Training and Retaining *Shasthyo Shebika*: Reasons for Turnover of Community Health Workers in Bangladesh

Shasthyo Shebikas (SS) are community health workers forming the core of BRAC's Essential Health Care (EHC) programme. The SS dropout was 44 percent for study area and 32 percent for EHC programme. The SS discontinued their work due to lack of time, lack of "profit," and family's disapproval. The effects of the dropouts were decreased achievement of targets, and a loss of money in the amount of $24 (U.S.) per dropout SS for their training and supervision. The SS retention may increase if EHC strictly adheres to its existing guidelines when selecting trainees, and if it highlights during SS training that the SS's first and foremost role will be as that of a volunteer and then of a salesperson. Key words: *Bangladesh, BRAC, community health worker, NGO, rural, staff turnover, training*

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INTRODUCTION

Health care system in Bangladesh

Medical pluralism exists in Bangladesh, with a mix of the public, private, and traditional services.[1] Modern health care, consisting of public health and family planning activities, is mostly provided by the government free of charge or at minimal fee. The government system is divided into tertiary, secondary, and primary levels of health care. The tertiary level care has specialized hospitals at the divisional level and in big cities. The secondary level care has hospitals at the district/regional and subregional levels. The primary level care has hospitals and delivers health services using the primary health care approach. The first contact health stations at the primary level are Rural Dispensaries and Family Welfare Centres, which have both

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domiciliary and fixed health workers at the grassroots level. In Bangladesh there are non-government organizations (NGOs) like BRAC (formerly the Bangladesh Rural Advancement Committee) who give community health care services to the rural population. Private health care services are also available, and people have to pay for these services out of pocket. These private services include many clinics in urban areas that have sprung up in the last decade. The use of health insurance is quite insignificant in Bangladesh.

BRAC

BRAC is one of the largest national development organizations in Bangladesh, which started its activities in 1972. BRAC has multi-sectoral programmes such as microcredit, health, and education. Currently BRAC's programmes are spread over 50,000 out of a total 86,038 villages in Bangladesh.[2] BRAC disburses small loans to the marginalized population in the village, particularly women. This is done through Village Organizations (VOs). Five women form a group, and about ten such groups constitute a VO. VO members are able to take out loans ranging from US $25 to $250. (All monetary costs in this article are stated in terms of U.S. dollars.) Each VO member gives weekly savings and loan installments. The VO members are involved in income-generating activities, such as poultry farming, livestock, fishculture, sericulture, horticulture, and rural trading activities. The VO is conducted by BRAC personnel stationed at area offices such as Programme Organizer (PO) and Programme Assistant (PA). BRAC has organized over 59,000 poor landless groups totaling 2.2 million members from each household in rural areas, disbursing to them a sum of $417 million as credit without collateral. Side by side with its credit scheme, BRAC imparts skills training to the VO members in various income-generating activities, and reaches 1.2 million of their children with a non-formal primary education (NFPE) programme. BRAC defines "poor" as those people who own less than half an acre of land (including the homestead) and those who earn their living by selling their manual labour. The VOs are designed to mobilize the collective strength of the poor with a view to empowering them to self-reliance. BRAC programmes are designed to alleviate poverty, create employment opportunities, increase income for the rural community, and also mobilize the landless poor women in Bangladesh.

BRAC health programme

The BRAC health programme addresses the health and nutritional status of women and children in the country and covers 25 million people with 12,536 health workers.[2] The BRAC health programme started in 1972, and a component of this was incorporated into the Rural Development Programme (RDP) in 1991. This component emerged as Essential Health Care (EHC) in 1996. The EHC programme engages in preventive health activities but proceeds in the knowledge that such work cannot be achieved overnight as people have to be first made aware of proper health behaviour. Thus, curative services related to preventable diseases were added to the programme objectives. The EHC programme consists of water and sanitation, immunization, health and nutrition education, family planning (FP), and basic curative services.[3,4]

EHC's community health workers

The community health workers (CHWs) or *Shasthyo Shebikas* (SS) are the core of EHC.

Currently EHC utilizes 7,740 SS, of which 28 are in Fulbaria, a subdistrict in Mymensingh District of Bangladesh (a subdistrict consists of 200,000 to 250,000 population). The Fulbaria SS presently cover 6,000 households (population about 30,000).

In countries like Bangladesh, where the government health infrastructure is poorly developed in the rural areas, non-governmental organizations have a major potential role to play. The CHWs are part of BRAC's rural development programme. These CHWs are members of the BRAC VOs, which consist of women from the poorest communities and which are aimed at improving their socio-economic conditions. Most of these women are aged 25–35 years, illiterate, and from the poorest households. They are not paid a salary but they retain a small profit from the sale of drugs prescribed for common illnesses.[5(p.170)]

With this in mind BRAC trains CHWs such as the SS.

SS recruitment, job description, and training

Initially PAs ask VO members to suggest names of prospective SS during VO meetings. Then PAs nominate the SS. Then at a general meeting of POs and PAs at the RDP area office, another selection is made. The final selection interview is made at the RDP regional office. Selection is based on the following criterion: female, socially acceptable, age 25 to 35 years, married, youngest child's age above five years, eager to do work, preferably educated, and not living near a local health care facility or big *bazaar*.[3]

The SS give health education, motivation, and mobilization regarding the five components of EHC. The SS sell medicine, contraceptives, sanitary latrines, tubewells, and vegetable seeds. They diagnose, treat, and provide health education on diarrhoea, dysentery, fever, common cold, anaemia, worm infection, gastric ulcer, allergic reaction, scabies, and ringworm infection. The SS go on follow-up visits in the afternoons and encourage pregnant women to utilize government facilities. Furthermore, the SS are involved in attending their daily household chores, VO-related income-generating activities, establishing liaison with government health workers, and preparing and submitting monthly progress reports. Total monthly working days for each SS are 15.

The SS are given foundation or basic training, which lasts 16 days, at 4 days per week, done at the RDP area or regional office. Then refresher training of one day every month for two years at the RDP area office is given. 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. As with almost any training activity there is some SS turnover. Since EHC expends resources to recruit, train, and supervise the SS, dropout SS represent lost resources and may affect the programme by delaying achievement of its targets. See Table 1 for a general profile of the SS.

THE STUDY RATIONALE

The few studies available on the SS usually mention them using the terms "*trained*" and "*active*," and the numbers differ for the two categories.[6–9] Such statement indicates that SS dropouts might be occurring. The term "*trained*" means those SS who received foundation or basic training. The term "*active*" means those SS who are still working or those who participated in two consecutive refreshers, visit 15 households daily, and take part in two health forums per month. The term "*dropout*" means those SS who stopped working as an SS, who do not make house

Table 1. Profile of the SS

	Active SS	Trained SS	Dropout rate (%)	Over how many years (duration of programme)*
Total EHC (national)	7,740	11,285	32	10 (1986–1996)
Mymensingh (region)	121	174	31	5 (1991–1996)
Fulbaria (area)	28	50	44	3 (1993–1996)

*at the time of the study

visits, or no longer take part in health forums, after participating in the basic training and two consecutive refresher training.

EHC also anticipated dropouts and has a strategy to overcome this. 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. Fulbaria had 50 trained SS and of them 28 were active. Mymensingh region had 174 trained SS with 121 of them active. EHC programme had 11,285 trained SS with 7,740 of them active. The dropout rate was 44 percent in Fulbaria, 31 percent in Mymensingh region, and 32 percent for EHC. Thus, it was observed that Fulbaria had one and a half times greater dropout rate than the Mymensingh region and national figures. The SS are the core and the backbone of the EHC programme and retaining them in the system is crucial for its viability. It was thus imperative that we study the reasons for dropout so that the programme could take remedial steps to meet the situation.

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OBJECTIVES

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

METHODOLOGY

This was a rural case study done in the EHC working area in Fulbaria-Mymensingh, Bangladesh. The study unit comprised 10 SS who dropped out of the EHC programme over the last three years, and who had worked for a duration of three months to three years. These dropouts were identified and purposively selected from the refresher's training register kept at the RDP area office. The data was collected during December 1996. The variables considered for SS were age, marital status, parity, family size, education, occupation, BRAC membership, reasons of dropout for the SS, and the effects of dropout on the EHC programme. Data were 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.

FINDINGS

Scale of drop out

In Fulbaria there were 50 trained SS (trained in three years), and 28 of them were active. This made the dropout rate to be 44 percent. This percentage should be considered very high for any programme, and even more so for a programme that relies heavily upon its CHWs. The dropout rate was 31 percent in Mymensingh region, and 32 percent for EHC. Thus, it was observed that Fulbaria area dropout was one and a half times higher than Mymensingh region and the EHC national figures. There were different types of dropouts: some SS dropped out after only a few months and there were others who did so after a few years of service.

Socioeconomic and demographic characteristics of the respondents

The age of the dropout SS ranged between 25 to 55 years, averaging 39 years. Seven dropouts were married, two were widowed, and one was divorced. The number of living children per woman ranged between one to six, with the average being three. Education ranged between nil to Class Five, average being Class Three. Eight dropouts were VO members, one was an ex-VO member, and one SS was a non-VO member.

The reasons of the SS dropout were apparent in their stories; one such case is described.

Case story: Khaleda

Khaleda was a 25-year-old married woman with one living child, and a family of three. She had studied up to Class 5 in a government school. She had been a VO member for eight years. Her main income source was from VO-related activities. Her current credit status amounted to $70. She invested this loan in a fishery project for which she had received a one-day training. She worked as an SS for two-and-a-half years. She received a 16-day training on 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 big profits from this work, because the BRAC PAs had said so. She quit the SS work because she earned little profit after walking around all day leaving her household chores unattended. After walking so much, a profit of $0.02 from selling a specific medicine was not worth it and not enough to get by. Furthermore, people were reluctant to buy the medicine, saying BRAC medicine was not good or it was more expensive or BRAC got the medicine free so why should they pay for it. Khaleda opined that this type of work could not be done without a salary. Moreover, her husband used to get angry because she went off and locked the door and he would come home from work and not be able to get inside. Thus, he asked her to stop working.

Reasons for becoming an SS

The other SS also mentioned various reasons for becoming an SS such as to do some work for children, earn a profitable income, to have access to medicine, to make people aware about contraception and immunization, to learn about health and hygiene of her own children and neighbours, the assumption that if she or anyone in the village became ill there would be an advantage in knowing all this health information, to earn name and fame if she gave treatments for such illnesses, and to get a salary. Despite these laudable reasons for joining the SS health cadre, many SS dropped out within three months to three years of starting this work.

Reasons for SS dropout

The dropout SS in the case study mentioned multiple reasons for discontinuing this work: 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 buying medicine on credit purchase basis, people reluctant to buy medicine because of their perception that BRAC got the medicine free, availability of cheaper medicine at the local *bazaar*, 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, too many doctors working nearby, not enough time to visit the BRAC office, hampered other VO work, family members disliked the work, socially unacceptable for a woman to do this work, discourteous BRAC officers, did not know her way in the village well enough, difficult to work on her own, and illness.

Effects on the EHC programme

Effects of the SS dropouts on the EHC Fulbaria programme were identified by the PAs and Area Manager (AM). These were

- Hampered PA activities as entire work load fell on PAs;
- Hampered achievement of the target of each component of EHC;
- Medicine, sanitary latrine, and tubewell sales fell below set target;
- More FP client dropouts;
- Motivation and mobilization process slowed down as it was difficult to inform the rural community about the various EHC activities;
- EPI facilitation programme was hampered as parents were not able to be motivated or mobilized;
- EHC Health Fora were not held properly and attendance fell.

When an SS quit, the Centre Leader of her VO was asked to take on the SS's responsibilities. This put extra pressure on the Centre Leader and affected her VO activities.

Another effect was the costs incurred by the EHC programme and the SS. The minimum resources used in one EHC area were four personnel (one AM who gave 5% of his time, one PO who gave 30% of his time, and two PAs who gave 100% of their time) 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 $24 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 EHC personnel, the cost of food for trainees, the cost of training materials, and other costs. This $24 was a loss for EHC. Since there were 22 dropouts in Fulbaria, the total loss was $537 (for a basic training, one month of work, and a refresher's training). 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 $15. Opportunity costs included training and other SS activities. Table 2 gives a breakdown of the costs per SS.

Yet an SS earned between $2.30 and $7.00 on average per month, which made the eco-

This questions the voluntary role of the SS, since a philosophy behind the incorporation of the SS within EHC was that rural women could be motivated and trained into doing voluntary community health work. There was confusion regarding the role played by the SS in delivering the services. EHC perceives them as volunteer workers, but the SS perceive themselves as salespersons aiming to make a profit. The PAs were asked 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 such statement: (1) voluntarism was not a motivation for joining the SS cadre, and (2) interestingly enough neither the PAs nor the SS mentioned selling sanitary latrine, tubewell, or contraceptive as profitable or nonprofitable spontaneously at all. This may indicate momentary forgetfulness or the fact that they did not give enough importance to this vital part of the EHC preventive health activity.

BRAC more costly

Eight respondents mentioned the community's reluctance to buy medicine from an SS. These were primarily that BRAC medicine was perceived as more expensive than those available in pharmacies or shops located in the nearby *bazaar*. This problem also arose due to the less than honest dealings of the local shops where they dilute liquid medicine or sell half of tablets at half the price to the illiterate villagers. This may have been avoided if EHC had done market research in this area before introducing its services. Also, people were unwilling to pay for medicine they thought BRAC got free from the local *Thana* Health Complex. In addition, people said that BRAC medicine was not good.

Selection of the SS

Non-VO

According to EHC guidelines, one of the selection criteria for being selected as SS trainee is to be a VO member. Yet one of the dropouts was a non-VO member. Another dropout was an ex-VO member.

Age

One ex-SS was 42 years old, and two ex-SS were 55 years old. 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.

Multiple activities

The SS also dropped out if they were involved with multiple BRAC activities, such as VO membership and activities related to that.

Demand on SS time at home

The SS work demanded greater time and attention than the SS had anticipated or wished to invest. They had other household work, their work pertaining to VO membership, work as a centre leader, *Shetchsa Shebika* work, the work of a mother, wife, and so forth. They said, "Children were young and needed looking after"; "The SS's work hampered daily household chores and vice versa." SS dropped out if they had four or more children as they needed extra time to look after more children.

SS's popularity: not in much demand

The SS were known in their immediate community and village, but their acceptabil-

ity and popularity were not yet fully known. The issue here is more one of acceptability and credibility and not of known or unknown. 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. Two ex-SS who had complained about lack of customers lived two kilometres apart, and their houses were a five-minute walk from the main road. These SS were competing for the same customers from the same programme. Moreover, people wanted to utilize the BRAC services but they were unwilling to pay for services rendered. "People bought medicine on credit purchase basis and it was difficult to collect the money afterwards."

SS "not a doc"

It was quite a dilemma in the community that the SS were not doctors but delivered health care services. 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 increases. On the other hand people were willing to avail themselves of the services of the traditional healers even though they too were uneducated. The dynamics behind this should be explored further. However, one positive attitude shines through this pessimism; an awareness has been successfully created among the villagers that education can teach some things better and give better 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 45 and had worked for more than a year. The reason for this may be that this group was less inhibited, or they had little to lose from being forthright and confrontational. "I quit because BRAC officers were discourteous, and used harsh and insulting words because I did not work up to their expectations."

Gender and social issues

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 socio-culturally acceptable. They said, "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 and/or son) disapproved of the work." Some women were uncomfortable doing this work for the above reasons, even though none mentioned any snide remarks being made at them publicly or privately.

Access to medicine and health information

Some ex-SS had joined the EHC health cadre to get access to medicine and informa-

tion that they thought might be beneficial for their families. This indicated that there was a demand for information in the rural areas, which EHC was fulfilling in its limited capacity. As soon as that need for gathering information or medicine was over the SS quit the work. These were strong and important enough incentives for them to have participated in the rigorous training and the subsequent job.

CONCLUSION

SS dropouts have programmatic implications not only for BRAC, but also for other national and international health programmes using CHWs. SS dropout rate was 44 percent in Fulbaria, 31 percent in Mymensingh region, and 32 percent for EHC programme. SS turnover in Fulbaria was one-and-a-half times higher than the regional and the national rates. A trained SS who drops out represents lost resources. The effect of the dropouts was in terms of delayed or decreased achievement of targets, and a loss of $24 per SS.

It is recommended that EHC strictly adhere to its existing guidelines when selecting SS trainees, such as selecting only VO members for SS work, not selecting SS whose working area will be near a big *bazaar* or health care facility, selecting SS between 30 and 40 years of age, selecting SS who do not have more than two young children, selecting women who are not involved with multiple other activities (or have them do a package of activities), and selecting only one SS per four kilometer radius working area. BRAC personnel should try to be more courteous in their dealings with the SS; after all the SS are the nucleus of the EHC programme. It is difficult and trying when a programme lags 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 were unrealistic to begin with. 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 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. EHC uses a general formula for executing its services. Thus, the Fulbaria findings may be used in other areas of the BRAC health programme. Only a study with a larger sample and in different areas will enable the findings to be generalizable. There are other Bangladeshi nongovernmental and governmental organizations, and international organizations, who have various types of community health care programmes and employ CHWs. Such programmes can utilize the findings of this study to modify their own strategy on training and staff development since no programme can claim a 0 percent dropout rate.

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