Capacity-building of Health Managers for Local-level Planning: Lessons from Rural Bangladesh

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ICDDR,B Working Paper No. 139

Edited by: M. Shamsul Islam Khan

Design and Desktop Publishing: Jatindra Nath Sarker
Manash Kumar Barua

ISBN: 984-551-221-6

ICDDR,B Working Paper No. 139

Published by
ICDDR,B: Centre for Health and Population Research
GPO Box 128, Dhaka 1000, Bangladesh
Telephone: (880-2) 8811751-60 (10 lines); Fax: 880-2-8811568
E-mail: msik@icddrb.org; URL: http://www.icddrb.org

Printed by: Sheba Printing Press, Dhaka

Acknowledgements

The Operations Research Project (ORP), a project of the ICDDR,B: Centre for Health and Population Research, works in collaboration with the Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, and is supported by the United States Agency for International Development (USAID).

This publication was supported by the USAID under the Cooperative Agreement No. 388-A-00-97-00032-00 with the ICDDR,B. The Centre is supported by the following countries, donor agencies, and others which share its concern for the health and population problems of developing countries:

- Aid agencies of governments of: Australia, Bangladesh, Belgium, Canada, European Union, Japan, the Netherlands, Norway, Saudi Arabia, Sri Lanka, Sweden, Switzerland, the United Kingdom, and the United States of America;
- UN agencies: International Atomic Energy Agency, UNAIDS, UNICEF, and WHO;
- International organizations: CARE Bangladesh, International Center for Research on Women, International Development Research Centre, Swiss Red Cross, and World Bank;
- Foundations: Ford Foundation, George Mason Foundation, Novartis Foundation, Rockefeller Foundation, and Thrasher Research Foundation;
- Medical research organizations: Karolinska Institute, National Institutes of Health, New England Medical Center, National Vaccine Programme Office, Northfield Laboratories, Procter and Gamble, Rhone-Poulenc Rorer, and Walter Reed Army Institute for Research-USA;
- Universities: Johns Hopkins University, London School of Hygiene & Tropical Medicine, University of Alabama at Birmingham, University of California at Davis, University of Göteborg, University of Maryland, University of Newcastle, University of Pennsylvania, and University of Virginia;
- Others: Arab Gulf Fund, Futures Group, international oil companies (Cairn Energy PLC, Occidental, Shell, Unocal), John Snow International, Pathfinder, UCB Osmotics Ltd., and Wander AG.

Acronyms

AHI	Assistant Health Inspector
ARI	Acute Respiratory Infection
CAR	Contraceptive Acceptance Rate
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FPI	Family Planning Inspector
FWV	Family Welfare Visitor
FGD	Focus-group Discussion
FWA	Family Welfare Assistant
GoB	Government of Bangladesh
HPSP	Health and Population Sector Programme
HFWC	Health and Family Welfare Centre
HI	Health Inspector
HA	Health Assistant
IMP	Improving Management and Performance
IUD	Intra-uterine Devise
MOHFW	Ministry of Health and Family Welfare
MO-MCH	Medical Officer-Maternal and Child Health
MA	Medical Assistant
MIS	Management Information System
NGO	Non-government Organization
NIPHP	National Integrated Population and Health Programme
OSPR	Open System Performance Rating
ORP	Operations Research Project
OPV	Oral Polio Vaccine
RSDP	Rural Service Delivery Partnerships
RTI	Reproductive Tract Infection
STD	Sexually Transmitted Disease
SACMO	Sub-Assistant Community Medical Officer
TT	Tetanus Toxoid
UHFPO	Upazila Health and Family Planning Officer
UFPO	Upazila Family Planning Officer
TA	Technical Assistance
UNC	University of North Carolina

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Executive Summary

Background: There is a growing global trend in reforming in public services toward greater decentralization and increased managerial autonomy at the implementation level and for more involvement of consumer groups. As part of its Health and Population Sector Programme (HPSP), the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), is also planning for greater administrative decentralization by more actively involving elected representatives and other stakeholders in the delivery of Essential Services Package (ESP) at the local level. This calls for developing the competence of staff and fostering their attitudinal changes of the staff.

The Pathfinder International, a component of the National Integrated Population and Health Programme (NIPHP), in collaboration with the University of North Carolina at Chapel Hill, USA, conducted a 3-month training course for 64 upazila health managers of the GoB and local NGOs. The training accomplished two tasks: (i) the trainees learnt a set of fairly sophisticated, usable and relevant techniques of analysis for decision-making, and were also taught how to apply this know-how to their own situation; and (ii) use of a variety of activities, including exercise, simulation and role modeling, to bring about the changes in their mind-set that ESP services are important, their current state is less than satisfactory, they are largely responsible for the current state and they need to take a leadership role to improve these services. The training course was organized to improve the management and performance of ESP service-delivery in the low-performing upazilas aiming at developing local action plans and introducing monitoring procedures to increase the use of ESP services, improve the quality of these services, and establish teamwork among the government and NGO staff for organizing and supervising the field activities. An action plan for each upazila was prepared jointly by its upazila team (trainees) and its implementation was their shared responsibility. The plan included 29 indicators in the light of programme priorities and other demand of health and family-planning programme at local levels.

In 1998, the Pathfinder International requested the Operations Research Project (ORP), of the ICDDR,B: Centre for Health and Population Research, to assist in the documentation of the field activities of the managers, who were trained as part of this intervention, to improve the management-support systems for better performance.

Methodology: During February-June 1999 information from the government and NGO staff in 8 (5 study and 3 comparison) purposively selected upazilas was collected. Information was collected through: (i) in-depth interviews, (ii) observation of field activities and meetings at the upazila and union levels, and (iii) focus-group discussions. Data from the minutes of meetings, registers, and reports were also collected and analyzed. The data collection tools were developed in consultation with the Pathfinder International. The tools were pre-tested prior to collection of information.

Findings

Knowledge about Action Plans - Eighty-five percent of the union-level supervisors and all the FGD participants, i.e. field worker, were aware of the new action plans. In most study upazilas, the trained managers oriented the field staff on the action plans after returning from the training course. The field staff, however, had inadequate knowledge about targets included in the action plans. The field staff and the trained managers agreed that the effectiveness of the orientation sessions was hindered due to lack of funds to meet transportation and other expenditures.

Perceived Usefulness of Action Plans - The staff of the study upazilas reported that the action plans helped improve the performance in following areas:

- Led to merging of all satellite clinics with EPI spots
- Helped focus attention on targets and increased supervision from the upazila level
- Improved recording and reporting of health information
- The health staff referred more clients to the family-planning facilities and the family-planning staff referred more clients to the health staff/facilities
- The government field workers covered the adjacent vacant areas in addition to their own normal working areas before the introduction of the action plans. After training, the trained managers distributed the vacant areas among the NGO field staff, resulting in the reduced workload of the GoB field workers.
- Over 80 percent of the paramedics reported that the number of patients increased in the Health and Family Welfare Centers (HFWC) after the introduction of the action plans in the upazilas.

After training, there was an increase in the contraceptive acceptance rate in 3 of the 5 study upazilas, and the immunization coverage also increased in most upazilas.

Teamwork - Although the trained managers made some joint visits to supervise special activities, such as observation of the National Immunization Day and organization of sterilization camps, the practice of preparing an individual advanced tour programme continued in all upazilas. The managers and the union-level supervisors reported that individual supervisory findings were used for providing feedback to the field staff on their performance and for initiating administrative actions.

All the trained managers reported that initially they prepared the monthly reports jointly, but could not continue the process because the team members failed to get together to prepare the reports due to their preoccupations.

Staff meetings at all levels were not regularly held, except the monthly upazila salary- day meetings. All the meetings observed at both upazila and union levels, reviewed the action plans. The staff reported that joint performance reviews were not held regularly in the upazilas due to lack of coordination among the trained managers. The practice of setting agenda for meetings, reviewing the minutes of the previous meetings, reviewing performance (use of data), and holding joint meetings was higher after the training.

Open System Performance Rating - Although the Open System Performance Rating (OSPR) had not been implemented at the time of the first visit to the upazilas, the trained managers and the union-level supervisors were positive about it. Most of them reported that the system encouraged the field staff to work as they could compare their performance with that of other unions. Most field staff had no correct knowledge about the ranking systems and how frequently the board should be updated.

Quality of Care - The paramedics interviewed reported that recording and reporting of information, targets, and joint planning for the satellite clinics and EPI activities, introduced by the managers after their training, were useful to their own work. Most paramedics perceived that their workloads had increased after the introduction of action plans in their upazilas. All the paramedics reported that the number of clinical method users and the number of clients for side-effects managed at the clinics had increased after the introduction of action plans. Nevertheless, activities relating to care for side-effects and follow-up management were inconsistently recorded, and there were no adequate records for referrals.

Most paramedics reported that they destroyed their clinic wastes at an interval of 3 months by burning through a drum incinerator given to them from GoB central level.

About 20 percent of the clinics visited did not have a working tube-well, and half of the clinics visited had unsatisfactory toilet facilities in the compound.

Suggestions for Addressing the Problems Encountered during Implementation

- Although the trained managers worked as teams during their training in Dhaka, there was a lack of coordination after their return to their working areas among them as observed and reported by the trained managers themselves. Lack of coordination was due to separate administration structures in the Directorates of Health and Family Planning.
- A formal government order or instruction was needed specifying the post-course responsibilities of the upazila managers for implementing the action plans at the upazila level and below. Officers from each directorate at the central and district levels, should be assigned responsibilities of taking part in the training and in supervising, monitoring, and reviewing the implementation of the action plans.
- To ensure the action plan implementation process, a clear line of command is needed at the upazila level.
- The components of the action plans should be consistent with timing as well as with components and indicators for the HPSP, including the role of the community in the process and strengthening ESP service-delivery.
- The training course should incorporate written guidelines or a manual outlining the procedures for field implementation, including ideas for field orientation/training for union staff.
- The Rural Service Delivery Partnership (RSDP) Technical Assistant units could be more involved in providing technical assistance to supported NGOs focusing on the action plan-implementation process.

- The transfer of trained upazila managers affected the implementation of the action plans. Further assurance needs to be obtained from the GoB and NGOs alike, so that the trained managers are not transferred during the implementation period.

Conclusions: Training itself is not sufficient for implementing the action plans at operational levels. The trainees reported a perceived ambiguity on their role and responsibilities, as the government had never formally approved the action plans. Greater involvement of the concerned Civil Surgeon and Deputy Director, Family Planning should be ensured at the stages of planning and developing the training programme and in the field implementation phase.

After the first visits of the research team, most trained managers only completed some important activities included in the course. The activities included: introduction of open system performance rating, routine review of implementation status of the action plans, orientation of field staff, plan for joint supervisory visit, and preparation and submission of ESP reports. It appeared that the visits acted as a course follow-up from the central level highlighting the importance of post-training facilitation and monitoring activities from higher levels to ensure the availability of sufficient administrative and technical support at the field level during the implementation of the action plans.

Background

In recent years, in many countries health care organizations in the public sector have been the focus of reforms. The trend in reform in public services around the world is to decentralize management, involving more managerial and financial leeway for people entities, and to create more semi-autonomous units. The United Kingdom, New Zealand, and Australia have often been cited as countries where decentralized management has been carried farthest. This trend of decentralization is aimed at "debureaucratizing" public services, and is part of "new public management" reforms.

Some developing countries have also adopted such reforms. In some cases, e.g. Ghana, such changes are taking place in the context of structural adjustment programmes driven by donors and related policy transfers. Management reforms in developed countries may also have a "demonstration effect" in developing countries. The executive agency type of reform has become an "export article" and suggests convergence in public management reforms [1].

It has been proposed in the Health and Population Sector Programme (HPSP) of Bangladesh to decentralize the health and family-planning activities at the upazila level. The Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), has already taken some positive steps to decentralize administration and to involve NGOs and other stakeholders. The HPSP has introduced annual operational plans for allocating resources and for monitoring their use. Initially, the plans relate to the major components of the HPSP. Subsequently, each district and upazila will produce their own plans. It is important to develop the necessary competence and foster the needed attitudinal changes among the government functionaries for preparing the annual plans and for adopting and using the existing tools and techniques for participatory appraisals and implementation monitoring of the delivery of Essential Package Services (ESP). The staff will also be required to strengthen teamwork and collaboration with other stakeholders at the upazila and district levels [2].

The rural service-delivery programme has been implemented by the Pathfinder International in partnerships with BRAC and BCCP. These three organizations together constitute the Rural Service Delivery Partnership (RSDP), which is a part of the National Integrated Population and Health Programme (NIPHP). The RSDP is aimed at increasing the accessibility and use of high-quality, high-impact family health services by rural families in Bangladesh. The partnership will focus on the low-performing, under-served rural areas, low-performing pockets in high-performing areas, and strengthening the GoB, NGO, and private sector capabilities for family health services. The partnership will make ESP services available in approximately 200 upazilas in the low-performing areas through the existing GoB, NGO, and private-for-profit sector. To maximize the quality of services, both GoB and NGO service providers of the upazilas will be trained in the management of ESP services management, including client management, operation and management of a responsive referral system, and management of logistics. Quality of services will be improved, and use of services will be enhanced in the public sector (especially HFWCs), NGOs, and private-for-profit sector with inputs from the partnership. The partnership will train providers to improve their competence in ESP service-delivery [3].

To complement the competence-building process, a training programme was designed and conducted in 16 selected upazilas of rural Bangladesh by the RSDP as part of its generalized support to the GoB in ESP service-delivery.

Training Design

The Pathfinder international collaborated with the University of North Carolina (UNC) at Chapel Hill, USA to conduct a 3-month training course for the upazila managers of health and family-planning programmes of the government and the managers of local NGOs supported by the RSDP in 16 upazilas. The training also involved a 12-month follow-up managed largely by the Pathfinder International.

The training course was organized during January–March and during April–June 1998 to improve the management and performance of ESP service-delivery at the upazila level. ESP performance was broadly defined as increased use of the ESP services, improvement in their quality, and inculcation of team behaviour among health, family planning, GoB and NGO personnel.

The training programme was attended by the Upazila Health and Family Planning Officers (UHFPO), Upazila Family Planning Officer (UFPO), the Medical Officers for Maternal and Child Health (MO-MCH) of the GoB programme, and the managers of the local NGO of each of the 16 upazilas.

Training design was based on a series of interconnected theories which are as follows:

1. Since humans are the only active agents in any system, any effort to improve productivity needs to be focused on them.
2. Humans are not machines, and they do not produce anything on command. They produce because they are motivated from within.
3. Motivation is not totally a rational process; it contains a fair amount of emotionalism. Further, the rational and emotional personalities of individuals are interactive.
4. To improve productivity, it is necessary to influence both rational and emotional personalities of individuals.
5. While rational personality is driven largely by calculation of risks and rewards, emotional personality is governed by personal values and perceptions of staff.
6. Since rational and emotional selves are interactive, any effort to achieve improvement in productivity should address both of these simultaneously [4].

Based on this thought-process, the following two-pronged approach was adopted in designing of the training programme:

1. The training should be a vehicle for improving self-perception of trainees on one hand and their perception of "what is important" on the other. To achieve this, the training accomplished two tasks: (a) taught them a set of fairly sophisticated, usable and relevant techniques of analysis for decision-making, and make them aware of this important improvement in know-how by making them apply this know-how to their own situation; and (b) use of variety of activities including exercise, simulation, seminars, and role modeling to bring about the following changes in their mind-set: ESP services are important, their current state is less than satisfactory, they are largely responsible for the current state, and they need to take a leadership role to improve these services.
2. The existing system accords little authority/power to the upazila officials to either discipline or to reward their subordinates, and is, therefore, considered ineffective to a large extent. This system needs to be replaced without going through a long, cumbersome, politically-sensitive and uncertain route of change in the national policy. The key hypothesis is that the training itself could become the instrument for this change.

To ensure that the changes achieved in the knowledge and mindset of trainees are translated into well-defined actions to achieve desired improvements, each upazila team (UHFPO, UFPO, MO-MCH, and NGO upazila Manager) was required to prepare a one-year action plan. It was decided to achieve the desired change in the risk/reward system by instituting the open system performance rating (OSPR) in these upazilas through the action plans. The OSPR is a system of rating/accountability, which had to be performed quarterly reviewing performance and supervisory findings jointly by trained managers for each union. The system also includes preparation and hanging boards in every HFWC at the union level, showing the rank of individual union and updating the boards quarterly. The system had to have features, such as simple to understand (very good, good, satisfactory, not satisfactory), be limited to those factors which are in the joint of influences, not be used to punish but to help, be accepted by those being rated, and be done for public attention [4].

Action Plan

The action plan of each upazila was prepared jointly by the upazila team. Implementation of the plan was a shared responsibility of the upazila team. The plan included the following components:

1. A list of 29 ESP/quality/team-work indicators (Box A) developed by the trainees in the light of NIPHP priorities and other demands on them [5].
2. A statement assigning weight to each indicator in the light of NIPHP priorities, data availability, and workload associated with the delivery of services and/or carrying out the activity.
3. Upazila baseline for each indicator on 31 March for first batch and 30 June 1998 for second.

4. Minimum goal for each indicator which all 16 training upazilas should be able to achieve.
5. Each upazila's own goals, which were equal to or higher than the minimum goals.
6. Strategy for achieving these goals, mainly OSPR.
7. Main activities to be achieved during 1 April 1998-31 March 1999 and 1 July 1998- 30 June 1999 respectively for the two groups of upazilas.
8. Persons responsible for each of these activities.
9. Item 1, 2 and 4 above were the products of class-wide exercise, and, were therefore, common to all upazilas.

Follow-up

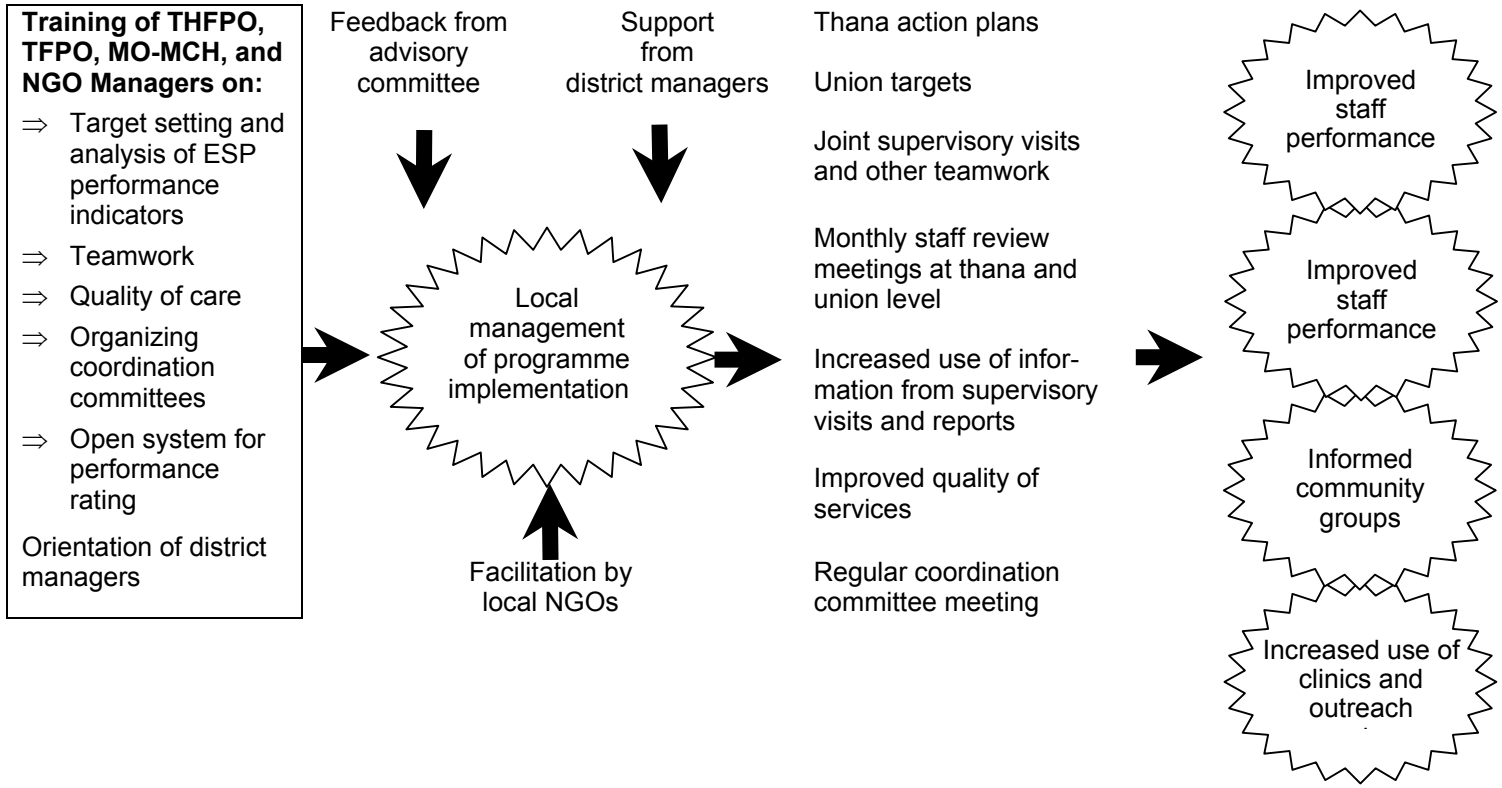
A 12-month follow-up of implementation of the action plans was an integral part of the training. This phase was managed by the RSDP under the guidance of University of North Carolina (UNC), and with support from a follow-up committee appointed by the Secretary, MOHFW. Each upazila team was expected to submit monthly/quarterly reports with the joint signatures of the team members of the RSDP on prescribed forms. In these reports, they were supposed to note the progress made by them and impediments, if any encountered. These reports were to be reviewed by the follow-up committee, and necessary actions would be taken by the committee and feedback given to the concerned upazila teams [4].

Box A. List of ESP/Quality/Teamwork indicators

Area	Sl. no.	Indicators
Reproductive health services	1	Contraceptive acceptance rate (CAR)
	2	Contraceptive method-mix (clinical methods)
	3	Reproductive tract infection (RTI) cases treated by drugs
	4	Sexually transmitted diseases (STD) treated by drugs
	5	Antenatal care, including folic acid supplementation (1^{st} and 2^{nd} visits only)
	6	TT-2 and TT2+ shots for pregnant women
	7	Delivery by trained personnel
	8	Postnatal care
Child health services	9	Children immunized at one year of age for BCG, DPT3 and measles
	10	Vitamin A administration to children aged up to 6 years
	11	Acute respiratory infection (ARI) to children aged less than 5 years treated
	12	Diarrhoea cases treated
Other health services	13	Tuberculosis (TB) cases treated
	14	Leprosy case detected and treated
	15	Malaria control
	16	Health education, number of sessions per union per month
Quality services	17	Supervision
	18	Cleanliness and waste disposal
	19	Management of side-effects
	20	Management of complication
	21	Record-keeping
	22	Follow-up of customers of clinical methods
Teamwork	23	Joint goal development
	24	Joint strategy development
	25	Joint planning
	26	Joint implementation
	27	Joint monitoring
	28	Joint reporting
	29	Joint accountability

Framework for Analysis of Field Activities for Improving Management and Performance Training

Initial training inputs	Monitoring inputs	Expected activities	Expected outcome



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Objectives

The overall objective of this study was to document processes involved in the implementation of action plans as an integral part of the management training and to assess the effects of the implementation of the action plans on the improvement of management and performance in the selected rural upazilas of Bangladesh.

The specific objectives were to:

- Understand how the action plans were implemented in the selected upazilas
- Assess the effects of implementation of the action plans in the selected upazilas
- Identify the barriers that affected the implementation of the action plans
- Formulate appropriate recommendations for making the action plans more effective.

Methodology

Eight upazilas were purposively selected for the study (Table 1 and Fig.1). Five of the 8 upazilas were selected from the study areas. For comparison purposes, the service statistics from 3 upazilas were also analyzed. The selection was made jointly by the RSDP and the ORP. The upazilas were:

Table 1. List of study and comparison upazilas

Areas	**Division**	**Upazila**
Study areas	Sylhet	Kamalganj
		Zakiganj
	Dhaka	Kuliarchar
	Rajshahi	Gobindaganj
		Debiganj
Comparison areas	Chittagong	Banshkhali
		Sitakunda
	Khulna	Keshabpur

The following methods were used for collecting information for documentation of the processes involved in the implementation of action plans:

1. In-depth interviews of the trained managers and union-level supervisors[1]
2. Observations of the field activities and meetings at the upazila and union levels
3. Focus-group discussions with the field workers (HAs and FWAs)
4. Analyses of secondary data from the minutes of meetings, registers, and reports.

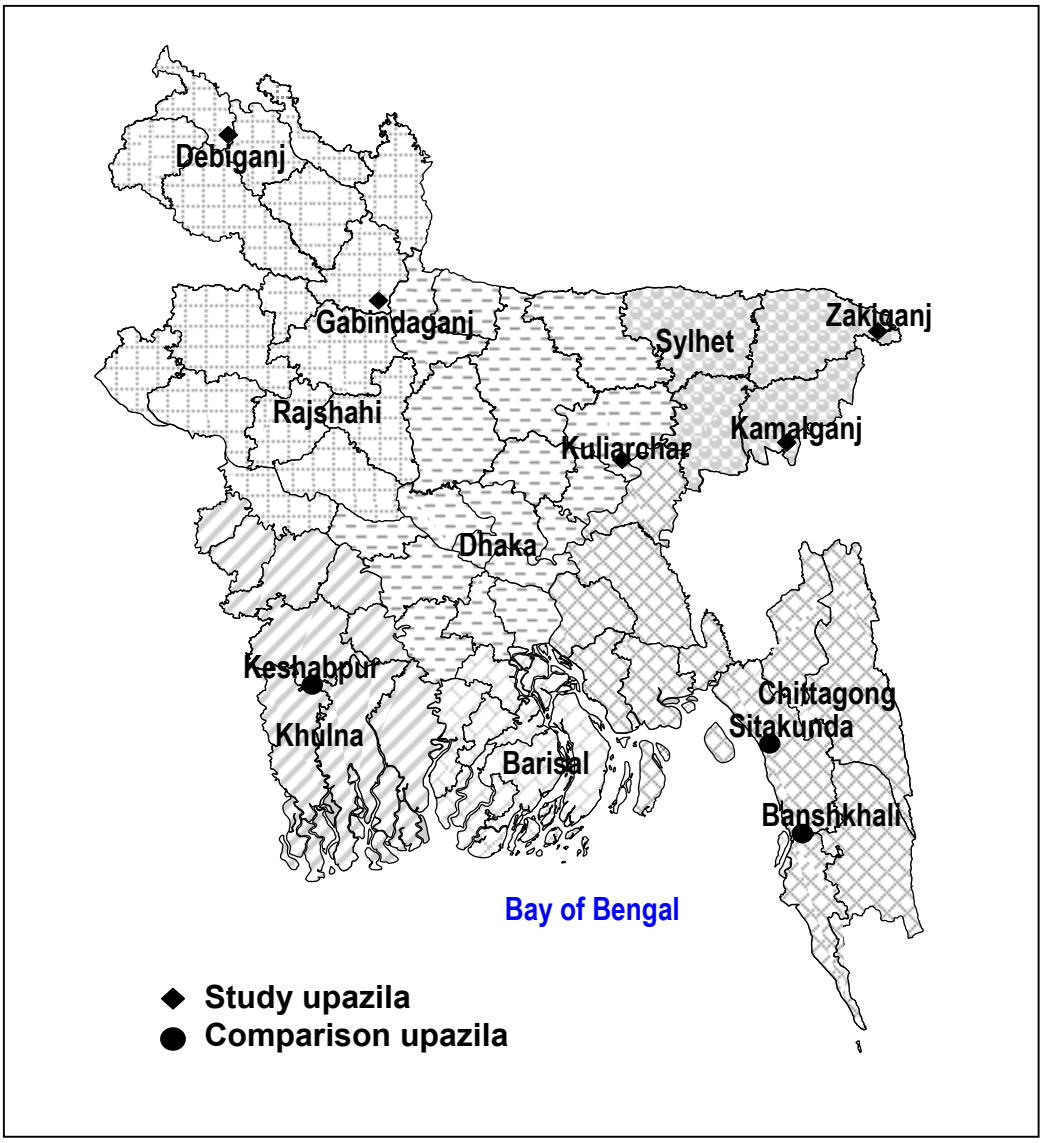
Observation checklists, open-ended questionnaire, and FGD guidelines were developed and used for collecting information to document the action plan-implementation process. All the data-collection tools were developed in consultation with the RSDP. The tools were pre-tested prior to collection of information. A research team of the ORP observed the field activities and meetings, conducted interviews, and collected information. They were oriented both in class and field before starting data collection. Each upazila was visited once a month during February-June 1999. The members of the research team stayed at least one week in each upazila in every visit, met the trained managers and union-level supervisors, and observed the field activities, clinic (HFWC) activities, and meetings. Both upazila and union-level meetings were observed for documenting action plan-implementation process in the study areas.

FGD sessions were organized with the field workers (Health Assistants and Family Welfare Assistants) for collection of information in the study areas. In total 10 FGD sessions (2 in each upazila) were conducted in the 5 upazilas. To maintain homogeneity with the participants, 5 FGD sessions were organized with the Health Assistants (HAs) and 5 with the Family Welfare Assistants (FWAs). The participants for the FGD sessions were selected in consultation with the trained managers of the upazilas, and the number of participants per sessions was 8-10. The FGD sessions were conducted in each upazila after the first visit of the ICDDR,B research staff. The topics of FGD sessions were selected focusing on the problems identified in their first visit relating to the implementation of action plans. One team, consisting of 2 members (one moderator and one note taker), conduct the FGD sessions in all the selected upazilas. All sessions were taped with prior consent of the participants.

The study assessed the effects of training and introduction of the action plans on the volume of service outputs by reviewing the reports of family-planning and immunization services in the selected upazilas. The records reviewed referred to the "base month" (previous month of implementation of action plan), "mid-month" (6 months after implementation), and "end-month" (last month of the follow-up period).

[1] The union-level supervisors included Assistant Health Inspectors (AHI), Family Planning Inspectors (FPI), Family Welfare Visitors (FWV), Medical Assistants (MA), and Sub-Assistant Community Medical Officers (SACMO).

Fig 1. Map of Bangladesh showing the locations of study and comparison upazilas



Findings

Action Plan

The study-findings revealed that 85 percent of the union-level supervisors and all the FGD participants were aware of the action plan of their respective upazila. The trained managers oriented the field staff on the action plans after the completion of their 3 months training, except for the health staff of Debiganj upazila. The orientation sessions were held during regular staff meetings at the upazila. One upazila (Kuliarchar) organized separate orientation sessions for the field staff in every HFWC, in addition to the orientation at the upazila-level staff meeting. The field staff reported that the orientation sessions were not sufficient for them, because the duration of the sessions was 30 minutes to one hour. Besides, they could not understand the contents of the orientation sessions as so many people from health, family planning and NGO sat in a hall rooms. The trained managers agreed that the orientation sessions were not sufficient to teach the necessary contents to the field staff that they learnt from the training. According to the trained managers, they could not organize the orientation sessions as per requirement due to some constraints, especially due to lack of funds to meet the expenditures required, including providing allowances to the participants. Since the UHPO of Debiganj did not participate in the training organized by the UNC, he was not involved with the implementation process of the action plan initially and did not allow the field staff of his department to attend the orientation session organized by the trained managers of the upazila. But after the second visit of the research team, he organized an orientation session for his staff members (on 16 May 1999). In answering the question, "why so late?" he replied, "ICDDR,B staff members are frequently visiting the upazila which insists me to organize the orientation session and to implement the action plan prepared by the trained managers of the upazila".

One upazila (Kamalganj) took the initiative to brief upazila officials after IMP training. The trained managers of the upazila organized meetings with other officials of the health and family planning departments, and disseminated the contents of the training course. They also shared the training course contents with the officials of other departments at the Upazila Unnayan Committee meeting. This helped organize the meetings of the union coordination committee.

The trained managers were supposed to form union teams consisting of the AHI, FPI, FWV, and SACMO/MA in each union to coordinate the implementation of the action plans at the union level. Nevertheless, no evidence of this activity was found in any upazila. Most trained managers mentioned the following reasons for not forming the union teams:

- The trained managers reported that it was not practically possible to form teams at the union level, because the union-level supervisors have the responsibilities to carry out the instructions given from the supervisors of his/her own department, and they provide importance to it. According to them, functional teamwork is not feasible within this environment of dual administration. They also added that the formation of a team at the union level with the supervisors of health and family-planning departments is not feasible until functional integrated ESP services are introduced at the upazila level and below.

- There is a coordination gap between the health and family-planning wings, which also affected the formation of union teams. The trained managers stated that they did not cooperate with each other in the formation of union teams.
- Since there was no official order/instruction from the district or national level to form union teams the trained managers did not take any initiatives to form the teams.

Apparently, in all the 5 upazilas, targets were set for the field staff without their involvement. The findings showed that 62 percent of the union-level supervisors and all the FGD participants were not aware how targets were set and how to achieve the targets. The targets set for the field staff were announced in orientation sessions held at the upazila. Two upazilas (Kamalganj and Kuliarchar) issued special circulars containing targets for unions which were kept with the union-level supervisors. Despite the orientation and circulars, the field staff had inadequate knowledge about their targets. After repeated prompting most staff recalled the NIPHP/ESP targets which they did not seem to consider as part of the normal programme. The field staff (HAs and FWAs) of all the 5 upazilas mentioned that they had targets on too many indicators, which were very difficult to keep in mind and to implement. These indicators were: reproductive tract infection, sexually transmitted diseases, folic acid supplementation, joint reporting etc. They also added that they could not make available sufficient time to important indicators, such as recruiting new clients for family-planning method use, especially for clinical contraceptives, antenatal care, child immunization, ARI, and diarrhoea, since they had targets for too many indicators. According to the field staff of Kamalganj, Zakiganj, and Kuliarchar, the targets were set for them without considering the local situation. They reported that the targets were nothing, but indicator-wise equal distribution of upazila performance. They also reported that these targets (equal distribution) were easy to achieve for some workers, but were harder to achieve by others as their working area and population size were different. The field workers of Gobindaganj and Debiganj upazilas informed that they had no targets because their performance on all indicators was higher than the targets set by the upazila teams during their training.

In response to the question of how the action plans were used at their level, half of the trained managers and union-level supervisors of the upazilas mentioned that the action plans were used for preparing and submitting the ESP reports. About 18 percent of the respondents reported that the action plans were used for working toward achieving the targets and for reviewing the programme performance of the upazila and union-level meetings (Table 2).

Table 2. Use of action plans at upazila and union levels

Use of action plans	Percentage distribution of respondents (n=179)
Action plan was used for preparing ESP reports only	51
Action plan was used for working on achieving set targets	10
Action plan used for reviewing programme performance of the upazila and union-level meetings	8
Did not know how the action plan was used	31

The field staff were asked whether the action plans helped improve the programme performance. Most field staff mentioned that the action plans helped improve the programme performance in the following ways:

- Since the upazila managers were more concerned about the targets set during their training than MIS targets, they tried to motivate the field staff to be committed to achieve the targets. The findings showed that the family-planing clinical method users and the immunization coverage increased in the upazilas during the implementation of action plans compared to before-IMP training.
- The field staff indicated that supervision from the upazila level increased after the introduction of action plans which made the workers to be regular in field.
- The upazila managers became more careful on recording and reporting after their training. They instructed the field staff to maintain recording and reporting carefully which decreased under-reporting and over reporting in the upazilas.
- Some attitudinal changes occurred among the field staff after the introduction of action plans in the upazilas. The health staff referred the family-planning clients to family-planning staff /HFWCs, and the family-planning staff referred the patients suffering from ARI, diarrhoea, pregnant mothers for TT vaccine, and children aged less than 2 years for immunization to health staff after the training. This helped increase the programme performance especially with the family-planning clinical method users and immunization coverage (Table 3 and 4).
- Before the training the government field workers had to cover the vacant areas in some upazilas in addition to their own assigned working areas. The upazila managers distributed the vacant areas among the NGO field staff which decreased the work load of the government field workers after the introduction of the action plans in the upazilas.
- The Satellite Clinics were merged with the EPI spots after the introduction of action plans which helped the field staff spend more time in motivation work.

Table 3 shows that the contraceptive acceptance rate (CAR)[2] increased in all the 5 study upazilas at the end-month. In most upazilas, the percentage of users of clinical contraceptive methods, such as IUD, injectable, and sterilization also increased after the training. There was a slight increase in the number of IUD users of at the end-month compared to the base-month in Kamalganj, Zakiganj, and Gobindaganj upazilas. The percentage of injectable users increased in all the 5 areas during the study period. The table also shows that, although the CAR increased in 2 of the 3 comparison upazilas, the percentage of users of clinical contraceptive methods decreased at the end-month.

Table 3. Reported family-planning performance before and after training and implementation of the action plans in the study and comparison areas

Upazila	Contraceptive acceptance rate			Clinical method users (%)								
				IUD			Injectables			Sterilization		
	Base-month	Mid-month	End-month	Base-month	Mid-month	End-month	Base-month	Mid-month	End-month	Base-month	Mid-month	End-month
Kamalganj	62	63	66	9	10	11	13	13	14	6	7	7
Zakiganj	56	56	59	7	7	8	24	24	25	6	7	7
Kuliarchar	60	61	63	9	8	9	22	23	23	13	13	13
Gobindaganj	59	65	66	4	4	4	7	8	9	16	15	18
Debiganj	68	70	71	3	3	3	8	9	11	22	21	22
Banshkhali	55	56	54	8	7	5	13	11	12	10	9	9
Keshobpur	68	69	69	5	4	4	16	15	14	16	15	15
Sitakunda	61	60	62	6	5	5	18	17	17	15	14	13

Source: *Service statistics. Directorate of Family Planning, Ministry of Health and Family Welfare*

The child-immunization coverage increased in most study upazilas after the IMP training compared to before training. Table 4 shows the status of immunization coverage in the study and comparison areas during base-month, mid-month, and end-month.

[2] Contraceptive acceptance rate is the percentage of eligible couples of an area that accept family-planning contraceptives from providers.

Table 4. Reported child-immunization coverage before and after training and implementation of the action plans in the study and comparison areas

Upazila	BCG			DPT3			Measles		
	Base-month	Mid-month	End-month	Base-month	Mid-month	End-month	Base-month	Mid-month	End-month
Kamalganj	122	114	113	105	96	116	92	117	99
Zakiganj	89	116	94	127	106	145	77	94	110
Kuliarchar	118	101	138	112	115	123	79	90	92
Gobindaganj	112	84	125	96	87	96	96	98	100
Debiganj	102	99	119	110	99	111	99	88	93
Banshkhali	129	108	90	132	121	103	105	100	79
Keshobpur	111	68	63	111	75	69	78	92	53
Sitakunda	108	107	107	125	119	80	101	105	78

Source: *Service statistics. Directorate General of Health Services, Ministry of Health and Family Welfare*

Table 4 shows the increase in reported coverage of BCG immunization in Zakiganj, Kuliarchar, Gobindaganj, and Debiganj upazilas at the end-month. A major increase was observed in DPT3 coverage in Kamalganj, Zakiganj, and Kuliarchar upazilas after the training. The measles coverage increased in all the study upazilas, except Gobindaganj and Debigonj, at the end-month of implementation of the action plans. The table also shows that the child-immunization coverage as a whole decreased in the 3 comparison upazilas at the end-month. The immunization coverage was more than 100 percent in some cases as the actual target population was more in the upazilas than the targets set from the national level. The factors that affected the increase in the performance after the training in the study upazilas were: (a) the upazila managers insisted the field staff to become committed and to achieve their set targets after the training, (b) the upazila managers increased their supervision, and (c) logistics supply became regular.

In response to a question about the factors that affected the implementation of action plans at the upazila and union levels, the trained managers and the field staff identified the following areas:

1. Absence of coordination among the trained managers
2. Absence of instruction/order from the district or national level to implement the action plans at the upazila levels and below
3. Absence of follow-up/monitoring from higher levels
4. Absence of facilitation from NGOs or any other agencies
5. Unavailability of integrated ESP services in the field
6. Inadequate orientation for the field staff
7. Change/transfer of the trained staff, and
8. Non-participation of 2 UHFPOs of 2 upazilas in the training programme.

Joint Supervisory Activities

The findings showed that the practice of preparing an individual advanced tour programme continued in all the study upazilas. Although the trained managers paid some joint supervisory visits during the data-collection period, they had no joint supervisory plan in any upazilas. The joint supervisory visits were made focusing on some special activities, such as observation of the National Immunization Day and organization of sterilization camps.

The following issues were mentioned by the trained managers as constraints for organizing joint supervisory activities:

1. Joint supervisory field visits were not always feasible due to diversity of activities of the managers
2. Absence of specific official instructions from the district or national level
3. Lack of coordination among the trained managers, and
4. Absence of follow-up/monitoring from higher levels.

In answering the question about the use of supervisory findings, 40 percent of the respondents (upazila managers and union-level supervisors) reported that the individual supervisory findings were used for providing feedback to the field staff on the spot, while 29 percent reported that the findings were shared in meetings. About 17 percent mentioned that the supervisory findings were used for initiating administrative actions.

To improve the joint supervisory activities of the upazila and union level, the trained managers and the field staff emphasized on the need to develop effective mechanisms to strengthen coordination among the upazila team members. They suggested that official instructions/orders and regular follow-up and monitoring from the government upper levels might help ensure such coordination.

Joint Reporting

According to the training design, the upazila teams were supposed to prepare monthly ESP reports jointly in prescribed forms developed by the UNC. They were also supposed to send the reports to the RSDP and to the concerned district officials with joint signatures. One upazila (Kamalganj) took initiatives to prepare reports jointly during the first 2 or 3 months. The UHFPO of the upazila reported that he convened a meeting, named as "NIPHP" meeting, once a month and prepared the reports jointly with all the trained managers. But subsequently they could not continue that process, as all the team members did not attend the meeting. They reported that they became busy with other priority works. Either the HI or Assistant Health Inspector AHI or another person, assigned by the UHFPO, prepared the reports in the upazilas and later upazila managers signed and sent the reports to concerned offices. The field workers and the union-level supervisors of Zakiganj, Kuliarchar, and Gobindaganj reported that the ESP reporting system was to some extent, a duplication of work. The trained managers of the upazilas introduced a reporting format containing all the ESP indicators for the field workers and the supervisors. The field workers prepared the reports every month, in addition to their normal reports. The FPIs and AHIs of the upazilas collected the reports from the field workers, compiled the reports and sent to the upazila headquarters for necessary action.

All the trained managers commented that, in reality, it was very difficult for them to prepare the reports jointly. The managers mentioned the following reasons behind this:

- The upazila officials are busy, and they have to perform so many other official tasks. So, they could not manage enough time to prepare reports jointly. The managers reported that they initially prepared the reports jointly, but could not continue the process as the team members failed to get together to prepare the reports due to their other preoccupations.
- They also reported that lack of coordination among them was another factor, which did not allow them to prepare reports jointly. The trained managers blamed each other for not cooperating in this regard.

The trained managers suggested that an on going reporting system should be used instead of developing separate and parallel systems, and some trained managers suggested that responsibility be given to one skilled person to prepare the reports and the trained managers will review the reports prior to their signature and sending to the concerned offices.

Meetings

One of the main components of the action plan was to make sure that the mandated meetings were held at the upazila and union levels. Systematic holding of meetings at the upazila and union HFWC levels can ensure the monitoring of data. It seemed to the research staff, who visited the upazilas, that although there were meeting schedules the meetings at both levels were not held regularly except monthly (salary day) meetings at the upazila level. The research staff failed to attend some meetings as the meetings were not held as per schedule. However, they (research staff) could observe 10 (5 union and 5 upazila level) meetings at the 5 upazilas. The meetings observed included

monthly (salary day) meetings, special (NIPHP/ESP) meetings at the upazila level, HFWC (fortnightly) meetings, and last working-day (report preparation day) meetings at the union level. A distinct formal procedure was visible in the meetings in terms of topics covered (Table 5).

Table 5. Activities observed at meetings in intervention upazilas

Activities/topics covered	Percentage of meetings	
	Union	Upazila
Agenda prepared	20	30
Minutes of the last meeting read	-	20
Reviewed action plan	40	60
Reviewed performance	30	40
Field problems discussed	50	30
Initiated decisions	-	20
Decisions implemented	-	10
Held jointly	10	10

Source: *Observation data*

The meetings both at upazila and union levels reviewed the action plans. The meetings held at the union level discussed the field problems more than the meetings at the upazila level. Culture of initiation and implementation of decisions were concentrated at the upazila-level meetings. The issues discussed in the upazila and union-level meetings focused on the improvement of programme performance, timely preparation and submission of reports, and coverage of workers/paramedics' vacant areas.

The study reviewed and analyzed the minutes of meetings of the 5 upazilas for 12 months during July–December 1997 (before IMP training) and July–December 1998 (after IMP training). The minutes from union and upazila level meetings included monthly (salary day), special (NIPHP/ESP), upazila family-planning coordination committee meetings at the upazila level and fortnightly (HFWC), last working day (report preparation day) and union family-planning coordination committee meetings at union levels. Little improvement was observed in the meetings held during the action plan-implementation period (after IMP training) compared to before-training in terms of topics covered and organization of the meetings jointly (Table 6).

Table 6. Topics covered and meetings held jointly before and after training

Activities/topics covered	Before training/ July-December 1997 (%)		After training/ July-December 1998 (%)	
	Union (n=15)	Upazila (n=22)	Union (n=28)	Upazila (n=32)
Agenda prepared	2	3	5	8
Minutes of last meeting reviewed	2	3	5	12
Reviewed the action plan	NA	NA	1	3
Reviewed performance	2	3	8	4
Field problems discussed	1	2	1	2
Initiated decisions	2	3	6	10
Decisions implemented	0	0	1	1
Held jointly	0	0	4	5

NA = Not applicable **Source:** Meeting minutes

The status of decisions implemented in the meetings before the IMP training could not be ascertained due to absence of recording of the minutes.

The table shows that the status of holding the meetings (source: meeting minutes) with agenda, reviewing the minutes of last meeting, data use (review of performance), initiation and implementation of decisions and organizing meetings jointly were better during the period of implementation of action plans compared to before IMP training. The issues discussed, field problems identified, and decisions initiated in upazila and union level meetings concentrated on the improvement of programme performance, timely preparation and submission of accurate reports, performance of NGO activities, and community involvement.

Some differences were observed in Kamalganj compared to other upazilas in terms of organizing joint meetings and activating coordination committees. Kamalganj upazila organized fortnightly union HFWC meetings jointly with the health, family-planning and NGO staff members after the introduction of action plans. To activate the coordination committees, the upazila also organized union and some upazila family-planning coordination committee meetings. As reported by the local NGO manager, BRAC an NGO played a vital role in organizing such committee meetings as this was also an agenda of their own programme. The concerned AHI of Kuliarchar upazila attended the last working day (report preparation day) meetings of the family-planning staff at the union level at the later part of follow-up period. No evidence was found in any other upazilas either organizing meetings jointly or attempting to organize coordination committee meetings at the union or upazila level.

Open System Performance Rating

Kamalganj upazila introduced the open system performance rating (OSPR) system before the first visit of ICDDR,B research team for data collection. They displayed the boards in all the HFWCs in November 1999 but information was not regularly updated. The OSPR boards were available in other 4 upazilas, but they were not in use. During the first visit of the research team, the boards were found in the storerooms of either UHFPO or NGO office of the upazilas. During their second visit, these boards were found to be displayed in the HFWC of Kuliarchar, Gobindaganj, and Debiganj. It was observed during the subsequent visits of the team that, although the boards were displayed in the HFWCs, these were not updated regularly. Zakiganj upazila did not hang the boards in the HFWCs even at the end of follow-up period (June 1999). Since the UHFPO of Zakiganj did not participate in the training, he was not involved in implementing the action plan in the upazila. According to the trained managers of the upazila, the UHFPO neither attended any review meetings nor provided performance reports of his department to them that are required in introducing OSPR in the upazila. Knowledge gaps among field staff were observed on the process of updating the OSPR boards. Most of the field staff had no correct knowledge of what was the basis for ranking the boards, and how frequently the system had to be updated.

The following barriers were mentioned by the trained managers and union-level supervisors while introducing the OSPR:

- The trained managers did not receive any orders or instructions from the district or national level after their training, and they were confused whether they were required to hang the boards in the HFWCs or not.
- Prior to hanging and updating the OSPR boards, ranking needs to be done through reviewing the union ESP performance and supervisory findings. But as joint performance reviews were not done regularly in the upazilas, the trained managers could not introduce the system.
- Due to lack of coordination among the trained managers especially between health and family-planning wings, they could not complete the necessary formalities, i.e. organization of meetings, review of performance and ranking the unions, and hanging of the boards which are required for introducing the OSPR.
- Some trained managers did not give the importance to the OSPR. They rather considered the OSPR as part of training, but not necessarily something to be implemented in their working areas.

Although the introduction of OSPR was delayed, and the boards were not kept updated regularly, the impression of the respondents (trained managers and union-level supervisors) about the OSPR system was positive. Two-thirds of the respondents reported that the system encouraged the field staff to do work seriously as they could know the status of their own and union performance and could compare the performance with that of other unions. However, a low percentage of the respondents reported that the OSPR was useful to the community and outside visitors (Table 7).

Table 7. Perceptions of respondents regarding usefulness of open system performance rating

Responses	Percentage distribution of respondents (n=179)
OSPR was useful, because it encouraged the commitment of field staff as it compared the performance of their union with that of other unions of a upazila	69
It helped the community know about the status of health programme of their union which may motivate them to support the programme	15
The system may help the outside visitors know about the performance of the health and family-planning programme at a glance	8
Do not know anything about the usefulness of OSPR	8

All the FGD participants also commented that the OSPR was an useful mechanism to encourage them to achieve their targets.

Quality of Care

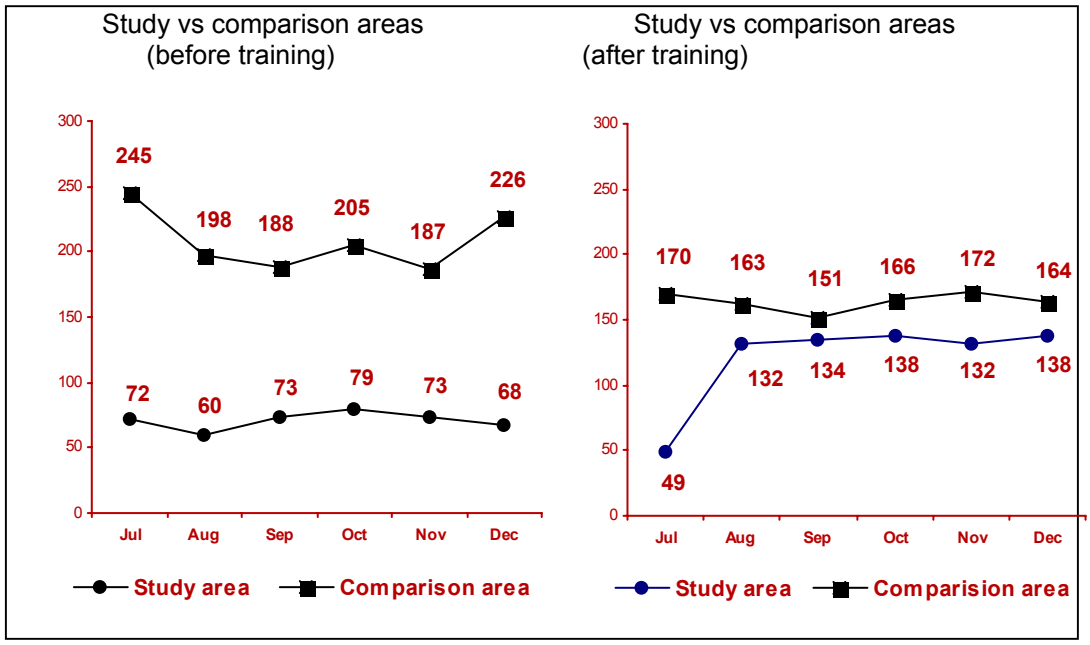
Eighty-eight percent of the paramedics (FWV and MAs/SACMOs) got orientation on the action plan-implementation process at their upazilas with other field staff. In response to a question of which of the components of the action plans they found to be useful, 41 percent reported that recording and reporting were useful, and another 41 percent reported that target setting and joint planning for the satellite clinics and EPI activities were useful. Joint meetings and OSPR were reported to be useful by 12 percent and 4 percent respectively. Increased supervision was viewed as useful by 2 percent of the respondents (Table 8).

Table 8. Views of paramedics on useful components/activities of action plans

Components	Percentage distribution of respondents (n=49)
Recording and reporting	41
Targets set for union/field staff	21
Joint planning for satellite clinics and EPI activities	20
Joint meeting	12
Open system performance rating	4
Increased supervision by upazila managers	2

Eighty-four percent of the paramedics reported that the number of patients increased at the HFWCs after the introduction of action plans in the upazilas. According to them, most patient, who visited the clinics were family-planning clients. All the respondents reported that the umber of patients who visited for the management of side-effects also increased in their clinics after introducing the action plans. The Fig. 2 shows the number of clients who attended clinics in the study and comparison areas, for the management of side-effects associated with the use of contraceptives over the study period. The figure shows that the number increased sharply after the action plans were introduced in the study areas and the trend of management of side-effects decreased in the comparison areas both before and after the training. The total number of clients with side-effects included the patients who visited the clinics staffed by paramedics, and were recorded as having complaints of side-effects due to the use of family-planning methods. The figure further shows the average number of side-effects managed in 5 study and 3 comparison upazilas. The reason behind the sharp increase of side-effects management in the study areas after training may have been due to the join efforts of the paramedics, field staff, and trained managers to achieve their set targets. Greater awareness among clients about management of side-effects due to the joint efforts may as well be a reason of this.

Fig 2. Trend in management of side-effects in HFWCs before (July-December 1997) and after (July-December 1998) training in both study and comparison areas.



Source: *Service statistics. Directorate of Family Planning, Ministry of Health and Family Welfare.*

The status of referral cases from the clinics could not be calculated since no proper records were maintained in the clinics. The paramedics reported that since the number of clinical method users increased in the upazilas, the number of patients with side-effects also increased.

The following reasons were mentioned by the respondents for the increased number of patients in their clinics after the introduction of action plans:

- Since the field staff members (FWAs) had target at clinical method users, they became active in achieving their targets. They motivated clients to use clinical methods and sent more patients to the HFWCs than before.
- Support of logistics, especially supply of medicines, was more regular during the implementation of the action plan than before.
- After the introduction of action plans in the upazilas, the field staff of the health wing also referred patients (family-planning clinical method users, pregnant women, ARI, diarrhoea, and abscess cases) to the clinics which they did not do earlier.

Most paramedics interviewed reported that they destroyed their clinic wastes quarterly by burning it in drum incinerators given from the GoB national level.

Sixty-three percent of the paramedics reported that their roles and responsibilities have changed little after the introduction of action plans in their upazilas (Table 9). According to them, the changed activities were: timely preparation and submission of reports, new targets and pressure from the upazila levels for achieving targets, increased work loads, etc.

Table 9. Perceptions of paramedics about changed roles and responsibilities after introduction of action plans

Activities	Percentage of respondents (n=49)
Timely preparation and submission of reports	43
New targets and pressure to achieve targets	23
Increased workloads as health workers sent more patients than before	10
Follow-up of increased number of clinical method users	6
Others (attending meetings, organizing health-education sessions)	18

The respondents were asked whether they found any change in their clinics on client flow, quality of services, referrals, etc. All the respondents gave an affirmative answer. According to them, client flow, supply of logistics, i.e. supply of medicines, and supervision from the upazila levels had increased significantly after the introduction of action plans (Table 10).

Table 10. Views of paramedics about areas of change occurred in HFWCs after introduction of action plans

Areas of change	Percentage of respondents (n=49)		
	Increased	As before	Decreased
Client flow	88	6	6
Supply of medicines	84	16	
Supervision from upazila level	76	24	-
Quality of services	57	40	3
Quality of information (Improvement in record-keeping and reporting)	55	44	-
Skill of providers	41	59	-
Referral	33	53	14
Cleanliness of clinics	31	69	-

The research team observed the cleanliness of the HFWCs in the 5 upazilas during their visits. Findings of their observations relating to cleanliness of the clinics are presented in Table 11.

Table 11. Status of cleanliness of HFWCs in 5 upazilas

Areas observed	Status found (n=39)	
Toilet	Clean 20	Not clean 19
Cleanliness of doors and windows	Clean 27	Not clean 12
Pure drinking water (tubewell available in clinic compound)	Available 32	Not available 7
Registration system	Present 27	Absent 12
Sterilization of equipment (IUD set)	Sterile 36	Not sterile 3

Comparison of Process Followed by 5 Upazilas in Implementing Action Plans

Different procedures were followed in implementing the action plans in the 5 upazilas. Table 12 shows the comparison of process followed by the 5 upazilas in implementing the action plans.

Table 12. Comparison of process followed by 5 upazilas in implementing action plans

Activities	Process followed				
	Kamalganj	Zakiganj	Kuliarchar	Gobindaganj	Debiganj
Orientation for field staff	1. Orientation session was held at a regular staff meeting at the upazila level	1. Orientation session was held at regular staff meeting at the upazila level	1. Orientation session was held at a regular staff meeting at the upazila level 2. Organized separate orientation sessions at every HFWC	1. Orientation session was held at a regular staff meeting at the upazila level	1. Orientation session was held at a regular staff meeting at the upazila level
Dissemination of targets set for field staff	1. Announced in orientation session 2. Trained managers issued a circular mentioning of union targets	1. Announced in orientation session	1. Announced in orientation session 2. Trained managers issued a circular mentioning the union targets	1. Announced in orientation session	1. Announced in orientation session
Joint ESP reporting	1. ESP reports were prepared by a person assigned by UHFPO 2. Initially, reports were jointly prepared by trained managers for 2 or 3 months	1. ESP reports were prepared by a person assigned by UHFPO	1. ESP reports were prepared by a person assigned by UHFPO	1. ESP reports were prepared by a person assigned by UHFPO	1. ESP reports were prepared by a person assigned by UHFPO

Contd...

Table 12. *(contd.)*

Activities	Process followed				
	Kamalganj	Zakiganj	Kuliarchar	Gobindaganj	Debiganj
Meetings at upazila and union levels	1. Organized HFWC meetings jointly with health, family-planning and NGO staff	1. All meetings held individually	1. Meetings held individually 2. Concerned AHI attended the report preparation day meeting of family planning staff at union level	1. All meetings held individually	1. All meetings held individually
Activate coordination committees	1. Organized some union and upazila family-planning coordination committee meetings	1. No evidence was found in this regard	1. No evidence was found in this regard	1. No evidence was found in this regard	1. No evidence was found in this regard
Open system performance rating	1. OSPR boards were hung in November 1998 and updated once during the follow-up period	1. OSPR boards were not hung in any HFWCs	1. OSPR boards were hung after March 1999 and updated once during the follow-up period	1. OSPR boards were hung after March 1999 and not updated after that date	1. OSPR boards were hung after March 1999 and not updated after that date

The table shows that Kamalganj and Kuliarchar upazila took more initiatives than other upazilas to implement the action plans. The reasons behind this were coordination among the upazila team members, and team understanding of the two upazilas was comparatively better than that of other upazilas. The table also shows that different processes were followed by different upazilas in implementing the action plans. The reasons were that the training design did not include any standard (similar) implementation procedure and expected that the upazila team would take initiative to identify a suitable process for implementing their respective action plans.

Comparison of Some Process Indicators between before and after First Visit of Research Team

The findings revealed that the action-plan implementation process required follow-ups and facilitation to implement it at the upazila level and below. Visits of the research staff proved this more prominently. Although the research team worked as observers, and did not facilitate anything with regard to the implementation of the action plans during their visits, but some activities were carried out by the trained managers after their first visit. Annexure shows the activities that were performed after the first visit of the research staff, but were not done before the visit. The major activities done after their first visit were as follows:

Upazila	**Activities apparently prompted by research team visit**
Gobindaganj	- OSPR boards were hung in all HFWCs after ranking - Organized special meetings to review the action plan - All unions submitted ESP reports to the upazila office on time
Debiganj	- Organized orientation sessions for the health staff - Organized refresher session for family-planning and NGO field staff along with health staff - OSPR boards were hung after ranking
Kuliarchar	- OSPR was introduced after ranking - Concerned AHI attended the last working (report preparation) day meeting of family-planning staff at the union levels, discussed the field problems relating to health programmes, and sought solutions
Kamalganj	- Union-level family-planning coordination committee meetings were held regularly
Zakiganj	- Union staff members became regular in submission of ESP reports

The reasons for performing the activities after the first visit of research staff that were not done earlier were:

1. The staff members asked the trained managers about the implementation status of the action plans in every visit which they (trainees) considered as follow-up and that reminded them to implement the action plans.

2. Some NGO managers found the visits as support for them to facilitate the implementation of the action plans. The managers reported that the GoB trained managers did not listen to them regarding the implementation of the action plans as there was no instruction from GoB higher authority. According to the NGO managers, visits of the research staff members helped them use as reference of follow-up from the national level to the GoB trained managers in implementing the action plans.

Discussion of Key Findings

Although the service statistics showed that the programme performance improved after the introduction of action plans, but in the absence of community-based data, this impact of the training and of the introduction of action plans could not be properly assessed. The reports prepared based on the service statistics varied widely in their accuracy. In addition, the timeframe of one year is rather limited, and the major changes would not be expected to occur in such a short period.

Nevertheless, data from the comparison areas showed the status of family planning and immunization in the absence of a training programme. The increased CAR rate in the intervention areas was not apparent in the comparison upazilas. The reports also showed a decreasing trend in the performance of upazilas with the trained managers in later months. Thus, the impact of training may have been short-lived, and may be followed by a gradual loss of interest on the implementation of action plan particularly in the absence of follow-up and facilitation activities from higher levels. Therefore, greater emphasis should needs to be laid on those aspects of the training course that deal with ensuring that the formal orders and instructions of the government are circulated to the trained managers and their immediate supervisors. This applies not only to the introduction of action plans but also to the implementation of policies and strategies for service-delivery, such as ESP.

The findings showed that the staff at all levels reported positive attitudes toward the performance-rating system. The field staff claimed that the system motivated them as it enabled them to compare their respective local performance. This is an area that needs further attention. The motivation of the health workers, particularly during periods marked by the introduction of far-reaching health sector reforms, did not receive adequate attention, and many initiatives to improve motivation of health workers have been designed and implemented with no adequate justifications [6].

The staff members also reported that their orientation on the implementation process of action plans was not sufficient. This may be due to the fact that there were gaps in knowledge about the targets and goals in the action plans and also in the understanding of strategies to attain these goals. The findings showed that the managers followed different implementation strategies after the training. This in itself is not bad, and perhaps local initiatives are needed to ensure the implementation of action plans in widely different environment and conditions. Nonetheless, there is a need to provide guidelines and manuals to support the trained managers in orienting their staff and implementing the action plans.

The question of involving staff in identifying the goals and setting targets also deserves consideration. Apparently, all the managers had set their targets without involving their field staff. But working areas and catchment populations varied widely. Ostensibly, this combination of different workloads, coupled with the lack of involvement in target-setting, led to some field workers being able to attain their targets, while others could not, because the targets set for them were not realistic.

Neither were joint supervisory visits always feasible and nor was the practice of joint ESP reporting introduced in any upazila. Other conflicting priorities got on the way of attending meetings to prepare joint reports. On the other hand, the fact that most managers did initiate the practice of integrating health and family-planning services by merging the paramedic outreach clinics with the male field workers' immunization sites was indicative of increased coordination. At the same time, there was evidence that the meetings held at the upazila and union levels were more systematic during the implementation of action plans than before the training. The issue of coordination, particularly between NGOs and the government agencies, is of significant importance. The study produced some evidence that this collaboration was more effective in areas in which the organization of coordination committee meetings was high in the agenda of NGOs themselves. In other words, it was dependent on the NGOs own interest to coordinate activities with the government.

The findings showed that the implementation of action plans was affected due to lack of follow-ups from the district and national-level supervisors. The future training programmes should, therefore, give prior attention to involve responsible persons from higher levels to monitor follow-ups and review the implementation process of action plans. The field staff reported that too many indicators used in the current action plans also affected their implementation. This suggests to use less (most relevant) indicators in future training programmes.

Lessons Learned and Constraints in Implementation of Action Plans

1. The training programme designed and conducted by the University of North Carolina focused on the ESP programme. Nevertheless, an integrated ESP programme was yet to be introduced in the field. Implementation of the training programme was hampered as it was done before the introduction of the ESP programme. So, the training programme needs to be designed and implemented following the existing programme in the field.

2. Training itself is not sufficient for implementation at the operational levels. The study findings showed that there were confusions among the trainees that the action plans developed for implementation at the field or as part of the training and academic purposes were not formally approved by the government. Therefore, the training programme requires formal orders/instructions from the government to be implemented.

3. One of the thrusts of the training programme was the integrated delivery of health and family-planning services, with the personnel of health, family-planning, and local NGO working as a team. The findings revealed that there was no significant evidence of joint planning and joint implementation to achieve the agreed upon targets. So, effectiveness of teamwork needs to be further explored.

4. Absence of monitoring and supervision from the district and national levels affected the implementation of the training programme at the upazila level and below. To implement the training programme as per design, monitoring from the district and central levels is required.

5. Absence of facilitation from any agency in the implementation of action plans affected the programme seriously. The findings showed that although the ICDDR,B research staff did not facilitate the implementation of the action plans, their regular visits influenced the trainees. Therefore, facilitation from a recognized agency may help the upazila managers implement the action plans.

6. Transfer of trained staff after training affected the implementation of the action plans.

7. Non-participation of the head of the health departments (UHFPOs) of two upazilas in the training course also affected the implementation of the action plans. The trained managers of Zakiganj could not introduce the OSPR, and orientation for the field staff of health department of Debiganj was not held as the UHFPOs of the two upazilas did not participate in the IMP training. Therefore, participation of all concerned staff in a training programme needs to be ensured.

8. The findings showed that the absence of a standard procedure or guidelines led the trained managers to follow different processes in implementing the action plans. So, existence of a manual/guidelines on the action plan-implementation process may help maintain a standard process.

9. Some other fundamental constraints, such as absence of fund, affected the implementation of action plans. Therefore, the fundamental constraints should be resolved before a training programme is initiated.

Recommendations/Suggestions on how Action Plans can be Made More Effective

1. Findings of the study showed that confusions existed among the trainees about the implementation of action plans at the field level or as part of the training and academic purpose as the action plans were not formally approved by the government. Therefore, formal order/instruction of the government is essential to implement the action plans more effectively at the upazila level and below.
2. Functional integration between health and family-planning wings at the upazila level needs to be established, and one officer should be responsible for the action plan- implementation process.
3. The action plan at the upazila level should be consistent with the overall national plan (HPSP), and training needs to be done after the introduction of the ESP programme in the field.
4. Responsible persons from each directorate should be assigned to follow up monitoring and review of the implementation of action plans.
5. The components of action plans should be consistent with the HPSP. Any duplication of work should be avoided. An ongoing reporting system should be used instead of developing separate and parallel systems.
6. There were too many indicators used in the current action plans. Less (most relevant) indicators can be used, and should be measurable, monitorable, and available within the existing MIS.
7. The findings showed that different processes were followed in different upazilas in implementing the action plans, and the action plans did not contain a standard implementation procedure. Besides, there was no guidelines/manual to use in implementing the action plans at the upazila level. To maintain similar procedures and to support the trained managers in implementing the action plans, some guidelines or a manual may be developed.
8. Concerned Civil Surgeon and Deputy Director, Family Planning (DD-FP) should be involved in follow-up of the implementation of the action plans regularly.
9. More visits and follow-up by personnel of the RSDP TA units may improve the action plan-implementation process.
10. To implement the action plans or a training programme as designed, no trainees should be transferred during the follow–up period.
11. More effective orientation/training for the field staff on relevant components of the action plans is needed. After completion of IMP training, how to disseminate the training components with field staff should be a part of the action plans.
12. The role of the community in strengthening health and family-planning service-delivery is important. There is a provision of HPSP to involve the community in the programme-implementation plan. Therefore, to address the plan of HPSP,

community leaders should be involved with the action planning and implementation process at the upazila-level and below.

References

1. Larbi GA. Policy arena international constraints and capacity issues in decentralizing management in public services; the case of health in Ghana. Int Dev 1988;377-86.
2. Bangladesh. Ministry of Health and Family Welfare. Health and Population Sector Programme; programme implementation plan, part-1, 1998.
3. National Integrated Population and Health Programme. Report on design workshop, Rajendrapur, Bangladesh, 1996.
4. Request for proposal (REP) from qualified firms to conduct a study to assess the impact of the training programme: “Improving management and performance (IMP) of the delivery of ESP at upazila level in 8 upazilas”. Dhaka: Pathfinder International, Bangladesh, 1998.
5. Action plan for improving management and performance of delivery of ESP at upazila level. Trainees of Kamalganj, Zakiganj, Kuliarchar, Debiganj, Gobindaganj and Fatikchari upazilas, 1998.
6. Bannet S, Miller L. Public sector health worker motivation and health sector reform: a conceptual framework. Bethesda, MD: Abt. Associates Inc., 1999:27-9.

Annexure

Comparison of some process indicators between before and after the first visit of the research team

Upazila	Activities	Observed during first visit	Observed during subsequent visits
Gobindaganj	Introduction of OSPR	OSPR boards were found in THPO office and some HFWC store rooms	OSPR boards hung in all HFWCs after ranking
	Review of action plan	No review was done after orientation of field staff	UHFPO organized two special meetings with all FWVs, MAs, and SACMOS on 19 April and 9 May 1999 and reviewed progress of action plan implementation
	ESP reporting	Some unions (Harirampur, Nakhai and Salmara union) were irregular in submitting ESP reports to upazila office	All unions submitted reports to upazila offices timely due to special instruction from UHFPO
Debiganj	Orientation for field staff	Orientation for field staff of health department was not held	Orientation for health staff was organized on 16 May, 1999.
			Refresher session was organized for family planning and NGO field staff along with health staff on May 16, 1999
	Introduction of OSPR	All OSPR boards were found at THC	All unions of the upazila hanged OSPR boards after ranking
	Implementation of other components of action plan	Confusion among trained managers as to whether they would start implementation of action plan or not	Took initiative to implement the action plan, i.e. regular submission of ESP reports updating OSPR boards.

Upazila	Activities	Observed during first visit	Observed during subsequent visits
Kuliarchar	Introduction of OSPR	Not hanged OSPR boards in any union of the upazila. The boards were found in the storeroom of local NGO office	Hung the boards in all the unions of the upazila in March and updated the boards in June 1999
	Joint meeting	No joint meeting held except monthly staff meeting which is going on since last four years	In last working (report preparation) day meeting of family-planning staff at the union levels, concerned AHIs attend meetings, discuss field problems relating to health programmes and seek solutions
	Joint supervisory visit	Neither planned nor made any supervisory visit by trained managers	Planned to make joint supervisory visit from June 1999
Kamalganj	Family Planning coordination committee meeting	Family Planning coordination committee meetings held at union levels but the meetings were not regular	Union level family planning coordination committee meetings held regularly
	Introduction of OSPR	OSPR boards were hung in November 1998 in all the HFWC but did not update after hanging the boards	Boards were updated in March 1999
Zakiganj	Preparation and submission of ESP reports	Union staff members did not submit ESP reports timely which delayed in preparation and submission of reports by upazila managers	Union staff members became regular in submission of ESP reports due to pressure from trained managers