Urban FP/MCH Working Paper No. 13

Urban Health Extension Project

Urban Volunteer Service in the Slums of Dhaka: Community and Volunteer Perceptions

Sandra L. Laston
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International Centre for Diarrhoeal Disease Research, Bangladesh

October 1993

The **International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)** is an autonomous, non-profit organisation for research, education, training and clinical service. It was established in December 1978 as the successor to the Cholera Research laboratory, which began in 1959 in response to the cholera pandemic in southeast Asia.

The mandate of the ICDDR,B is to undertake and promote research on diarrhoeal diseases and the related subjects of acute respiratory infections, nutrition and fertility, with the aim of preventing and controlling diarrhoeal diseases and improving health care. The ICDDR,B has also been given the mandate to disseminate knowledge in these fields of research, to provide training to people of all nationalities, and to collaborate with other institutions in its fields of research.

The Centre, as it is known, has its headquarters in Dhaka, the capital of Bangladesh, and operates a field station in Matlab thana of Chandpur District which has a large rural area under regular surveillance. A smaller rural and a large surveyed urban population also provide targets for research activities. The Centre is organised into four scientific divisions: Population Science and Extension, Clinical Sciences, Community Health, and Laboratory Science. At the head of each Division is an Associate Director; the Associate Directors are responsible to the Director who in turn answers to an international Board of Trustees consisting of eminent scientists and physicians and representatives of the Government of Bangladesh.

The **Urban Health Extension Project (UHEP)** is a follow-on activity of the Urban Volunteer Program (UVP). In 1981, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) began training women volunteers in urban Dhaka in the use of ORS packets for diarrhoeal disease on the assumption that community women could play an important role in teaching others about the home treatment of diarrhoea with ORS. The United States Agency for International Development (USAID) began funding the project in 1986 with a mandate to provide primary health care services to the urban slums and conduct research on child survival related issues. UHEP continues to focus on health and family planning issues of the urban slums with an overall goal to strengthen the ability of the government and non-governmental agencies to provide effective and affordable family planning and selected maternal and child health services to the urban poor through research, technical assistance, and dissemination of its research findings.

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Foreword

I am pleased to release these reports on urban health and family planning issues which are based on the activities of the Urban Health Extension Project (UHEP). UHEP is a follow-on activity of the former Urban Volunteer Program, a pilot project funded by the United States Agency for International Development (USAID).

The poor health status and the health needs of the urban poor continues to be an important emerging public health issue in the Developing World. Bangladesh is no exception. Despite the constraints of poverty and illiteracy, there are proven strategies to provide basic health and family planning services to the urban poor. In Dhaka alone, aside from the Government health care facilities, there are numerous NGOs and private sector providers giving needed services to the urban population. The Centre's own Urban Health Extension Project continues to focus on the urban poor, especially the slum populations, in providing basic family planning and health services through outreach activities (viz. health education, ORS distribution and referral services to service points).

However, enormous challenges remain in providing an optimum level of services to the urban poor. The UHEP, with the support of the USAID, will focus on health and family planning services delivery strategies in reaching the needed services to the urban poor. We certainly look forward to learning more about the health and family planning needs of the urban poor, testing sustainable strategies and applying these proven strategies in collaboration with other partners in government, NGOs and the private sector.

Demissie Habte, MD
Director

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Urban Health Extension Project (Formerly, Urban Volunteer Program),
Community Health Division,
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Contents

Figure

Summary

Nearly half of the women currently working as volunteers (389) in the Urban Health Extension Project (formerly, the Urban Volunteer Program) in Dhaka, Bangladesh have remained with the program for seven years or longer. To gain some understanding of why these women continue to serve in their community as volunteers, focus group discussions were conducted with a sample of both volunteers and mothers from volunteer-served areas. Twenty-eight focus group discussions were conducted during April-May 1992. Findings from these group discussions indicated that an important reason for continued volunteer service was that these women found increased respect in the community through their service and association with ICDDR,B. Some of the volunteers felt that their work allowed them greater mobility in the community. The volunteers and the community mothers viewed their service as important. Many of the volunteers also hoped their work and experience in the community would help them get a job in the future. Although some family members initially objected to volunteers' participation in the program, the benefits their work brought to the household and community eventually outweighed these initial misgivings.

Introduction

Although the Government of Bangladesh has a structured health and family planning service-delivery system for the rural population, there is no comparable infrastructure for the urban population. Most of the health services in the urban areas, particularly in the slums, are provided by the private sector, including private physicians, pharmacies, and international and local non-governmental organizations (NGOs), which may provide limited services in certain areas. Government facilities are primarily used for serious illnesses (hospitals) and immunizations (1).

To address this inadequacy of health care facilities, a cadre of women (volunteers) was recruited and trained by the Urban Health Extension Project (formerly the Urban Volunteer Program) from the urban and peri-urban slum areas of Dhaka city (2). The target groups for service delivery were mothers and children under five years of age living in the slums of urban Dhaka. The volunteer model for basic health care, education, and referral was viewed as an appropriate strategy for the urban slums of Dhaka, because women living in the community could provide oral rehydration solution (ORS) and support to community mothers in their homes. It was assumed that mothers residing in the urban slums of Dhaka would be more responsive to someone they knew from the community who was familiar with their needs and problems in the slum setting.

It is important to assess the sustainability of volunteer service delivery in urban slums if other health care providers (Government, NGOs) consider the use of the volunteer service-delivery model. Nearly half of the current

volunteers (45%) have worked 7 years or more in the urban slums (Figure 1). Three of the volunteers have been with the program since it began in 1981. This high retention rate of volunteers in the Dhaka slums led to the study described in this paper.

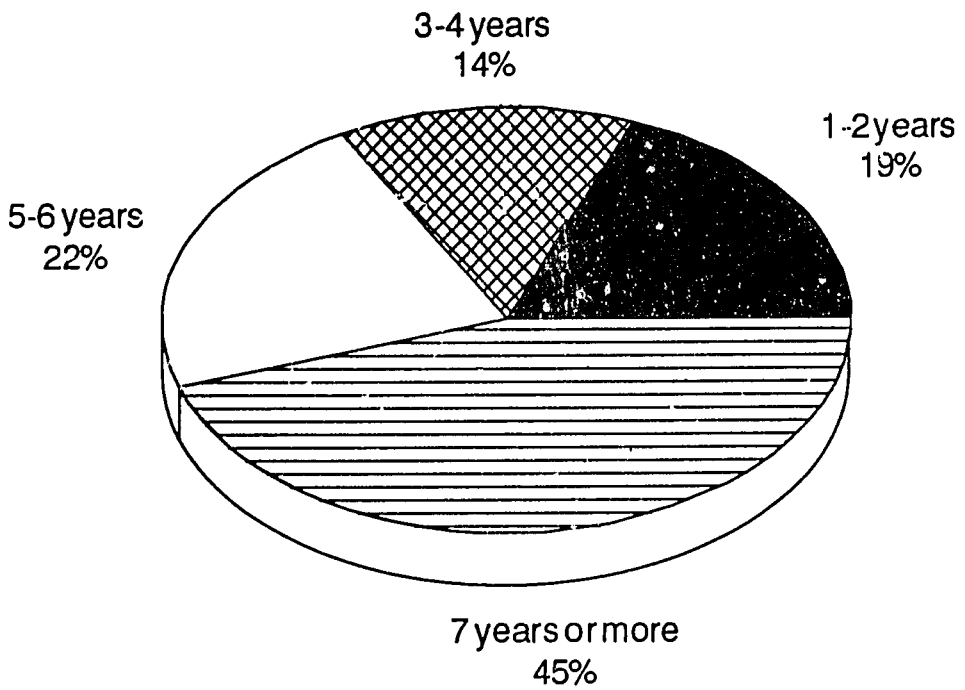

Fig. 1 Distribution of Volunteers by Years of Service
Source: UHEP Data, 1992

Other questions raised frequently during discussions of the volunteers in the Urban Health Extension Project (UHEP) are: why would economically disadvantaged slum women continue to work as a volunteer in their community?; and what do they expect to gain from this work for themselves and their families? Focus group discussions with some of the volunteers and slum mothers provided some insights into their service within the community.

History of the Urban Volunteer Program

The Urban Volunteer Program, the predecessor of UHEP, originated in 1981 when the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) began recruiting and training women volunteers to provide diarrhea prevention education and the use of ORS to treat diarrhea within the slum communities of Dhaka. Sister Eva, an Australian nurse-midwife, spearheaded this initial phase of the project. By 1986, about 1,600 volunteers were recruited and trained from urban and peri-urban Dhaka. Over the years, the training curricula was appropriately expanded to include immunization, nutrition, and family planning.

In 1986, USAID began to support the Urban Volunteer Program and the goals and service areas of the volunteers were formalized. The objectives of the project were to provide basic maternal and child health-family planning (MCH-FP) services to the urban slums of Dhaka and to evaluate the effectiveness of the volunteer-based urban health services-delivery system. During 1987-1989, the project tried to locate all the volunteers and determine which ones were still active, where they were living, and what services they

were providing. Their experiences and input were used to develop suitable parameters for the urban volunteer system. Training curricula and educational materials were developed and the supervisory system of the volunteers was strengthened.

In 1990, the project was restructured and remains essentially the same today. The volunteers were too scattered and the project did not have the infrastructure to support a total of 1,600 volunteers. Furthermore, maintenance of this large cadre of volunteers seemed inappropriate for operations research purposes. Volunteer services were consolidated to five *thana* (administrative units) slums of the 14 *thana* in Dhaka city which scaled the number of volunteers down to approximately 500 women. The remaining 1,100 volunteers were no longer encompassed under the supervision and support of the project and constituted the group of released volunteers*.

For recruitment, potential volunteers were identified by the community leaders or supervisory field staff from the project. The criteria for selection from these identified women include:

- a self-motivated woman (priority criteria)
- a respected member of the community
- willingness and ability to learn and teach others
- willingness and ability to collect basic service data
- minimum one year resident of UVP target slum
- preferably a woman over 18 years of age
- preferably a housewife with no more than two children

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* Participants in the focus group discussions with released volunteers were selected from these women.

Volunteers attend a two-week basic health training session. The training focuses on four areas: a) diarrhea prevention and treatment, b) nutrition, c) immunization, and d) family planning. Every four months the volunteers receive a refresher course. The training techniques include lectures, group discussions, role playing, demonstrations, videos, and service point visits.

The volunteers are given a pre- and post-test during their basic health training. If the post-test score is between 75% and 100%, the volunteer is considered graduated. If the score is between 60% and 75%, a trainer visits the volunteer in the field.

The trainers conduct field follow-up visits three to six months after the basic training to observe the teaching methods of the volunteer in her community and her relationship with the mothers. Refresher training is provided when necessary.

Each volunteer is responsible for 30-50 households and is expected to visit these households at least once each month. They provide health education and referral services. They also accompany clients to health and family planning centers and distribute packets of ORS to diarrhea patients. Volunteers fill in symbol calendars each month, indicating the services they provide to their catchment households (provide ORS, education messages, referrals) with tally marks. Over one-third of the volunteers have received no formal education*. The symbol calendars were designed specifically for use by illiterate volunteers. They receive calendar training to help them record the services they provide on the calendar.

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* Data Source: Volunteer education update, May 1992.

Field supervisors, a total of 16, visit each volunteer every two weeks to answer any questions, provide support, replenish ORS supplies, and check the symbol calendar. Each field supervisor is responsible for one specific group of 25 volunteers. Three community health coordinators (CHCs) are responsible for the supervisors and one health services coordinator (HSC) is responsible for the overall supervision of the service component of the project.

Objectives of the Focus Group Study

The primary objectives of the focus group discussions were to assess the perceptions of the volunteers regarding why they were motivated to work as volunteers, to determine their expectations and incentives for their work, and to identify barriers and problems they encounter during their work. Another objective was to assess the community mothers' attitudes and understanding of the role of volunteers and the use of their services.

Methodology

Twenty-eight focus groups were conducted during April-May 1992 by the Associates for Community and Population Research (ACPR), a private consultancy firm located in Bangladesh. Initially, UHEP research personnel planned to conduct the group discussions but the test focus group sessions suggested that the responses of the volunteers were influenced by the presence of project personnel. This resulted in a decision to use outside consultants to administer the questions devised by the UHEP research scientists. A pre-test of the questions by the consultants indicated that they were recording responses that were more open and straight forward than the previous test sessions. The groups were stratified by age and years of experience to promote participation by all group members. Younger women with fewer years of volunteer experience were grouped together, while the older women with more experience were separately grouped. Each focus group had from six to eight participants, a total of 209 individuals. Participants in the 28 focus groups were selected from lists of current and released volunteers and mothers living in slums in the catchment areas of urban volunteers.

Current volunteers (18 groups) were selected from computer lists of volunteers who were currently working in the UHEP service areas. The lists for selecting the sample of volunteers for the focus groups were stratified by age and number of years of volunteer experience.

Released volunteers (4 focus groups) were selected from three *thana* that had previously been included in the volunteer program but were de-activated when the project limited its coverage to five *thana* of Dhaka for improved supervision and administration .

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* For further explanation of released volunteers, refer page 4.

The sample of mothers (6 focus groups) was randomly selected from a partial list of 20 volunteers who had not been included in the sampling frame of the current volunteers. This provided wider areal coverage of the slum areas for women included in the various focus groups.

All of the focus group sessions were held at 'neutral' locations but within the field area. Locations included NGO offices, community centers, and *samity* (association) offices. The focus group team from ACPR consisted of a moderator, a note-taker, and an additional member who assisted during the sessions to facilitate recording and coordinate the group.

All of the focus group sessions were tape recorded. Each day, the focus group team listened to the tapes and transcribed the recorded information. They also edited the hand-written notes into a final copy of guidelines. All edited copies were then translated into English and entered into the computer. Focus group transcriptions for community mothers, current volunteers, and released volunteers were analyzed separately. Transcripts were coded and grouped by topics (sorted) to facilitate the interpretation of results. Repeated reviews of the transcripts provided themes and patterns for each of the topic areas. Verbatim responses that helped represent important themes were selected from the transcripts to present examples of the points

Results

The results of the focus group sessions are discussed separately for current volunteers, released volunteers, and community mothers. There was no apparent variation in responses due to age or length of service as a volunteer, so the information was combined to make final categories.

Current Volunteers

Current volunteers (18 groups) were asked why they decided to become a volunteer. The most frequent response was they wanted to learn, to gain knowledge. They hoped to help others in their community. Another reason for becoming a volunteer was that they hoped to get a job sometime in the future.

Volunteers were asked how they felt about working as volunteers. The responses were very positive toward their experience. A predominant theme in all groups was that, through volunteers' efforts, patients were recovering from diarrhea, and deaths due to diarrhea were less. They mentioned that mothers said their children would have died without the saline provided by the volunteers. Many volunteers said that everyone comes to them for saline or for counseling on other health matters or family problems. They felt that they had little knowledge about health before their training but now they are able to educate others in their community. In about half of the focus groups, the volunteers described the respect they have gained in their community

> People salute us (*salam*) and call us doctor.

> They respect me and call me *Apa* (respected sister).

Another interesting theme mentioned in two of the focus groups was that before they became volunteers, they were virtually confined within their home. Once they become volunteers, they reported that they were able to go out of the house and become acquainted with many people in their community. It seems that service as a volunteer provides these women increased community respect and familiarity with their neighbors. Their work allows them to move more freely within the community and develop relationships with members of the urban slums.

When volunteers were asked why they were motivated to continue working as a volunteer, they most often mentioned the treatment of sick children and the respect and praise they receive in the community for their work.

> Intimacy has developed between me and my neighbors.
>
> Being acquainted with mothers, I feel happy to talk to them.
>
> Rich people who would never have visited my house now come for saline.

Some of the volunteers mentioned that when they accompanied a seriously ill patient to the Cholera Hospital, the personnel treated them with respect and provided quick treatment. The hospital personnel praised the volunteer in front of the mother who, in turn, told the neighbors in her area.

They were also asked what their family members and neighbors thought about them working as volunteers. In all of the focus groups, at least one of the respondents mentioned that their family and neighbors were suspicious in the beginning, but now they feel that the volunteer accomplishes good work for the community and her family. The son-in-law

of one volunteer calls her "Doctor mother-in-law." Some specific statements that demonstrate these points include:

> When I started working as a volunteer, my husband and mother-in-law drove me out of our home. Now my husband knows I am doing good and moved to live with me.

> People used to tease, "Here comes the family planning people. You can prevent a child birth but you cannot give a child." Now their attitude has changed and they accept saline and family planning advice from us.

> Our family used to be frequently sick. Now we eat nutritious food at a low cost and my husband often praises me.

The volunteers were asked to describe what they did as volunteers. The most frequently mentioned service was to teach saline preparation and distribute saline packets. Other important areas were educating and counseling mothers on immunization, nutrition, cleanliness, and family planning. Two-thirds of the focus groups of current volunteers said that they accompanied severe diarrhea cases to the hospital and mothers to immunization centers when necessary.

Volunteers were asked how much time they spent visiting households for their volunteer activities. The most frequent responses were that they visited households one day during the week and usually spent a total of two to three hours talking with mothers. Some volunteers mentioned that since they live in the neighborhood, mothers come to visit them when they have need. This passive delivery of volunteer services seems effective since the mothers know there is someone in the community they can go to for advice at night, if necessary, when other facilities are closed.

Volunteers were asked what benefits they and their families received from volunteer service. The most frequent response was education, particularly about cleanliness, for themselves and for family members. They felt that since they now maintain cleanliness in their households, there is less diarrhea among family members. The volunteers also said that with their knowledge of oral saline use, they can treat their children and family members without going to others. A few groups mentioned that their knowledge of family planning allowed them to keep the size of their own family small and also motivate their relatives to use family planning.

The volunteers felt the most difficult and frustrating part of their work was when mothers wouldn't listen when they gave their educational messages. Some mothers felt the volunteers were making money (profiting) and only giving them saline and no other medicines. Some of the people tease them about family planning, and call them "Maya Bori" (name of an oral contraceptive pill brand). A few of the volunteers mentioned that their husband or mother-in-law became angry or objected because they worked without receiving money (voluntarily).

Six of the eighteen focus groups of current volunteers were composed of volunteers who were also employed outside the home. When the employed volunteers were asked if work as a volunteer helped them get their job, most of the women replied that the experience did help in gaining employment. In half of the focus groups, respondents mentioned that becoming a volunteer gave them courage to go outside the home for employment.

> (Before becoming a volunteer) I could never go anywhere, I was blind although I had eyes. Now I can go anywhere, say, going to different hospitals.

I was not able to go out the door (outside), but when I became a volunteer I was able to search out a job for myself.

I could never go outside the home. After becoming a volunteer, going out to visit mothers gave me courage. When my husband has no job, I go for employment to maintain the family.

Volunteers were asked what would help them work better and more effectively. Most of them mentioned a monthly allowance or salary. Receiving some type of an identification badge, a sari, an umbrella, or a bag would be helpful in their work (these are not currently provided by the project). Many volunteers requested further training and education.

Released Volunteers

Released volunteers (4 groups) were asked if they would work for other organizations as a volunteer. A theme expressed in every focus group was, "it is better to learn something than to sit idle at home." They enjoyed serving others in the past and would like to resume that role.

Released volunteers were asked what volunteer activities (if any) they were currently engaged in despite being released from the program. Members from the four focus groups said they continued to teach the preparation of oral saline in their community. In three of the focus groups, released volunteers mentioned they still accompany diarrhea patients to the hospital if necessary. Members of two of the focus groups said mothers still come to their home for free saline packets and they refer them to pharmacies for the saline. The released volunteers also mentioned that they counsel women on family planning and sometimes accompany them to the family planning clinics. Some of the released volunteers said they continue to

educate about immunization and take children to the immunization centers. It is apparent that many of these women continue to practice the lessons they learned from their training and retain their position in the community to the benefit of their neighbors and themselves.

Community Mothers

The focus groups with community mothers (6 groups) living in volunteer target areas seemed to corroborate the findings from group discussions with the volunteers.

When mothers were asked about their relationship with volunteers, their responses were positive, overall. Some mothers viewed them as teachers. Others mentioned a close relationship with the volunteers. "Because of their frequent contact, they seem like relatives, like our near and dear ones, like our sisters." Conversely, one mother said she did not know where the volunteer lived.

When the mothers were asked what specific things the Cholera Hospital* volunteers do in their area, education was frequently mentioned. The mothers said, "the volunteers educate on diarrhea using flip charts. They discuss cleanliness and teach us how to make healthy foods."

In two of the focus groups, mothers mentioned that the volunteer takes them to family planning clinics (usually for injectables). In half the focus groups, mothers mentioned that volunteers accompany them to the hospital if there is severe illness.

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* ICDDR,B is known as the Cholera Hospital in the community.

Mothers were asked how often volunteers visited them and how much time they spent. Five of the groups said the volunteer visits them once each week. In half the groups, mothers said they had some contact as often as once each day. On the other hand, a few mothers said the volunteer visited just once every one or two months or that they never came.

The mothers were asked if they would go to visit a volunteer and for what reason. In all of the focus groups, the mothers mentioned going to the volunteer's home. They said that usually, when their child has diarrhea or another sickness, they will go to the volunteer for advice or for ORS. A few mothers said they went to see the volunteer when they needed counseling or other information on family planning.

The activities of the volunteers the mothers found most helpful included diarrhea education, saline distribution, and counseling on family planning. These services were mentioned in nearly all the focus groups. Immunization and hygiene education were mentioned in half the groups. Nutrition education was not often mentioned as a helpful volunteer activity.

The only difficulty mentioned by mothers in one focus group was timing of the volunteer visits. They felt that it was better for the volunteers to visit them in the afternoon (3:00 P.M.), a time that doesn't interfere with their household activities.

When mothers were asked what other activities they felt the volunteers could do for them, nearly all groups mentioned contraceptive distribution. They also suggested distribution of medicines for common illnesses, such as fevers and colds. A few said the volunteers could teach the mothers handicrafts and provide education.

Mothers were asked if they would be interested in becoming a volunteer and most expressed their interest. Reasons for becoming a volunteer included:

> We want to be educated like the volunteers and educate others in our community.
>
> It will help improve the health of my family.
>
> It will benefit the community.
>
> It may help me get a job in the future.
>
> I do not enjoy sitting idle at home. Doing something will make me cheerful.

In half the groups, women said they were not interested in working as a volunteer because their husbands do not like them going outside the home. Several mothers mentioned they had to spend their time taking care of their children and family problems. A few community women mentioned that it was not possible for them to work without money.

Conclusion

There are some lessons the project has learned from this study and working with volunteers in the Dhaka slums. Volunteers perceive their work as important to the community and their families. The volunteers and the work they do in the community seem to be well accepted by the community mothers. Most volunteers develop a relationship with community members that benefits all concerned. Not surprisingly, many volunteers hope they will eventually gain employment or salary, particularly with other NGOs or in clinics. In reality, the experience gained as a volunteer has helped some released as well as current volunteers find jobs with other NGOs or clinics in the slum areas. Also, the project tried to facilitate employment of volunteers after they were released from the program by providing certificates of their work experience with the volunteer program as well as directly referring some to NGOs for further training. However, while one motivation may be monetary, results from these focus groups indicate that increased prestige and respect in the slum community is a strong motivating factor for continuing to do volunteer work.

The time required from the volunteer should not interfere with her usual household duties or outside employment. Initial objections from relatives of the volunteers included the amount of time they spent away from household duties (without pay). The time allotted to volunteer work should not outweigh what the volunteer perceives as her benefits (respect, health knowledge, and supplies).

An evaluation of volunteers working in the urban slums of Dhaka found that these women were effective in increasing mothers' knowledge of diarrhea prevention and ORT use, immunization coverage, and contraceptive

use prevalence (3). There are other benefits of using volunteers that are difficult to quantify but affect the well-being of the slum communities. For example, the presence of a volunteer provides 24-hour access to basic health intervention (ORT) within the community. Volunteers provide improved access to health facilities through referral and accompanying their neighbors to clinics.

Studies from other countries have tried to evaluate the effectiveness of volunteers. In a slum area in Peru, 40% of trained, unpaid health promoters continued to provide health care, especially improving vaccination coverage and referral for care, 30 months after the training and supervision project ended (4). A review of six larger community-based health worker programs in various countries found that training, supervision, and adequate support are essential for successful programs (5). In Sri Lanka, a review of unpaid community health worker programs concluded that voluntary programs are more successful if there is consistent support and supervision and if there are built-in incentives, not necessarily monetary (6).

Finally, urban volunteers in Dhaka as well as in other countries and projects (6) require some recognition and support for their service. Besides monetary remuneration, the volunteers in the focus groups stated that ID badges or uniform saris would increase recognition in the community and improve their work. Also, presentation of certificates for recognition of service could help them compete for jobs with other NGOs if desired.

Results of this study imply that volunteers in the slums of Dhaka are accepted by community members and can provide the first link to health care. The volunteers are motivated women who feel that they provide an important service to their community. Other health programs interested in adopting a volunteer model should remember that an adequate system of support and supervision is necessary for sustainability of volunteer services.

Future research should address how volunteers could be more effectively linked to health services or outreach workers in their community to improve health care for slum residents. Another area for program research is assessment of suitable approaches to provide support to volunteers through additional training. This training could be developed by linking the volunteers interested in further training with developmental NGOs with program experience in skills training for income generation and adult literacy for women's groups. Finally, studies should evaluate the effectiveness of using the volunteers as depot holders for contraceptive pills and condoms within the community. This would be particularly useful if the volunteers are effectively linked with outreach workers in their communities.

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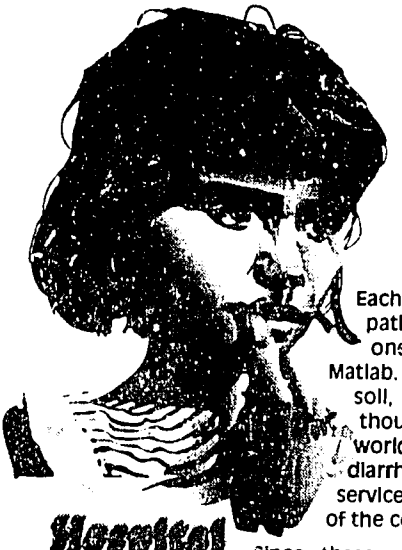

An Appeal

Hospital Endowment Fund

Each year, ICDDR,B treats over 70,000 patients attending its two hospitals, one in urban Dhaka, the other in rural Matlab. Though they are planted in Bangladeshi soil, they grow because of the dedication of thousands of concerned people throughout the world. The patients are mostly children with diarrhoea and associated illnesses and the services are offered free to the poorer section of the community

Since these services are entirely dependent on financial support from a number of donors, now we at the ICDDR,B are establishing an entirely new endeavour: an ENDOWMENT FUND. We feel that, given securely implanted roots, the future of the hospitals can confidently depend upon the harvest of fruit from perpetually bearing vines.

To generate enough income to cover most of the patient costs of the hospitals, the fund will need about five million dollars. That's a lot of money, but look at it this way:

JUST $150 IN THE FUND WILL COVER THE COST OF TREATMENT FOR ONE CHILD EVERY YEAR FOREVER!

We hope you will come forward with your contribution so that we can keep this effort growing forever or until the world is free of life-threatening diarrhoea. IT IS NOT AN IMPOSSIBLE GOAL.

Cheques may be made out to: ICDDR,B Hospital Endowment Fund.

For more information please call or write to:
Chairman, Hospital Endowment Fund Committee
GPO Box 128 • Dhaka, 1000, Bangladesh

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