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BRAC: Shasthya Shebikas’ Role in Delivering Health care Service to Rural Markets

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Dr. Kaosar Afsana, director of the Health, Nutrition and Population program at BRAC, the world’s largest non-governmental development organization, was reviewing the health care service delivery system in a meeting with her team in January 2017. At that time, the team was focused on delivering health care services for the rural and urban slum poor in Bangladesh. Substantial progress in health care service delivery was achieved through Shasthya Shebikas,[[1]](#footnote-1) female community health workers. Although the director acknowledged the substantial contribution of the Shasthya Shebikas in delivering health care services, she was concerned with the enormity of the task. Motivating and retaining the Shasthya Shebikas was a challenge for BRAC. Afsana was also aware of the presence of other potential service delivery channels. The 2007 Bangladesh Health Watch report had suggested improving the skills of these alternative informal health care service providers; it had suggested this as a short-term solution to meeting the huge challenge of serving the rural poor. The health care delivery challenges BRAC faced in Bangladesh were quite unlike the challenges faced in developed countries. The rural poor in Bangladesh lacked education and were conservative, and this affected the number of young women who volunteered to be a Shasthya Shebika. The Shasthya Shebikas were required to make house calls to promote and offer health care services, a task that was not viewed favourably by the community nor, quite often, by their family. Some volunteers even dropped out when required to attend the mandatory residential training program. The socio-economic context of rural Bangladesh posed a problem not only for the supply side of health care service but also for the demand side. The rural poor preferred traditional healers and were reluctant to use the modern health care services.

Given the unique challenges of delivering health care service to the rural poor in Bangladesh, BRAC staff tried new methods and often improvised on the existing approach. BRAC faced two important issues in health care service delivery. One issue related to including unqualified local health care service providers in BRAC, and the other related to strengthening the Shasthya Shebikas’ health care service delivery channel. These issues led BRAC to ask whether it should examine the other health care service providers to determine if they could complement the work of the Shasthya Shebikas. If so, which of the various types of health care service providers should BRAC consider? What steps should BRAC take to strengthen the Shasthya Shebika channel? What should BRAC do to motivate and retain the Shasthya Shebikas?

BRAC and its Programs

BRAC was founded by Sir Fazle Hasan Abed in 1972. Based in Bangladesh, BRAC operated in 11 other countries through its international arm. It had more than 111,000 employees providing health care, financial, and other social services to a population of over 138 million. Bangladesh had a predominantly rural population, and 24.8 per cent of the country’s population was poor (see Exhibit 1). BRAC strived to reduce poverty through its programs in the areas of human and social empowerment, education and health, economic empowerment and enterprise development, livelihood training, environmental sustainability, and disaster preparedness. Its business enterprises not only contributed to its revenues but also increased the effectiveness of its development programs. Of the total expenditure of US$904 million[[2]](#footnote-2) for the year ended December 31, 2015, the contribution from BRAC’s donors was only $100 million (see Exhibit 2). Enterprises and microfinance helped reduce its dependency on donors for its development programs (see Exhibit 3).

BRAC’s Health, Nutrition and Population Program (see Exhibit 4) was one of its critical development programs. The program had many components, which included Essential Health Care; Maternal, Neonatal and Child Health services for rural and urban populations; Tuberculosis and Malaria Control programs; Nutrition; Eye Care; Mobile Health Intervention; Health Care Financing and Innovations; Non-communicable Disease programs; and BRAC Facility Based Services. Essential Health Care was the basic platform for all of BRAC’s health programs, and the Shasthya Shebika delivery system was the low-cost method of BRAC’s health care service delivery.

Shasthya Shebikas and their responsibilities

BRAC had more than 117,000 community health workers who worked part-time. These were the Shasthya Shebikas, and they delivered basic health care services to rural consumers in Bangladesh and helped them to access public health care service. The Shasthya Shebikas also retailed health products. BRAC faced the challenge of attracting and sustaining Shasthya Shebikas; one published source indicated that their turnover rate was 15 to 20 per cent.[[3]](#footnote-3) One BRAC official believed that turnover rates varied over the years. According to her, the turnover rates were closer to 10 per cent. Whenever BRAC launched a new project, a large number of Shasthya Shebikas had to be recruited within a short period, which sometimes resulted in a poor fit between the newly recruited Shasthya Shebikas and their task requirements. The poor fit could also be attributed to the initial identification and screening done at the community level. New recruits were required to attend a residential training program. And at this stage, quite a few of them dropped out of the program.

The Shasthya Shebikas were offered incentives for rendering health care services. Their earnings depended on their delivery of the mix of BRAC’s product and service offerings. It was important for BRAC to identify the mix of products and services that would not only meet BRAC’s objective of providing affordable health care, but also provide financial incentives to motivate the Shasthya Shebikas. There were limitations on what could be sold through the Shasthya Shebikas. The territory covered by these women also influenced their income. The Shasthya Shebikas desired wide coverage, which at times conflicted with the intensity of coverage that BRAC desired.

The Shasthya Shebikas worked part-time, visiting village households to deliver health care services (see Exhibit 5). They contributed to preventing diseases and promoting health through health education. They organized health education forums, making house visits and spreading their message in community meetings. They spoke to villagers about family planning methods, child health, immunization, pregnancy related care, safe drinking water and sanitation, personal hygiene, nutrition, tuberculosis, and other topics. They also offered basic curative services. Shasthya Shebikas also provided treatment for common ailments such as diarrhea, dysentery, the common cold, anemia, and ringworm. For other ailments and cases that were beyond their capability, the women referred patients to government or private health facilities. The Shasthya Shebikas also identified possible tuberculosis cases, referring patients who had had a persistent cough for more than three weeks for sputum examination. The Shasthya Shebikas provided directly observed treatment, short-course (known as DOTS) for the treatment of tuberculosis patients, and performed follow-up of the treatment. They also sold over-the-counter drugs and health commodities. They encouraged villagers to access the primary health care facilities offered by the public health care system. It was observed that holding health education forums increased the sales of health care products and created demand for health care services.[[4]](#footnote-4)

Managing the Shasthya Shebikas

BRAC exercised care in recruiting and training the Shasthya Shebikas. It also regularly monitored the women’s performance, and its compensation package was designed to motivate and retain them.

Recruitment

The Shasthya Shebikas were young women between the ages of 25 and 35 or older, who were married and had no children under the age of two, and who were required to have passed standard 8 (eight years of schooling; standard 1 started at age six) in school. They were also required to have an entrepreneurship mentality. The women of a community nominated a person from among themselves, and the nominee had to be ratified at a meeting organized by the BRAC local office.5 If found eligible to be a Shasthya Shebika at the community level, the nominee was given two days orientation by BRAC staff and sent to the field for one month. If the nominee performed well, she was selected for training. After training, she started working as a Shasthya Shebika.

Training

BRAC provided regular group training for the Shasthya Shebikas at its residential training centres. The batch size for training the newly recruited Shasthya Shebikas was 18 to 20. BRAC organized an initial three weeks of training on maternal and child health and nutrition, immunization, family planning, water and sanitation, communicable disease control, and basic curative care for some common illnesses. The Shasthya Shebikas were also given training on specific topics such as nutrition intervention, maternal and newborn child health, reading glasses, and others.

A regular one-day refresher training was conducted once every three months by the program organizer, Health, at the local BRAC field office. As part of the refresher training, new health and nutrition issues were discussed; in addition, experiences were shared and problem-solving exercises were performed.[[5]](#footnote-5)

Monitoring

Shasthya Kormis were community-based front line workers who supported the work of the Sasthya Shebikas. Each Shasthya Kormi worked in the catchment area of 10 Shasthya Shebikas and met with all of them twice a month. During field visits, which they made six days a week, the Shasthya Kormis reviewed the activities of the Shasthya Shebikas and provided health care services alongside them. The Shasthya Kormis also educated the rural population during the health education forums in the village organized by the Shasthya Shebikas.

The Shasthya Kormis reported to the program organizer, Health, who was responsible for all of the health program activities that occurred in the catchment area of the field office. The Shasthya Kormis and the program organizer worked under the overall supervision of an *upazila* (sub-unit of a district) manager in an area. These upazila managers reported to district managers.

As part of the quarterly refresher training session, a work plan for the Shasthya Kormis for the following three months was prepared. The session was also used to check sales performances and replenish the stock of health products. The monthly performance report for the Shasthya Shebikas was generated at the field level by the Shasthya Kormis. Shasthya Shebikas’ performance was assessed based on the number of patients they served and products they sold, their attendance at refresher training, the number of patients/clients they mobilized for immunization, and so on. Shasthya Shebikas who did not take products from BRAC nor attend the refresher training were considered inactive.

Compensation

A Shasthya Shebika was an independent worker incentivized by BRAC. An example of the compensation for the rendering of health care services by a Shasthya Shebika was the payment she received every time she identified someone with tuberculosis, and every time the identified patient completed a six-month course of tuberculosis medicines.[[6]](#footnote-6) The patient receiving the service paid the Shasthya Shebika for the service rendered. Health products were sold by the Shasthya Shebikas at a 10 to 15 per cent markup. BRAC provided interest-free working capital of up to 1,000 taka[[7]](#footnote-7) for a regular Sasthya Shebika (one who received training on basic primary health care) and 4,000–5,000 taka for the upgrade/model Shasthya Shebika (one who received advanced training on non-communicable diseases care and eye care along with basic primary health care training). The income of Shasthya Shebikas was in the range of 500–1,500 taka per month. They earned income by selling medicines and commodities, and earned incentives from the sale of reading glasses, the completed treatments of tuberculosis patients, identifying pregnancies, providing antenatal and postnatal care, and the early initiation of breastfeeding (see Exhibit 6). Shasthya Shebikas received travel and meal allowances for attending quarterly refresher training sessions. About 1 to 2 per cent of Shasthya Shebikas reported earnings from health services outside BRAC.[[8]](#footnote-8)

Motivating the Shasthya Shebikas

Women in Bangladesh volunteered for community work in order to gain social recognition and financial independence. Most of the women who joined the Shasthya Shebikas had no income-generating activity before becoming a Shasthya Shebika. Many of them approached BRAC on their own initiative to take up the position. For some of these women, their job as a Shasthya Shebika was the main source of their household income. According to a BRAC official, the factors influencing the performance of Shasthya Shebikas were community trust, social recognition, BRAC monitoring and motivation, and income earned. A survey observed that the effort and performance of Shasthya Shebikas was greater when the household was dependent on their income. Shasthya Shebikas expected reasonable compensation for their efforts. In addition to monetary compensation, the opportunity to provide a service, social recognition, and respect were given as important motivating factors by a significant number of Shasthya Shebikas.

implications of product/service mix and territory size on income

The range of health care services offered by Shasthya Shebikas and the products they sold had implications on the income they earned. The influence of the product/service mix on income was observed in two situations. One was the introduction of new services by BRAC, and the other was the effort by Shasthya Shebikas to increase the range of services and products they sold outside of BRAC’s product and service offering.[[9]](#footnote-9)

Range of Offerings and Its Implications on Shasthya Shebikas’ Income

BRAC introduced the Maternal, Neonatal and Child Health (MNCH) pilot program in 2005. This program provided help during childbirth and care for the newborn. The additional services were rendered by the Shasthya Shebikas, but because of this, the territory they covered was reduced in order to increase effectiveness in the delivery of these health care services. The majority of Shasthya Shebikas attributed a perceived income reduction to the reduced territory. However, 34 per cent of Shasthya Shebikas perceived an increase in income, and of these women, 73 per cent attributed the increase to the additional services offered under the MNCH program.[[10]](#footnote-10)

Approximately 40 per cent of Shasthya Shebikas earned additional income by providing health care services outside of BRAC. That additional income came from referrals to health care facilities and from providing services such as neonatal care. A significant number of Shasthya Shebikas received training from external sources in addition to the training conducted by BRAC, enabling them to offer the additional services. Some of the Shasthya Shebikas even purchased medicines from sources other than BRAC.[[11]](#footnote-11) An interesting observation was that those who had taken outside training ultimately worked with BRAC for a longer period.

Territory Coverage and Income

The territory covered by Shasthya Shebikas was designed typically to include 400 households. Shasthya Shebikas spent their time on field visits for tuberculosis drug administration and primary health care from 7:00 a.m. until noon, usually making 20 visits in a day, six days a week. They ensured that they visited the households in their territory at least once in a month. Earlier, the number of households that Shasthya Shebikas were required to visit was 300, but this was subsequently increased to 400. Under the MNCH program, as mentioned above, the territory of Shasthya Shebikas was reduced and they were required to visit only 150 households instead of 300 households.

Efforts to retain Sasthya Shebikas

BRAC invested a significant amount in creating and maintaining an effective team of Shasthya Shebikas, and therefore the turnover of Shasthya Shebikas had cost implications for the organization. The cost incurred by BRAC when a Shasthya Shebika left the job was estimated to be $24. A reason for a Shasthya Shebika dropping out was that she considered the income insufficient for her effort. The increased literacy levels of a Shasthya Shebika and the availability of alternative employment opportunities for her also contributed to the turnover. There were other issues besides the issue of income, including the competing demands on Shasthya Shebikas’ time such as household work; the unfavourable light in which families and neighbours viewed these women’s taking up employment; and the difficulty the women faced because of people’s reluctance to seek advice on health problems from a local, as opposed to a fully qualified, practitioner.[[12]](#footnote-12)

Some of the steps BRAC had taken to increase retention of Shasthya Shebikas included proper recruitment practices; improvements to the incentive system, both monetary and non-monetary; and an increase of its product and service mix. In addition to this, BRAC carried out an experiment to improve delivery of health care service and to address the retention issue by introducing the “model” Shasthya Shebika program in July 2010. A pilot study was carried out in the urban slums of Dhaka city in an effort to develop an improved cadre of Shasthya Shebikas based on performance. The model Shasthya Shebika was defined as having the additional requirement of being literate, as well as owning and operating a grocery shop. The purpose of shop ownership was to enable Shasthya Shebikas to sell BRAC products in addition to rendering doorstep health care services. Ninety-four per cent of model Shasthya Shebikas perceived positive benefits after the program. Clients also gave positive feedback on the program, with most of them indicating that the model Shasthya Shebika visited their home more than once in a month. Furthermore, they believed that the model Shasthya Shebika had expertise in treating minor ailments.[[13]](#footnote-13)

Shasthya Shebikas and competition

Shasthya Shebikas offered heath care services to more than 100 million people, mostly women.[[14]](#footnote-14) Most of them were from poor households, but approximately 5 per cent were from well-off households. Around 40 per cent of Shasthya Shebikas’ clients were BRAC village organization members. Shasthya Shebikas were approached with cases of anemia, fever, diarrhea, and other ailments, as well as for the purchase of medicines.[[15]](#footnote-15) The poor, however, also used the health care services provided by the informal sector. Poor use of the formal health care service was evidenced by the number of births that took place at home assisted by untrained attendants—one-third of all cases.

Most Shasthya Shebikas perceived the presence of competition, mostly from pharmacies and village doctors. Some Shasthya Shebikas indicated that the competition affected their income. A small but significant number of them also mentioned government hospitals as competitors. The unavailability of preferred brands of medicines, and sometimes unavailability of the medicine itself, was considered by some Shasthya Shebikas as their weakness compared to competing service providers. A sizeable number of Shasthya Shebikas who did not face challenges because of competition indicated that the presence of other health care service providers in their territory was low. Shasthya Shebikas suggested that their clients preferred them to other health care service providers because of the doorstep service and flexible payment options they provided. In addition to this, many of their clients were female and preferred to buy most health products from other females. Familiarity and proximity were other reasons given for a preference for Shasthya Shebikas.[[16]](#footnote-16)

A study of informal health service providers checked the quality of treatment provided by these service providers, and observed that the quality of treatment by these village doctors and other informal service providers was poor. In most cases, inappropriate drugs were prescribed.[[17]](#footnote-17) Although Shasthya Shebikas were not qualified medical practitioners, they were trained to cure minor illnesses and to identify complex cases that required the attention of qualified physicians. The efficacy of their treatment was also due to the regular follow-ups they conducted. This was important because clients had a tendency to discontinue treatment, and the BRAC program provided incentives both to patients and to Shasthya Shebikas to finish the treatment.[[18]](#footnote-18)

Rural consumers and their preference for health care service providers

Attracting and retaining Shasthya Shebikas was only one of the challenges BRAC faced. Another critical aspect related to the delivery of health care service in Bangladesh. In the rural areas of the country, health care service delivery was carried out mostly by unqualified health care service providers. The presence of qualified medical professionals was minimal, because there were only 7.7 qualified professionals per 10,000 people. In contrast, there were 64.2 unqualified medical practitioners per 10,000 people.[[19]](#footnote-19) A review of the sector indicated that 60 per cent of the population, generally patients in the lower income group, sought the services of unqualified health care service providers. Studies that reviewed the health care service delivery system recommended enhancing the quality of care provided by the informal sector for the short term.[[20]](#footnote-20)

According to a BRAC official, “It is costly to have fully qualified medical practitioners and their availability is also limited. In the absence of qualified medical practitioners, the informal health care service providers fill a need-gap. The second reason for their existence is that at least some of them do have reasonable skill levels. These practitioners can attend to small ailments, but problems arise when they do not limit themselves to treating minor illnesses and also when complications arise.”

About 60 per cent of the population sought the services of unqualified health care services providers, and only a small percentage of people (13 per cent) used public health care services for treating illnesses.[[21]](#footnote-21) Different categories of health care providers existed (see Exhibit 7). However, one study indicated that there was an increasing preference among consumers for getting treatment from qualified doctors.[[22]](#footnote-22)

The health care seeking behaviour of rural consumers was examined by a BRAC University study that conducted in-depth interviews with 17 mothers from two villages. The study indicated that an important reason for rural consumers seeking unqualified service providers like “village doctors” for minor illnesses was proximity (see Exhibit 8). In addition to village doctors, some consumers also visited faith healers, for prayers. In the case that the illness worsened, they then sought treatment from qualified physicians. Although these consumers recognized the superior treatment of the qualified physicians, they did not seek qualified physicians in the initial stages because of the expense, distance, and loss of the day’s wages or income. The poor villager also favoured local practitioners because they did not always insist on immediate payment if the patient did not have money. In addition to cost and distance, approachability and familiarity also mattered. The perception of the villagers was that they received attention from the local practitioner. They also found it easy to communicate with the local practitioner, in contrast to their experience with public health care service providers. [[23]](#footnote-23)

A study on patients’ satisfaction with health care service providers and the factors influencing this indicated a higher rate of satisfaction with unqualified health care service providers. Satisfaction with the behaviour of unqualified practitioners was 90 per cent, compared to satisfaction with the behaviour of government health care service practitioners at 56 per cent. Aspects that led to increased patient satisfaction included the explanation of the illness provided to the patient, availability of medicines, and reduced waiting time.[[24]](#footnote-24)

According to a BRAC official, education and awareness among rural women was increasing, which created demand for formal allopathic medical practitioners. BRAC had noted this trend and was unsure about investing the effort in developing informal service providers, even for short-term use. Also, the income earned by some of these informal providers was much higher than the earnings of Shasthya Shebikas. Therefore, some of the informal heath care service providers would not be a viable option for BRAC. Information on the income earned by other types of health service providers was also available (see Exhibit 9).

Issues

The manager of BRAC’s Health, Nutrition and Population program indicated a need to revisit the community health worker model to further enhance the quality of service and to make it sustainable. This would involve creating a spirit of entrepreneurship among Shasthya Shebikas, which, according to the manager, required improving the competency of the community health workers, and increasing their income and motivation by exploring opportunities to enhance the basket of product and services offered by them. This would require training and increasing the women’s access to funds.

The program manager faced the challenge of increasing incentives for the Shasthya Shebikas to reduce turnover. Toward this goal, the program manager could consider the possibility of identifying the optimum territory size for the Shasthya Shebikas, and encouraging them to take up related services or products outside of BRAC’s offering, in addition to the option of increasing the service and product mix. It was important, however, that the efforts to increase the income of Shasthya Shebikas not take the focus away from BRAC’s objective of providing health care service. It was possible that, in an effort to increase their income, the Shasthya Shebikas could shift their efforts from providing service to selling products—and even push products not needed by their clients. The Shasthya Shebikas had a different view on the issue; most of them believed that providing health care service and offering health-related advice helped them to sell their products.

Another option available to BRAC was including local, unqualified health care service providers to complement the work of the Shasthya Shebikas. Some studies suggested exploring ways to use these unqualified health care service providers that were popular among the poor, but this involved improving the quality of the health care service they offered. If BRAC decided to use the services of local, unqualified health care service providers, it would have to identify acceptable service providers and determine the cost of using their services. BRAC would also need to determine when to use unqualified health care service providers instead of Shasthya Shebikas.

Exhibit 1: Bangladesh Population, Geography, and Income levels (2011)

Population

The population of the country stood at 149.8 million in 2011, with a population density of 1,015 persons per square kilometre. Close to 77 per cent of the population lived in rural Bangladesh.

**Bangladesh Population by Area**

|  |  |  |  |
| --- | --- | --- | --- |
| Area | Number of Households | Population (Enumerated) | Population (Adjusted) |
| Urban | 7,502,040 | 33,563,183 | 35,100,000 |
| Rural | 24,671,590 | 110,480,514 | 114,700,000 |
| Total | 32,173,630 | 144,043,697 | 149,800,000 |

**Geography**

Located in South Asia, Bangladesh was bordered by India and Myanmar. The country covered an area of 147,570 square kilometres. Its administrative divisions were Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur, and Sylhet. Each division was subdivided into *zilas*,and each *zila* into *upazilas*. Each urban area in an *upazila* was divided into wards, which were further sub-divided into *mohallas*. A rural area in an *upazila was* divided into *union parishads*,and a *union parishad* was further divided into *mouzas*.

**Income Levels**

Even though poverty rates had demonstrated steady improvement, with an average decline of 1.74 points per year during the past decade, the income disparity between urban and rural areas had widened over the last five years. The gross domestic product per capita for 2014 was US$1,086.80.

Source: “Population and Housing Census 2011,” Bangladesh Bureau of Statistics, accessed March 3, 2016, http://203.112.218.69/binbgd/RpWebEngine.exe/Portal?BASE=HPC2011\_short&lang=ENG; The World Bank, “GDP per Capita (Current US$),” 2016, accessed April 4, 2016, <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>.

Exhibit 2: BRAC (Bangladesh) Statement of Income and Expenditure for the year ended December 31, 2015

|  |  |
| --- | --- |
|  | **Amount in Taka** |
| **Income** | |
| Donor Grants | 13,785,992,217 |
| Social Enterprises | 13,345,427,760 |
| Microfinance Programme | 26,682,363,975 |
| Self-Financing Social Development Programmes | 1,055,881,151 |
| Investment Income | 1,739,681,517 |
| House Property | 92,370,223 |
| **Total Income** | **56,701,716,843** |
| **Expenditure** | |
| Social Enterprises | 11,747,263,079 |
| Microfinance Programme | 15,244,367,848 |
| House Property | 99,443,136 |
| Agriculture and Food Security | 334,185,896 |
| Community Empowerment Programme | 364,919,588 |
| Education Programme | 5,569,214,047 |
| Gender, Justice and Diversity | 402,633,544 |
| Health Programme | 4,578,956,175 |
| Human Rights and Legal Aids Services | 271,203,344 |
| Policy Advocacy | 170,883,319 |
| Water, Sanitation and Hygiene Programme | 1,218,247,312 |
| Ultra-Poor Programme | 2,779,602,037 |
| Other Development Projects | 851,311,420 |
| **Total Expenditure** | **43,632,230,745** |
| Surplus of Income over Expenditure before Taxation | 13,069,486,098 |
| Taxation | −165,000,000 |
| **Net Surplus for the Year** | **12,904,486,098** |

Note: Taka = BDT = Bangladeshi taka; 1 taka = US$0.0126 on December 31, 2015.

Source: Company files.

Exhibit 3: BRAC’s Development Programs

* The Disaster Management and Climate Change programs included predicting disasters, and developing community-level preparedness and coping abilities for these disasters.
* The Health, Nutrition and Population program focused on improving maternal health, reducing neonatal mortality, eliminating communicable diseases such as tuberculosis, and combating non-communicable diseases. The program reached the under-privileged community through its community health workers, and adopted a door-to-door service delivery approach.
* The Water, Sanitation and Hygiene program included efforts to increase access to safe drinking water, improve basic sanitation, and provide hygiene education.
* BRAC’s Education program included setting up non-formal primary schools in communities not reached by the formal education system, livelihood and skills development training for youth, and community learning centres to promote reading.
* The Migration program provided access to information and services for migrants.
* BRAC’s Agriculture and Food Security program included developing and diffusing better crop varieties and improved production technologies for higher agricultural productivity.
* The Integrated Development program was launched in a couple of regions where poverty was acute and where there was a high prevalence of malnutrition and diseases, to ensure that all necessary services were delivered in an efficient and timely manner.
* Microfinance activities included loan and savings products designed to meet the needs of the people living in poverty.
* Programs for the extremely poor included granting asset grants or soft loans, offering skill development, health care facilities, and ensuring social security through community mobilization.
* The Community Empowerment program involved capacity building for the poor in order to motivate them to raise their voices and take collective action.
* The Gender, Justice and Diversity program empowered women at the household level, and worked to ensure that girls and boys were equitably nurtured to their full potential, from pre-primary through secondary school.
* The Human Rights and Legal Aid Services program operated over 400 legal aid clinics in districts across Bangladesh.

Source: Company files.

Exhibit 4: Select Features of Some of BRAC’s Health Programs

(January–December 2014)

|  |  |  |
| --- | --- | --- |
| **Program** | **Brief Description** | **Districts Covered** |
| Essential Health Care | BRAC's basic health program included promotive, preventive, and basic curative services. It aimed to improve reproductive, maternal, neonatal, and child health along with the nutritional status of women and children. The program further aimed to reduce vulnerability to communicable diseases and non-communicable diseases. | 47 |
| Improving Maternal, Neonatal and Child Survival | This program addressed issues related to pregnancy, newborn, and child health, and facilitated access to obstetrics and newborn care at public and private facilities in the rural areas. | 14 |
| Nutrition | The Shasthya Shebikas and the nutrition promoters visited households with children below the age of two and pregnant women. They provided counselling, coaching, and demonstrations. The program organizer and the nutrition promoters also taught nutrition to the adolescents through school meetings and courtyard meetings. | 140 |
| Reading Glasses | This aimed to combat presbyopia, a chronic eye problem that created difficulty in near vision. It was implemented in partnership with social enterprise VisionSpring. | 61 |
| Tuberculosis Control | The Shasthya Shebikas disseminated tuberculosis-specific messages to the community, identified presumptive tuberculosis patients, and referred these patients for sputum examination. | 42 |
| Malaria Control | The Shasthya Shebikas diagnosed malaria patients using a Rapid Diagnostic Test kit, therefore providing treatment at a household level. In the case of pregnant women, children weighing less than five kilograms, and severe malaria patients, the Shasthya Shebikas referred them to the nearest government health facilities. | 13 |
| Marketing Innovation for Health | This aimed to increase access to and demand for essential health products and services through the private sector. It used extensive marketing and behavioural change communication campaigns. | 7 |
| Non-communicable Diseases (Integrated through the Essential Health Care platform) | The Shasthya Shebikas measured both blood glucose, using a glucometer, and blood pressure. They performed primary screening for diabetes and hypertension among people at risk, and referred patients with positive results to partner clinics/hospitals. | 42 |

Source: Company files.

Exhibit 5: Shasthya Shebikas’ Involvement in Programs (December 2014)

|  |  |  |  |
| --- | --- | --- | --- |
| **Program** | **Districts Covered** | **Shasthya Kormis** | **Shasthya Shebikas** |
| Essential Health Care | 47 | 4,792 | 48,713 |
| Essential Health Care for the Ultra-Poor | 44 | nil | nil |
| Improving Maternal, Neonatal and Child Survival | 14 | 4,421 | 36,050 |
| Nutrition |  | 3,408 | 28,816 |
| Reading Glasses | 61 | 2,788 | 22,557 |
| Tuberculosis Control | 42 |  | 63,810 |
| Malaria Control | 13 | 686 | 3,372 |
| Marketing Innovation for Health | 7 | 1,019 | 9,679 |
| Non-communicable Diseases | 42 |  | 3,422 |

Note: The total number of Shasthya Shebikas was lower than the total in the table because a Shasthya Shebika performed multiple services across programs. In addition to Shasthya Shebikas and Shasthya Kormis, BRAC’s health care workers included newborn health workers, community skilled birth attendants, and urban birth attendants.

Source: Company files.

Exhibit 6: Select Health care Services for which a Shasthya Shebika earned Income

|  |  |
| --- | --- |
| **Treatment Service** | **Percentage of Shasthya Shebikas Providing this Service** |
| Referring patients to other health facilities | 30 |
| Pregnancy testing | 91 |
| Infant care during delivery | 83 |
| Weighing a baby | 84 |

Mahjabeen Rahman and Sakiba Tasneem, “Issue 6 Determinants of Income of the Shasthya Shebikas: Evidences from a Pilot MNCH Initiative in the Nilphamari District of Bangladesh,” BRAC, December 1, 2008, accessed August 25, 2016, http://research.brac.net/new/component/k2/issue6.

Exhibit 7: Categories of informal health care providers

The informal (not registered with any government regulatory body) health care providers in Bangladesh were categorized into the following groups:

* Allopathic Paraprofessionals: These included medical assistants/sub-assistant community medical officers, family welfare visitors, and lab technicians/physiotherapists.
* Community Health Workers
* Unqualified Allopathic Providers: These included village doctors, and drugstore salespeople. Village doctors/rural medical practitioners were trained for a short duration in mostly unrecognized institutions.
* Traditional Healers: Also called Kabiraj, they could be self-trained and prescribed diets and herbs.
* Faith Healers: They largely chanted prayers.
* Traditional Birth Attendants: Some of these might have had training in delivering babies.
* Homeopaths: They were mostly self-trained, though some might have been trained in institutions.

Source: Syed Masud Ahmed, Md. Awlad Hossain, and Mushtaque Raja Chowdhury, “Informal Sector Providers in Bangladesh: How Equipped Are They to Provide Rational Health Care?,” *Health Policy and Planning* 24 (2009): 467–478.

Exhibit 8: Presence and Accessibility of Health Service Providers in Rural Areas of bangladesh

|  |  |  |
| --- | --- | --- |
| **Health Service Provider** | **Presence in Rural Location of the Health Care Service Provider (%)** | **Accessibility**  **(Distance the Patient travelled, in kilometres)** |
| Physicians | 0.7 | >= 5 |
| Allopathic Paraprofessionals | 0.6 | >= 5 |
| Village Doctors | 8.1 | 2-5 |
| Drugstore Salespeople | 6.4 | <2 |
| Traditional Birth Attendants | 24.8 | <2 |
| Traditional Healers | 48.6 | <2 |
| Homeopaths | 3.3 | 2-5 |
| Community Health Workers | 6.5 | <2 |
| Total\* | 100 |  |

Note: \*Some health care service providers have not been included and so the total does not add up to 100.

Source: Bangladesh Health Watch, Department for International Development, “The State of Health in Bangladesh 2007: Health Workforce in Bangladesh, Who Constitutes the Health Care System?,”James P. Grant School of Public Health, BRAC University, 2008, 8–9.

Exhibit 9: Health care service providers’ household income (%)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Monthly household income (taka)** | **Allopathic para-**  **professional** | **Community health workers** | **Rural medical practitioners (village doctors)** | **Homeopaths** | **Birth attendants** | **Herbalists and faith healers** | **Drugstore salespeople** |
| **Less than 5,000** | 11.1 | 30 | 24.1 | 31.4 | 65.4 | 57.7 | 29.7 |
| **Between 5,000 and 10,000** | 7.4 | 35 | 44.5 | 38 | 25.3 | 28.4 | 40.1 |
| **More than 10,000** | 84.5 | 35 | 31.4 | 30.6 | 9.4 | 13.9 | 30.2 |

Note: Many of the homeopaths and almost half of village doctors were also engaged in farming as a source of additional income; some of the service providers were engaged in trading; Taka = BDT = Bangladeshi taka; US$1 = 78.9031 taka on December 31, 2015.

Source: Bangladesh Health Watch, Department for International Development, “The State of Health in Bangladesh 2007: Health Workforce in Bangladesh, Who Constitutes the Health Care System?*,*” James P. Grant School of Public Health, BRAC University, 2008, 85.

1. BRAC rules specified the recruitment of young women as community health workers in the rural areas of Bangladesh. [↑](#footnote-ref-1)
2. All dollar amounts in the case are in U.S. dollars. [↑](#footnote-ref-2)
3. Antora Mahmud Khan and Syed Masud Ahmed, “Current State of the Model *Shasthya Shebikas* of BRAC: A Quick Exploration of the ‘Pilot Project for SS Sustainability,’” BRAC Research Portal, 2011, accessed August 25 2016, <http://research.brac.net/new/component/k2/shasthyashebikas>. [↑](#footnote-ref-3)
4. Syed Masud Ahmed, “Taking Healthcare Where the Community Is: The Story of the Shasthya Shebikas of BRAC,” *BRAC University Journal* 5, no. 1 (2008):37–43. [↑](#footnote-ref-4)
5. Ibid. [↑](#footnote-ref-5)
6. Tina Rosenberg, “What Makes Community Health Care Work,” *The New York Times*, February 18, 2011, accessed April 6, 2016, http://opinionator.blogs.nytimes.com/2011/02/18/what-makes-community-health-care-work/. [↑](#footnote-ref-6)
7. Taka = BDT = Bangladeshi taka; 1 taka = US$0.0129 on January 1, 2017. [↑](#footnote-ref-7)
8. Mahjabeen Rahman and Sakiba Tasneem, “Determinants of Income of the Shasthya Shebikas: Evidences from a Pilot MNCH Initiative in the Nilphamari District of Bangladesh,” BRAC Research Portal, 2008, accessed August 25, 2016, http://research.brac.net/new/component/k2/issue6. [↑](#footnote-ref-8)
9. Ibid. [↑](#footnote-ref-9)
10. Ibid. [↑](#footnote-ref-10)
11. Ibid. [↑](#footnote-ref-11)
12. Ahmed, op. cit. [↑](#footnote-ref-12)
13. Khan and Ahmed, op. cit. [↑](#footnote-ref-13)
14. Rosenberg, op. cit. [↑](#footnote-ref-14)
15. Rahman and Tasneem, op. cit. [↑](#footnote-ref-15)
16. Ibid. [↑](#footnote-ref-16)
17. Bangladesh Health Watch, Department for International Development, “The State of Health in Bangladesh 2007: Health Workforce in Bangladesh: Who Constitutes the Healthcare System?,” James P. Grant School of Public Health, BRAC University, 2008, 19. [↑](#footnote-ref-17)
18. Rosenberg, op. cit. [↑](#footnote-ref-18)
19. Bangladesh Health Watch, op. cit. [↑](#footnote-ref-19)
20. Syed Masud Ahmed, Md. Awlad Hossain, and Mushtaque Raja Chowdhury, “Informal Sector Providers in Bangladesh: How Equipped Are They to Provide Rational Health Care?,” *Health Policy and Planning* 24 (2009): 467–478; Bangladesh Health Watch, op. cit. [↑](#footnote-ref-20)
21. Ibid., 13. [↑](#footnote-ref-21)
22. Khan and Ahmed, op. cit. [↑](#footnote-ref-22)
23. Bangladesh Health Watch, op. cit. [↑](#footnote-ref-23)
24. Anne [Cockcroft](http://www.ncbi.nlm.nih.gov/pubmed/?term=Cockcroft%20A%5Bauth%5D), Neil [Andersson](http://www.ncbi.nlm.nih.gov/pubmed/?term=Andersson%20N%5Bauth%5D), [Deborah Milne](http://www.ncbi.nlm.nih.gov/pubmed/?term=Milne%20D%5Bauth%5D), Md Zakir [Hossain](http://www.ncbi.nlm.nih.gov/pubmed/?term=Hossain%20MZ%5Bauth%5D), and [Enamul Karim](http://www.ncbi.nlm.nih.gov/pubmed/?term=Karim%20E%5Bauth%5D), “What Did the Public Think of Health Services Reform in Bangladesh? Three National Community-Based Surveys 1999–2003,” *Health Research Policy and Systems* 5, no. 1 (2007). [↑](#footnote-ref-24)