale proceeds of the health commodities and essential medicines during the month by the SSs. The SSs are provided a

lump sum amount to cover conveyance and meal. Through this forum, BRAC Health programme is able to keep regular and formal contacts with the SSs.

Incentives for becoming a Shasthya Sebika: not solely volunteerism

The SSs are not paid worker of BRAC. Though they are supposed to provide voluntary services for their community, they may not always fulfill the three basic criteria for volunteerism: i) that it is not undertaken primarily for financial gain, ii) that it is undertaken of one's own free will, and iii) that it brings benefits to a third party as well as to the people who volunteer [20]. In one study, the SSs perceived themselves as 'salesperson aiming to make a profit' instead of a volunteer worker [19].

Besides earnings from sale of essential medicines and health commodities (and some charges for specific services) as a basic health service provider in the community, the only extra benefit she gets as member of the VO is a second loan over and above the current loan she has got for income-generating activities. The other VO members are not eligible for this second loan. But this is not the only incentive that motivates the prospective VO member to become a SS. Reasons mentioned for becoming a SS in different studies include earning a supplementary income for the family, getting access to health knowledge and medicine for the family and the neighbours, and help people become aware of contraception, immunization and hygiene practices [18,19,21]. Some becomes SS because of social prestige associated with the work (in course of time, they become known as *daktarni* meaning female doctor); sometimes they used to inflate the amount of their income as remuneration to the villagers to increase their status. Still others join because of peer pressure or motivation by BRAC field POs [18]:

"We requested X to become a Sebika in our village...she did not have much work in her household and her house was situated in a convenient place so that everybody can go there. Initially she was hesitant that her family may not allow her to work...we convinced her..." (a VO member)

"One day BRAC Apa came to suggest that I should become a Sebika...she explained that if

I become a Sebika of the village, the villagers would benefit from my activities..." (a SS)

However, economic incentives have been observed to be the prime motivation for becoming a SS as well as the main reason for drop-outs. This is plausible given the poverty status of these SS households; they are very unlikely to get involved in anything that does not contribute to their livelihood strategies. To quote a SS [18]:

"The earnings from Sebika activities have 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..."

Income earned by a SS depends on a number of factors: experience, seasonality, remoteness from local health infrastructure, competition from other types of providers, interpersonal communication skills and reputation [21] and community acceptability¹⁸. A case study of the SSs found that the SES of the household, especially the husband's income, has an important impact on her performance and sincerity [22]. The authors noted that when the household has to depend on the income from *Sebika* work to survive, the SS is more motivated and sincere in her work. Another exploratory study on their performance over time found that the SSs are serving better in terms of number of patients treated and commodity sales in areas where people have less access to public health services [23]. They also observed that the number of health education forums held is positively associated with sales of health products and number of patients treated. Thus, through these forums, effective demand for health care and health products is created and the scope of SS activities extended.

Drop-outs

As the monetary incentives are the prime mover, it is natural that everybody won't be satisfied with the meager income from the SS activities (on an average US \$ 7-8 per month). There was around 10-15% annual drop-out among the SSs in 1998 and constituted an estimated loss of about US \$ 24 per SS¹⁹. Studies have revealed that majority of the drop-outs occur due to dissatisfaction with the inadequate monetary return against the time and labour invested [19,18]. Other causes of drop-outs

mentioned are: time constraints for household chores, disapproval from husband and other family members, criticism from neighbours on religious ground, people's unwillingness to pay for services and their preference for an 'educated' doctor to an uneducated SS etc. BRAC tries to address this problem by adherence to the selection criteria during recruitment, devising incentive mechanisms to reward better performance, and providing non-monetary incentives (e.g., providing a dress and a bag with BRAC insignia on it which is regarded as a license for practice) to improve their status and acceptability vis-à-vis the community [19,18].

Perceived changes in the life of the SS: becoming empowered

The process of becoming a SS has changed the scenario for these poor rural women; they have been transformed from an ordinary, relatively unknown figure to a well-known public entity in the community. Initial disapproval from the husband and other family members usually give way to appreciation as they could see tangible economic benefits of the SS work. With the passage of time, they are also gradually accepted by the community and recognized as 'daktarni' (lady doctor) or 'daktar apa' (an elderly sister who is a doctor) of which they feel proud. As one woman said [24]:

"we regard her highly and consult her regularly before going to a doctor; we know that she is not a doctor, but she can solve our problems...she is a doctor to us..."

One SS said [18]:

"...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 SSs perceive themselves as an integral part of BRAC's health programme and are confident to sustain their activities even if BRAC support is withdrawn.

To quote a SS [18]:

"BRAC will not be able to take what we have learnt from BRAC's training. We will use our learning...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..."

The identity of SS has given them an improved status in the family, increased their credibility in the informal credit market, and appreciation in the community [21]. They have attained a certain degree of economic independence due to the earnings from the SS work and they themselves as well as their family also benefited through improved health and hygiene practices from knowledge gained in relevant fields [18].

III. LESSONS LEARNT FOR A SUSTAINABLE MODEL OF CHW

BRAC's experience of using village women as health worker in its health programme for the poor and the disadvantaged has a long history [25,26]. BRAC's *Shasthya Sebika* approach demonstrates that even semi-literate rural women can be trained to deliver preventive, promotive and basic curative services for common illnesses to the community. The initial resistance that they face gives way to gradual acceptance when the family and the community see the tangible benefits, including financial benefits, from the SS work. Their competency has been documented in DOTS treatment of tuberculosis [27], the management of acute respiratory infections of children [28], and the rational use of drugs for common illnesses [29], among others. To achieve this, the training need to be 'participatory, interactive, contextualized and sensitive to local culture' [24]. Organising regular refresher training is another key element in the model for supporting the SSs.

The model is sustainable because it is integrated with other credit-based development interventions of BRAC so that the *Shasthya Sebikas* can enjoy some financial benefits out of their supposedly voluntary work. As they come mostly from poor households, some opportunity cost for their work is needed. Towards this end, an elaborate mechanism of monetary incentives based on performance is practiced by BRAC. However, financial incentives are not the sole motivation behind one's aspiring to become a SS as has been described earlier and attention to non-financial incentives (such as appreciation and recognition by the supervisors and the community) is also needed [30]. Other factors like community acceptability, family cooperation, social status, distance from nearby health facilities, competition from other providers etc. also play an

important role for sustainability of the model. In this regard, the process of selection of SS warrants special investment in efforts and time. Experience shows that the pros and cons of the SS work should be explained to the prospective women and their families for informed decision-making and better compliance, and prevent lost resources to the organization through drop-outs.

IV. CONCLUSION

Human Resources for Health (HRH) is important for population health outcomes, and presumed to be one of the limiting factors for achieving the millennium development goals (MDGs) [31,32]. Developing countries of south Asia including Bangladesh suffer from deficient HRH [33], with associated imbalance in health workforce distribution in terms of geographical location, skills-mix, services delivered and gender sensitiveness [34,32]. Various types of trained CHWs at the grassroots level in the rural areas have been increasing in size with the expansion of the primary health care infrastructure (government and NGO) in the countries of south Asia. Given the shortage of supply of qualified health care professionals in this region as well as various demand-side barriers faced by the poor to reach the formal health system, the importance of these health workers should be recognized by the public sector and measures should be undertaken to develop their capacity in a planned way so as to ensure a minimum acceptable level of care for the poor in the short-term [35,36]. BRAC's *Shasthya Sebika* model can be instructive in this regard [37].

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