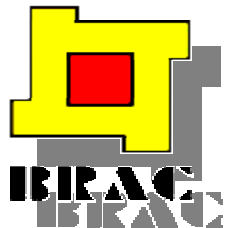


# Reaching Those Most in Need

**Faruque Ahmed**

BRAC Health Programme  
Bangladesh



# Bangladesh At A Glance

- Area (Sq. km) : 147,570
- Population : 144 million
- GNP per capita : 440 USD
- Life expectancy : 63.3 Years
- Population living below \$1 per day : 36 %
- Per Capita Health Expenditure (2004): \$12



Source: UNDP Human Development Report 2006

**BANGLADESH**

# Health Scenario

- Bangladesh has made considerable progress in improving health status in last few decades

<b>Indicators</b>	<b>1970s</b>	<b>2007</b>
Total fertility rate (TFR)	6.3	2.7
Immunization coverage	2%	82%
Under-five mortality rate	221	65
Maternal mortality ratio (MMR)	750	322

- NGOs working side by side with the Government have contributed significantly

Source: BFS 1975, BMHSMS 2001,  
BDHS 2007



## **BRAC's twin objectives :**

- Poverty alleviation
- Empowerment of the poor, especially women

# BRAC At A Glance

- **Working since 1972**
- **Reaching beyond Bangladesh in Afghanistan, Srilanka, Pakistan and in Africa.**
- **Annual Budget USD 495 million, of which 77% generated from own resources (2007)**
- **Reaching 110 million people in all 64 districts in Bangladesh**
- **More than 95,000 staff and 3,350 offices**
- **Core Programmes:** Economic development (micro-finance), Education, Health, Social development & Human Rights

# BRAC Health Programme

- *Improve maternal, neonatal & child Health*
- *Reduce vulnerability to and control infectious and common diseases*

ARI Control

Malaria (1.4 m)

TB (83 m)

CFPR-STUP  
(800,000 families)

MNCH Rural  
(2.5 m)

MNCH (Urban Slum)  
(1 m)

WASH  
(37.5 m)

HIV/AIDS

Facility based  
care

Pilot Initiatives

**Essential Health Care (EHC) Programme  
(over 92 million people)**

# Community Health Volunteers (CHVs): *Shasthya Shebika*

*The Nucleus of BRAC Health Programme*

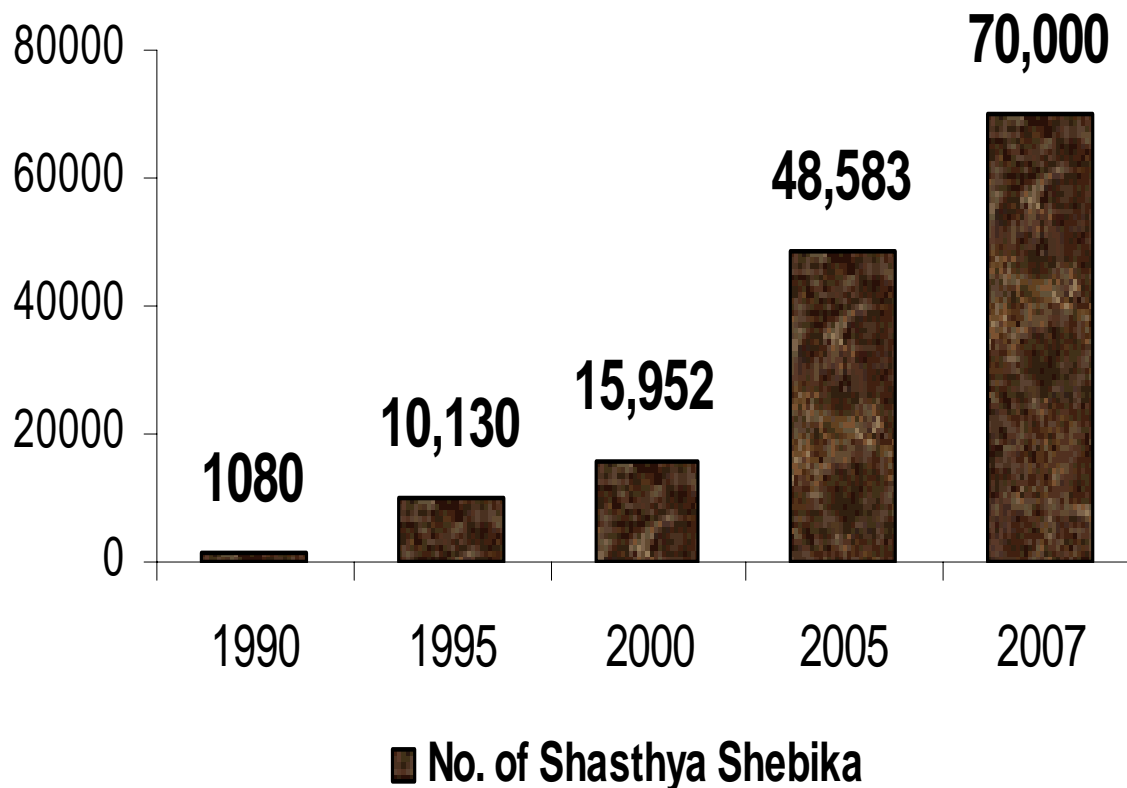
- BRAC Village Organization (VO) member, married and aged above 25 years
- They deliver preventive and basic curative health services through door-to-door visits.
- Each one covers an average of 250 households
- Trained to fill the critical health human resource gap in Bangladesh



***Shasthya Shebika***

# Development of *Shasthya Shebika* Programme at BRAC

Fig. 1. Number of Shsthya Shebika Working over time at BRAC



- BRAC began experimenting with *Shasthya Shebikas* in mid-1970s.
- Progressively scaled up since 1990's.
- Replicated CHVs model in Afghanistan and Africa



# Capacity Development of *Shasthya Shebika*

## A. Training

1. Four weeks basic training
2. Monthly refresher training

## B. Income/Revolving Fund

1. Essential drugs
2. Selected health commodities
3. Access to microfinance

## C. Supervision

1. One *Shasthya Kormi* (supervisors of CHVs) for 10 CHVs at community level
2. Programme Organizers supervise both *Shasthya Kormi* & CHVs

# Services Delivered by *Shebika*



**Shasthya Shebika examining an under 5 child during her home visits**

- Health & nutrition education
- Family planning methods
- Pregnancy related care
- Basic curative care of 10 common diseases including ARI
- DOTS services for Tuberculosis control
- Social mobilization for EPI, Vitamin-A campaign

# Examples of Measurable Impacts by *Shasthya Shebika*

## 1. Science to People

- 13 million house holds were trained in ORS in 1980s

## 2. Child Immunization

- Universal child immunization achieved only in the BRAC areas in 1990s

## 3. Tuberculosis (TB) Control

- Treatment completion rate over 90%
- TB Prevalence in BRAC areas (**with CHVs**) half the rate in other areas (**without CHVs**)

### References:

1. A Simple Solution: Teaching Millions to treat Diarrhea at Home, AMR Chowdhury, Cash R A, UPL, Dhaka (1996) p 10
2. Control of Tuberculosis by Community Health Workers in Bangladesh, [The Lancet](#), 1997 350: 169-1972 (1997)

# Measurable Impacts Cont...

## 3. Cost-Effectiveness of DOTs

DOTs implemented with Shasthya Shebika more cost effective than the programmes without CHVs (USD 64 per patients compared to USD 96 in other programme).

### Reference:

3. Islam, M. A.; Wakai, S.; Ishikawa, N.; Chowdhury, A. M. R.; Vaughan, J. P. Cost-effectiveness of community health workers in tuberculosis control in Bangladesh [Bulletin of the World Health Organization](#), 2002; 80(6):445-450

# Lessons Learned

- Small working area
- Selection by people whom they serve
- Continuous refresher training and on-the-job supervision
- Programmatic linkage with BRAC, Government and others
- Incentives e.g., income from sale of essential drugs and health commodities, access to micro-finance programme



Questions are :

- How to link CHVs with formal health sector ?
- How to sustain CHVs financial and other incentives ?



# Key Messages

1. Community health volunteers can deliver at scale
2. Community health volunteers model can be sustainable
3. Community volunteers model can be replicated



**THANK YOU !**