Functioning of Thana Functional Improvement Pilot Project: Perspectives of Managers, service Providers, Clients, and Community

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ICDDR,B Working Paper No. 147

Edited by: M. Shamsul Islam Khan

Design and Desktop Publishing: Jatindra Nath Sarker
Manash Kumar Barua

ISBN: 984-551-234-8

ICDDR,B Working Paper No. 147

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: Olympic Products Printing & Packaging, Dhaka

Acknowledgements

The Operations Research Project (recently renamed as Family Health Research Project), 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 study 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 who 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 Göteborg, University of California at Davis, 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 Inc., Pathfinder, UCB Osmotics Ltd., and Wander AG.

The authors gratefully acknowledge the support and encouragement received from Dr. Cristobal Tunon in accomplishing the work; and the contributions of Mr. Kees Groenendijk, Dr. Azam Ali, and Dr. Prasanjit Chakma of TFIPP for their active support in conducting the study. The authors would also like to thank Mr. Mahidul Islam, Dr. Thomas T. Kane, and Dr. John Stoeckel for their valuable comments on this report.

Acronyms

AD-CC	Assistant Director, Clinical Contraceptives
ATFPO	Assistant Thana Family Planning Officer
CS	Civil Surgeon
DD-FP	Deputy Director, Family Planning
DGHS	Directorate General of Health Services
DG	Director General
DM	District Manager
EPI	Expanded Programme on Immunization
FIAP	Functional Improvement Action Plan
FIT	Functional Improvement Team
FP	Family Planning
FPI	Family Planning Inspector
FWVTI	Family Welfare Visitor Training Institute
GoB	Government of Bangladesh
H&FWC	Health and Family Welfare Centre
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IPD	In-patient Department
MCH	Maternal and Child Health
MO	Medical Officer
MO-DC	Medical Officer, Disease Control
MOHFW	Ministry of Health and Family Welfare
MO-MCH	Medical Officer, Maternal-Child Health
MP	Member of Parliament
NGO	Non-government Organization
NSC	National Steering Committee
OPD	Out-patient Department
ORP	Operations Research Project
PIU	Project Implementation Unit
RMO	Residential Medical Officer
RD	Rural Dispensary
SC	Satellite Clinic
TA	Technical Assistance
TAG	Technical Advisory Group
TFPO	Thana Family Planning Officer
TFIPP	Thana Functional Improvement Pilot Project
THC	Thana Health Complex
THFPO	Thana Health and Family Planning Officer
TM	Thana Manager
TPC	Thana Project Committee
TT	Thana Team
TTT	Thana Training Team
UFIAP	Union Functional Improvement Action Plan
UP	Union Parishad

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Executive Summary

The Thana Functional Improvement Pilot Project (TFIPP), a project of the Directorate General of Health Services of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh, was implemented during 1994-1999. Its overall objective was to increase the demand for health and family-planning services in 55 thanas (now upazilas) of six districts of Bangladesh. The TFIPP was aimed at improving the government health facilities through a minor repair programme and at providing equipment, ambulance, and furniture to them. The TFIPP also provided training to different levels of staff on technical skills, communication, and managerial skills. It targeted to involve the community in planning and implementation of action plan.

The Operations Research Project (now Family Health Research Project) of ICDDR,B: Centre for Health and Population Research conducted a study in eight thanas of TFIPP project areas on the perceptions of managers, supervisors, community leaders, volunteers, and clients on selected interventions of TFIPP, such as local-level planning and community participation. Thana Managers (TMs), union-level service providers, and clients were interviewed using an anonymous semi-structured questionnaire. Group discussions were arranged with the thana supervisors. Informal interviews were conducted with the community leaders and volunteers. Content analysis of the meeting minutes was also done.

The study observed that the TFIPP formed a local Thana Training Team (TTT) and imparted job-related training to all categories of staff. It also arranged skill-development training for medical officers and paramedics of different training institutions to enhance their efficiency. Renovation of the existing facilities, construction of training facilities, supply of modern equipment, and provision of ambulances, bi-cycles and aprons, positively enhanced a sense of commitment among the staff.

Management of the hospital improved, and the unauthorized persons were prevented from misusing the hospital premises. Both service providers and clients observed noticeable changes in supply of new equipment, building repairing, cleanliness in the facilities, privacy of patients, seating arrangements, toilet facilities, and decoration of the facilities with posters and charts. In indoors, outdoors, FWCs, and satellite clinics, health-promotion sessions for clients and attendants of patients were regularly arranged.

Placement of funds at the local level accelerated small repairs and procurement of stationery articles. The service providers thought that the introduction of service charge in outdoors and indoors helped develop client's tendency to pay for service and reduced misuse of drugs. Generation of funds started with the introduction of pathological tests. Revolving Drug Fund was established, and clients could buy medicines at a nominal price from the hospital, if needed.

The service providers and supervisors acknowledged a strong record-keeping system implemented by the project. The thana and union-level service providers reported that flow of clients increased at the service centres during the project period due to better supply of equipment and medicines, a better referral network, and provision of ambulances.

All levels of staff felt that the preparation of an action plan was a very useful exercise for local-level planning and monitoring. The community leaders actively participated in the preparation of the union- level action plan. However, in many places, the thana managers reported that the implementation of action plan was hampered due to delayed release of funds and transfer of trained persons. The thana managers believed that external facilitation by the Functional Improvement Team (FIT) members in the implementation of action plan was very important. The thana managers opined that it was difficult for the FIT members to provide an expected level of assistance to them, since the FIT members were not within the administrative structure. The thana managers suggested for more involvement of district-level officials, e.g. Civil Surgeon (CS) and Deputy Director, Family Planning (DDFP) in implementation and monitoring the action plan.

In many places, meetings of the Thana Project Committee (TPC) were not held regularly. Although there was a target of holding 6 meetings, on an average, per year, the average number of meetings held per year ranged from 1.4 in Chittagong division to 2.3 in Rajshahi division. Sometimes the thana managers felt that it was difficult for them to ensure the continuous participation of community leaders and feared getting involved in local politics. The chairmen of union parishad did not often attend the meetings, which negatively influenced participation of other members in the meetings. Whereas the union-level staff reported that, during the project period, the union-level meetings took place regularly, which involved staff from both health services and family planning directorates. This increased coordination between the staff of both health services and family planning directorates.

The provision of financial and logistic support was a key factor to ensure formulation and monitoring of the Functional Improvement Action Plans (FIAPs). The service providers suggested for a more transparent procurement mechanism and an effective feedback mechanism for all levels of staff and for a rewarding system for better performance of staff. Although the community volunteers intended to continue their voluntary support to the community even if the project activity closes down, they anticipated regular communication with the health service centres. Efforts to ensure community involvement may require clearer terms of reference for the committees and more comprehensive orientation for the community representatives.

Background and Introduction

About TFIPP

The Government of Bangladesh has created an impressive infrastructure of rural dispensaries (RDs), Health and Family Welfare Centres (H&FWCs), and Thana Health Complexes (THCs) throughout the country to provide health services to its people. But it did not lead to an increased use of services. Many people in rural areas remained outside the reach of government health systems, resulting in under-use of services at the thana level and below. Results of a service-delivery survey of the Health and Population Sector Programme (HPSP) showed that 13% of the households used government health services, whereas 32% used private health services (1). Reasons for not using the government health services are many, complicated, and interrelated. Two major reasons, identified by this study, were (i) poor quality of services and (ii) social and cultural factors. Insufficient technical, communication and managerial skills of the providers, insufficient supply of drugs, and unpleasant behaviour of staff are responsible for the poor quality of services. Social and cultural factors included lack of knowledge of the people about services offered at different tiers and culturally-unacceptable arrangement of privacy at the service sites.

The Thana Functional Improvement Pilot Project (TFIPP), a pilot project of the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), was implemented during 1992-1999. Although launched in 1992, the actual project activities at the district and thana levels started in September 1994. Based on the experiences in 12 thanas, the Project expanded its operations to 43 additional thanas in early 1996. The overall goal of the TFIPP was to increase the demand for health and family-planning services in selected districts and to increase the use of these services by improving efficiency, effectiveness, and quality of services. The Project was aimed at improving health facilities through a minor repair programme. It provided equipment, transportation, and furniture and arranged training on technical communication and managerial skills for staff, and ultimately tried to increase the demand for health services through community involvement.

Objectives of TFIPP

The general objective of the TFIPP was to improve basic health and family-planning services in 55 thanas of six selected districts (Nilphamari, Barisal, Bagerhat, Comilla, Sunamganj, and Rangpur) of Bangladesh (2).

The specific objectives of the Project were to:

- increase the availability, accessibility, and acceptability of health and family-panning services in project thanas
- increase the professional competence of health and family-planning service providers
- promote local-level planning and improve management of health and family-planning services
- promote community participation in health and family-planning service-delivery
- develop a model for improving health and family welfare services (2)

Organizational Structure and Financial Support of TFIPP

The Project advisory and implementing structures at the national, district and thana levels through which the Project operated are shown in Fig.1.

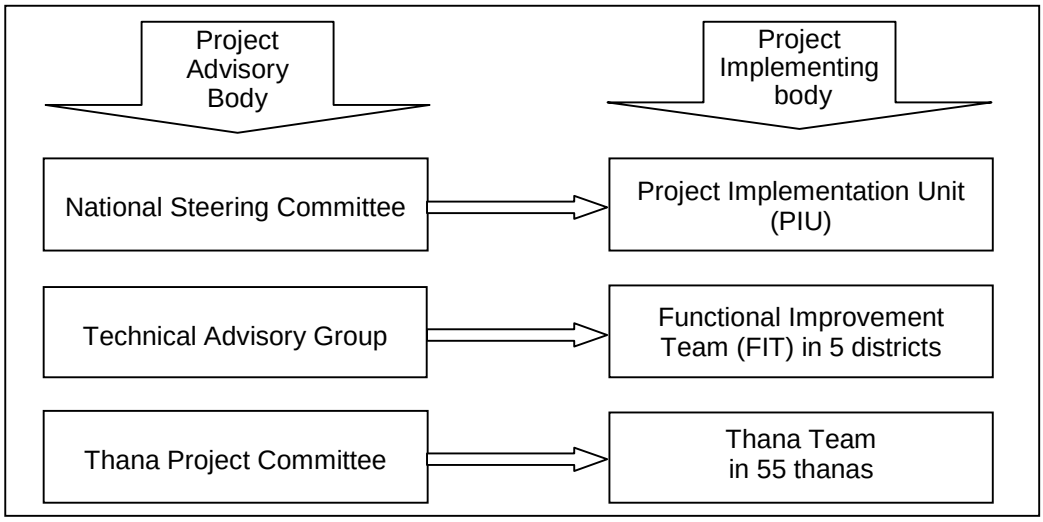
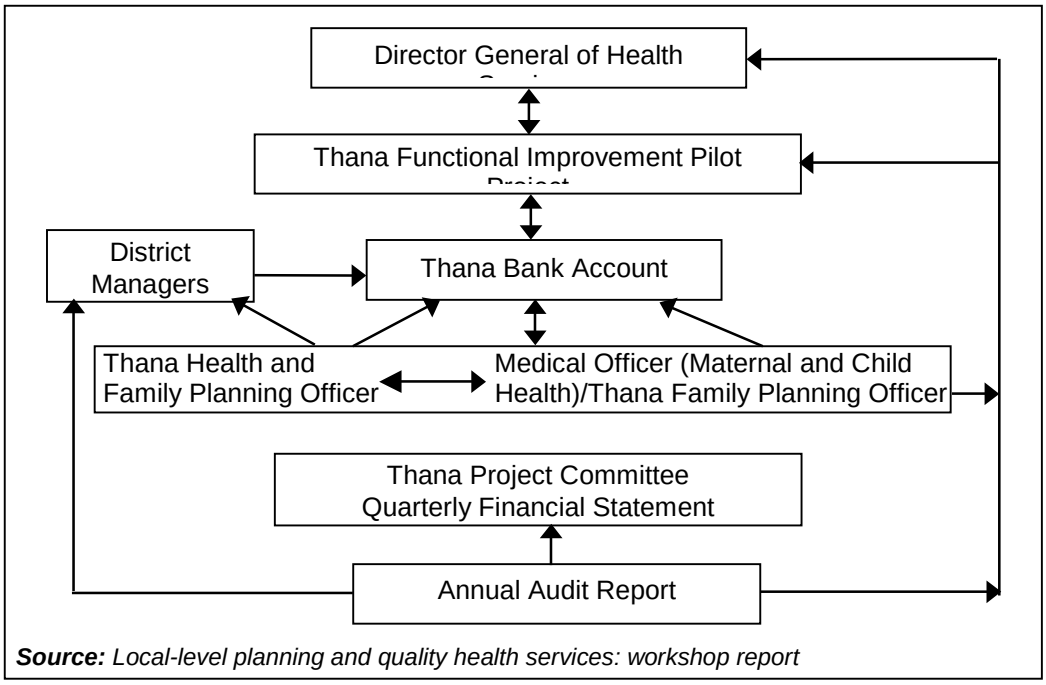


Fig 1. Organizational structure of TFIPP

At the national level, a 13-member National Steering Committee (NSC) was constituted. This committee was the highest policy and decision-making body, and was headed by the Secretary, MOHFW. Its other members included both Director Generals of DGHS and Family Planning (Appendix 1). The NSC oversaw the activities of the Project Implementation Unit (PIU), the main administrative body for the Project headed by a Project Director, appointed by the MOHFW and supported by a Technical Assistance Team consisting of one Public Health Consultant, one Administrator, Finance and Logistics Consultant, and one Training Consultant.

At the district level, a Technical Advisory Group (TAG), consisting of Civil Surgeon, Deputy Director, Family Planning (DDFP), and other district-level officials (Appendix 1), oversaw the work of the Functional Improvement Team (FIT). The FIT comprised of three members--a Public Health Expert, a Management Expert, and a Training Expert--and they were the representatives of the PIU at the project districts. The role of FIT members was to mobilize, motivate, and train the Project staff, and facilitate the project activities in the districts and thanas. The FIT supported the Thana Team (TT) consisting of Thana Health and Family Planning Officer (THFPO), Thana Family Planning Officer (TFPO), and other thana-level staff. The TT was responsible for the implementation of the Project at the thana level and below. At the thana level, the Thana Project Committee (TPC), headed by the local Member of Parliament (MP), supervised and monitored the implementation of the Project. The TPC consisted of 25 members, including the community representatives, such as MP, Union Parishad chairman, officials of Directorates of Health Services and Family Planning, other government departments, and NGOs (Appendix 2). This committee was responsible for (a) endorsing the Functional Improvement Action Plan (FIAP) at the thana level, (b) monitoring and overseeing of programme implementation, (c) ensuring community mobilization and participation, and (d) mobilizing local resources.



Source: *Local-level planning and quality health services: workshop report*

Fig. 2. Pattern of financial support of TFIPP

Figure 2 shows the pattern of financial structure of local-level planning in the TFIPP. The fund released from DGHS goes to the TFIPP. From the TFIPP, it is placed to the thana bank account, which is operated by a 4-member committee, including the district and thana-level managers. Two signatories can operate the account. Recollected money goes back to the thana bank account. All the procedures are followed under supervision of the TPC and auditing.

TFIPP Interventions

The TFIPP carried out the following major activities:

- Local-level planning
- Participation of the community
- Imparting of training
- Purchase of equipment and furniture
- Providing of transport
- Doable repairs
- Technical assistance from FIT
- Cost-recovery and sustainability
- Information, education and communication (IEC)

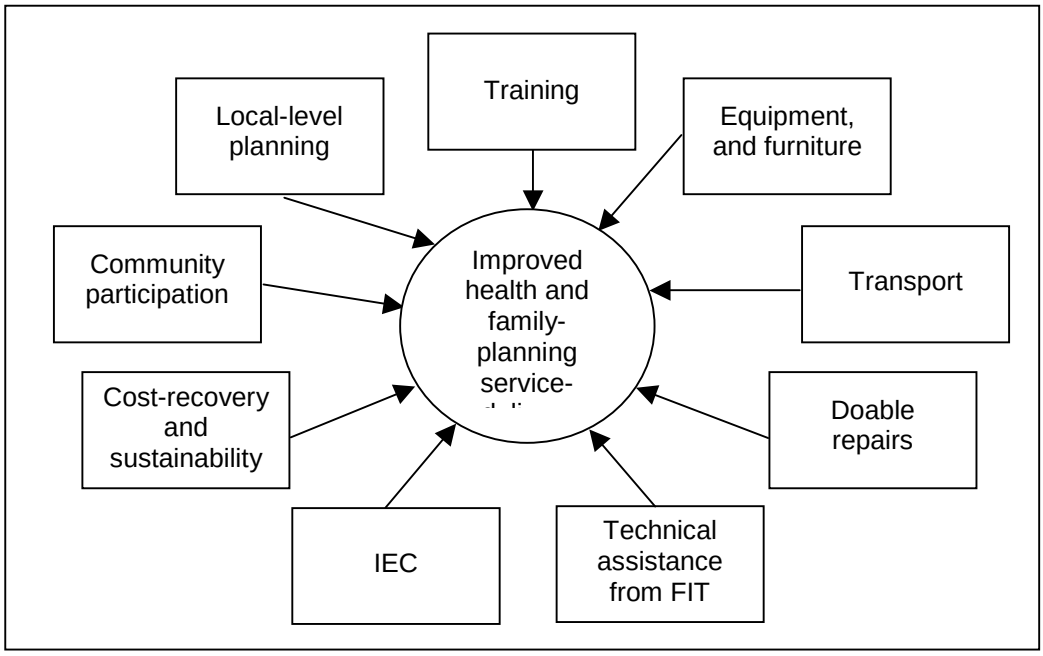


Fig. 3. Main interventions of TFIPP

Local-level planning

The TFIPP promoted the development of a local-level annual action plan named as Functional Improvement Action Plan (FIAP) at the thana level and District Action Plan at the district level. The FIAP was prepared jointly by the FIT members and selected representatives of the thana team mostly by the THFPO and TFPO of respective thana. The team identified and prioritized the local needs of a particular thana and its unions, planned activities, set targets, allocated funds, and assigned responsibilities, and was mainly responsible for the implementation. The TPC monitored the implementation of FIAP throughout the year.

Community participation

The community participation element was a vital component of the TFIPP. For this, a 25-member Thana Project Committee (TPC) was formed. The local Member of Parliament was the chairman of the TPC and the Vice-Chairman was a suitable Union Council chairman selected from among the Union Councils under the thana. The THFPO was the Member-Secretary. The TPC members also included the TFPO, MOs, Health Inspector, Sanitary Inspector, a representative of the third and fourth class employees of the THC, Thana Nirbahi Officer, Public Health Engineer, Rural Development Officer, Union Council Chairmen, a representative of NGOs, a local elite, and one FIT member (Appendix 2).

The key tasks of the TPC were to endorse the FIAP, monitor and oversee programme implementation, ensure community mobilization and participation, and mobilize local resources (2). The representatives in the TPC received an orientation provided by the FIT. There were other community leaders and volunteers who received orientations from the TFIPP to serve as the link persons between the community and the service system and who were to be involved with health-promotion activities. Selected community leaders, i.e. school teachers, social workers, Union Parishad members, and other opinion leaders received a one-day orientation training to increase their awareness about health and sources of health services.

The activities of village health volunteers (VHVs) of TFIPP took place in five unions of two thanas in Rangpur and Sunamganj districts. The number of volunteers varied in each place; and different supervisory and management authority for them are the distinguishing elements that characterize the TFIPP intervention relating to VHVs. In some places, such as Pirgacha thana (Rangpur), there were 15 VHVs, and in other places 48-60 VHVs have been working. In some places, such as Kolkolia union in Jagannathpur thana, the volunteers were supervised by NGOs, and in other places they were supervised either by the union council or by the health and family-planning workers. A four-day training package was developed for the VHVs, and a training manual was also developed as a reference book for the trainers.

The VHVs were expected mainly to:

- help organize Community Clinics (CCs)
- inform service recipients of the changes taking place in the health and population sector
- exchange their knowledge in relation to important health issues
- refer pregnant women for antenatal care (ANC), vaccination, and other services
- accompany patients to the MOHFW facility, if required
- motivate people to maintain basic practices of hygiene

Training

The health and family-planning human resource development activities in Bangladesh were concentrated mainly on institutional training provided at the National Institute of Population Research and Training, National Institute of Preventive and Social Medicine, Family Welfare Visitor Training Institute, etc. The TFIPP believed that relatively little attention had been devoted to develop more comprehensive health manpower, covering managerial and supervisory capabilities, career management, and also organizational structure and personnel administration procedures at the district and thana levels.

The TFIPP made training as one of the most important components of the programme, and provided training to staff at the district level and below on technical, managerial and communication skills. A Thana Training Team (TTT) was formed with THFPO, TFPO, and other thana-level staff at each THC to provide training to staff at the thana level and below. Initially, an in-service training model was developed that concentrated on different staff categories, but later on additional emphasis was placed on a more service and client-oriented training approach. Specialized training was provided to technical personnel, such as nurses and physicians, at the training institutions. The TFIPP used four approaches for the training initiative: (i) on-the-job training, (ii) in-service training arrangement at the thana level, (iii) training through FIT and DMs, and (iv) technical skill training in institutions for service providers (3). The expected outcomes of TFIPP training initiatives were:

- Development of technical, managerial and communication skills of service providers
- Better-informed community
- Involvement of the community leaders and volunteers in health-promotion activities

Equipment and furniture

Based on the inventory undertaken in project districts, the Project provided equipment and furniture to the thana and union outlets**.**

Transport

In some places, the Project provided transports, such as ambulances, motor cycles, and bicycles.

Minor doable repairs

One important aspect of the Project input was provision of minor doable repairing of the thana and union-level outlets. The TFIPP also constructed a training centre at each thana, and equipped it with necessary furniture and training equipment.

Technical assistants from FIT

The FIT members were the mobilizer, motivator, and trainer responsible for assisting and facilitating all the Project activities in the thana and district levels.

Cost-recovery for sustainability

The TFIPP introduced various measures, such as pricing for outdoor services, revolving drug fund for cost-recovery for sustainability.

Information, education and communication (IEC)

The TFIPP carried out extensive IEC activities which included group discussions and pictorial wall painting describing the health messages, services, and timing of services at the health outlets.

The ORP, with full cooperation of the TFIPP, conducted a study in eight thanas on the main interventions of TFIPP during April-May 1999. The main objective of the study was to learn and document the experiences of TFIPP and to use the key findings in the HPSP to be implemented during 1997-2003.

Rationale for the Study

Effects of the TFIPP need to be assessed in the context of strengthening the existing physical infrastructure and human resources, promotion of local-level planning, increased participation of the community for overall improvement of the health and family-planning service-delivery, and increasing demand for services.

There are several progress reports and impact assessments on various interventions of TFIPP. However, impact assessments did not focus on the perspectives of thana managers, supervisors, service providers, clients,

community representatives, and volunteers on TFIPP interventions relating to local-level planning, management, and community participation. The present study covered these areas of TFIPP interventions; was aimed at exploring the extent to which the TFIPP interventions have been able to involve the community in local-level planning, helped the staff improve their professional skills, and strengthen the local-level management. The study also explored the perceptions of providers, community representatives, and volunteers on sustainability issues of TFIPP, and finally tried to formulate possible recommendations to be replicated in the HPSP.

Objectives of the Study

The overall objective of the study was to assess the perceptions of health service managers, providers, clients, and community representatives on the effects of TFIPP. The specific objectives of the study were to:

a. assess the perceptions of thana-level managers and supervisors on major TFIPP interventions, such as preparation and implementation of FIAP, training of staff, sustainability measures, and their effects
b. assess the perceptions of service providers on training and their practices regarding the quality of services at the service points
c. assess the perception of clients on the quality of services and satisfaction of clients
d. explore the factors affecting local-level planning and community participation

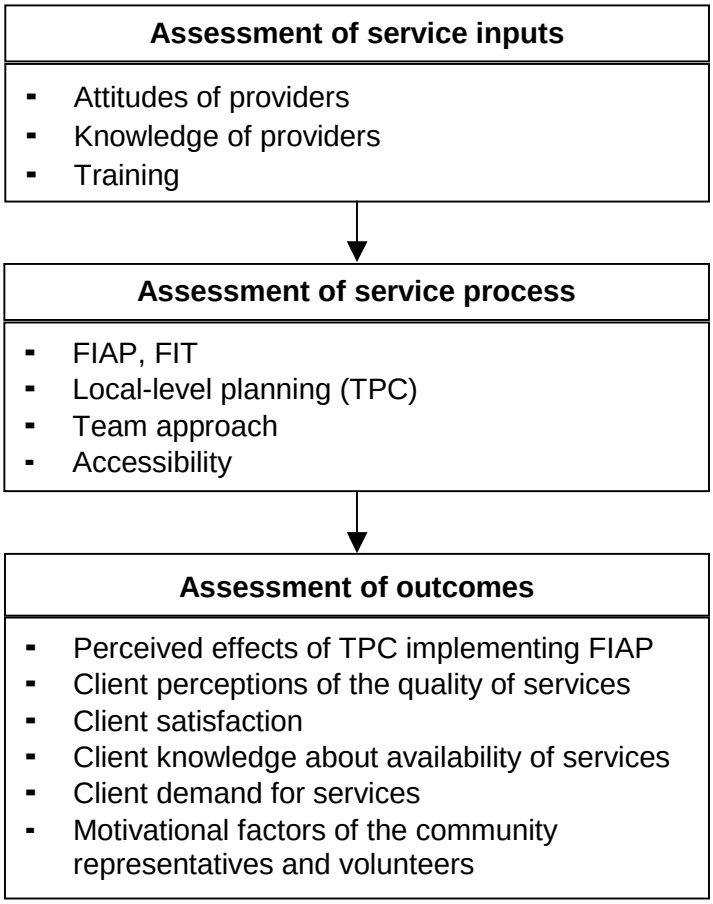


Fig. 4. Conceptual framework for the study

Materials and Methods

Study Area and Period

This study was undertaken during April-May 1999 in the following eight thanas of three TFIPP districts:

- Dimla and Jaldhaka thanas of Nilphamari district, Rajshahi division
- Mithapukur and Pirgacha thanas of Rangpur district, Rajshahi division
- Laksham, Daudkandi, Chandina, and Barura thanas of Comilla district, Chittagong division

The study areas were purposively selected jointly by the ORP and the TFIPP on the basis of location and performance. Since the study mostly looked at some process indicators, such as functioning of local committee (TPC), local-level planning, and development and implementation of action plan, and since most activities were thana-based, the study targeted to include high- and low-performing thanas. TFIPP programme personnel identified some low-performing thanas in Comilla district and high-performing thanas in Rangpur and Nilphamari districts. The study sample included four thanas of Comilla and four thanas from Rangpur and Nilphamari.

The study was designed to obtain information on selected process and outcome indicators, which are outlined in the conceptual framework (Fig. 4). All thana managers[1] from eight thanas were interviewed using an anonymous questionnaire. The questionnaire was self-administered and semi-structured. Although 32 thana managers were targeted to be interviewed, two interviews did not take place, because they were attending training courses. In each thana, one focus group discussion (FGD) was arranged with the thana supervisors[2]. In-depth interviews were held with the community representatives in the TPC, community volunteers, and community leaders who received orientation from the TPIPP. Two H&FWCs from each thana were randomly selected for interviewing the union-level providers[3]. Exit-point interviews were conducted with clients at the H&FWCs using a semi-structured questionnaire. Four clients from each of the identified H&FWCs were randomly selected and interviewed during one working day. Table 1 shows the sources of data for the study.

Table 1. Sources of data

Primary data sources	Secondary data sources
▪ Interview with 30 thana managers at the thana level ▪ Eight group discussions with thana-level supervisors ▪ Interview with 31 service providers, including FWV, MA, and SACMO, at 18 H&FWCs ▪ In-depth interviews of community representatives in TPC (16), volunteers (12), and community leaders (25) ▪ 72 exit-point interviews with clients at the FWC level	▪ Minutes of TPC meetings and actual attendance lists, registers, and progress reports ▪ Assessments and working papers

[1] Thana managers: TH&FPO, TFPO, MO-MCH, RMO, and MO-DC&MIS

[2] Thana supervisors: ATFPO, Senior FWV, Senior, Staff Nurse, HI, and Sanitary Inspector

[3] Union-level providers: SACMO, FWV, and MA

Data-collection Procedures

Two researchers from the ORP, conducted group discussions with the thana-level supervisors and in-depth interviews with the community representatives and leaders. The researchers also interviewed the thana managers. Four Research Assistants interviewed the service providers and clients at the H&FWC, and conducted in-depth interviews with the community-level health volunteers.

Limitations of the Study

The present study has some limitations. Selection of the study areas was purposive which tended to cover some high- and low-performing thanas from three districts. Since this study mostly looked at some process indicators, such as factor affecting proper functioning of TPC, community involvement in local-level planning, it did not require control districts. Another limitation of the study was that it used secondary data to support the perceptions of thana managers, supervisors, service providers, and community representatives regarding increased demand for services during the TFIPP project period.

Results

Perspectives of Thana Managers on TFIPP Interventions

Profile of thana managers

In total, 30 thana managers expressed their views on different interventions of the TFIPP. Of them, 6 were THFPO, 6 were TFPO, 12 were MO-MCH, 2 were MO, DC, and the rest 4 were RMOs and MOs.

Changes in role and responsibilities of TMs due to TFIPP interventions

Ninety-three percent of the thana managers stated, after the TFIPP's inception, that their roles and responsibilities were changed in terms of management, supervision, planning, and monitoring. Of the 30 thana managers, 27 reported that their supervision and management activities had increased, and had the responsibility of imparting training to subordinate staff, i.e. FPI, AHI, HA, FWV, nurses, sweepers, and ward boys.

Training received by thana managers

Seventy-five percent of the thana managers reported to have received training through the TFIPP. Eighty-three percent of them received training of trainer (TOT) and 17% received specialized training on surgery or gynaecology for six months. Regarding the duration of the training period, 59% of the respondents reported that the training period was enough, and 77% expressed that the

content of the training was adequate. Ninety-four percent of the respondents stated that the training was very good. However, the TMs suggested giving awards or award certificates to the participants who attended the training courses.

With regard to specialized training, some trainees (TMs) stated that a six-month training course was not sufficient to develop expertise. Some managers opined that the TFIPP could have maintained good communication with training institutes and professional trainers, and should have invited qualified guest lecturers during specialized training.

Perceptions of thana managers on training they imparted to health and family-planning staff

Most thana managers considered the training they imparted to different categories of staff, such as FPI, AHI, HA, FWV, nurses, sweeper, and ward boys, were of great use. The contents of training were based on the task each category of staff renders. Ward boys and sweepers also received training on cleanliness and maintenance. Their training had contributed to enhanced discipline and cleanliness, and, above all, enhanced the sense of responsibility toward the community. However, they suggested imparting refreshers' training, and advised that the staff nurses and FWVs should have received more intensive training.

Perceptions of thana managers on service-related changes after introduction of TFIPP

The inception of TFIPP caused significant changes in the thanas on different aspects. Table 2 shows the major changes and the limitations of TFIPP interventions as perceived by the thana managers.

Table 2. Perceptions of thana managers on major positive changes and limitations of TFIPP

Issues	Positive change	Limitations
Personnel	- Discipline among staff (availability of staff at working place, use of apron, maintenance of duty roaster, use of work plan, better record-keeping) instituted - All categories of staff trained - Staff became more enthusiastic after training - A positive change in staff attitude	- The trained persons were posted outside the TFIPP areas - The district-level authority was not involved to the expected level
Facilities/ logistics	- Bi-cycles, aprons, and equipment were provided - Training facilities were built - Existing facilities were renovated - Small repairs and procurement of stationery articles was quicker	- A huge amount of reagents was wasted, because those had reached thana-level before training of laboratory technicians completed - There was delay in releasing funds - Some equipment were not appropriate for thana-level use (for example, eight renal biopsy needles were supplied in one thana, but there was no skilled person to use it) - The district-level hospitals were not sensitized side by side the thana-level hospitals; as a result, the district hospitals lost credibility as a referral point from the thana level - Some of the supplies were of low quality

Contd…

Table 2 (*contd.*)

Issues	Positive change	Limitations
Management	▪ Management improved, and the unauthorized persons prevented from misusing the hospital premises ▪ Physical environment of the hospitals improved, and was neat and clean ▪ Misuse of medicine decreased	▪ Lack of transparency in regard to central-level procurements (thana managers complained that they did not know about the purchase value of many supplies, so problems encountered in maintenance) ▪ MP, in certain cases, was reported to have given undue benefit to party men in procurement of supplies for the Project
Performance	▪ In general, client flow increased due to better treatment and better referral network ▪ Satellite clinics were better used ▪ Bed occupancy rate of hospital increased due to increased hospital delivery	▪ TMs from 5 thanas reported that clients in out-patient department decreased due to introduction of service charge
Sustainability	▪ Clients tendency to pay for services developed to some extent ▪ Fund-generation started with pathological tests ▪ Wastage of vaccines was minimized ▪ Revolving drug fund was established, and clients could buy medicines at a nominal price from the hospital, if needed	▪ No initiatives were taken to mobilize local resources

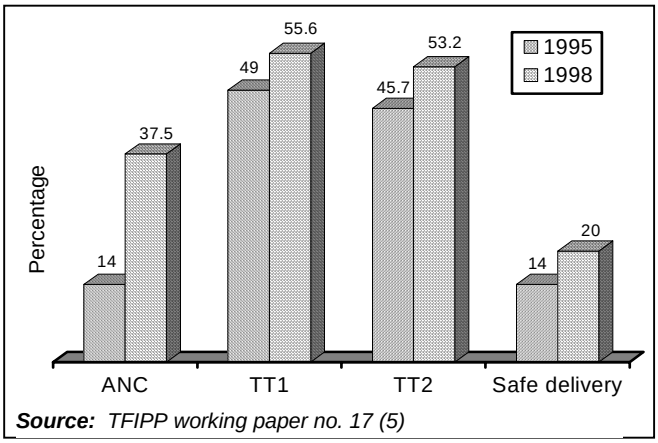
Contd…

Table 2 (*contd*.)

Issues	Positive change	Limitations
	▪ Collection of free drugs by some clients by making false statements at outdoors decreased after a fee of Taka 3 per client was introduced ▪ Attendants of indoor patients or hospital staff could not collect free medicines after the introduction of the pricing system (5 Taka on admission and drugs at nominal prices)	
IEC	▪ Community awareness increased ▪ Health and family-planning messages were highlighted on wall, billboards, and posters	
Community involvement	▪ Barriers between the community and the providers reduced because of orientation of community leaders	▪ One shot orientation training was not sufficient ▪ Local committee (TPC) was too large

Findings from service statistics that support increased demand for services

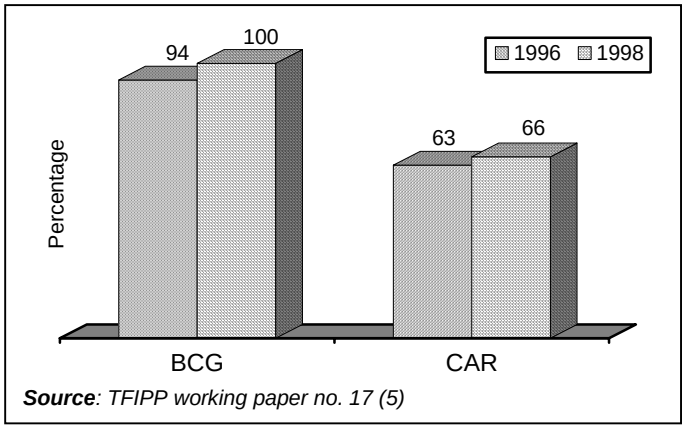
Results of analysis of data from service statistics showed that demand for selected services had increased (Fig. 5). In 1995, 14% of the pregnant women in the TFIPP areas visited the facilities for antenatal check-up after the first visit (revisit), while in 1998, 37.5% of them revisited the facilities. The TT1 coverage



Source: *TFIPP working paper no. 17 (5)*

Fig. 5. Coverage of ANC, TT1, and TT2 in TFIPP

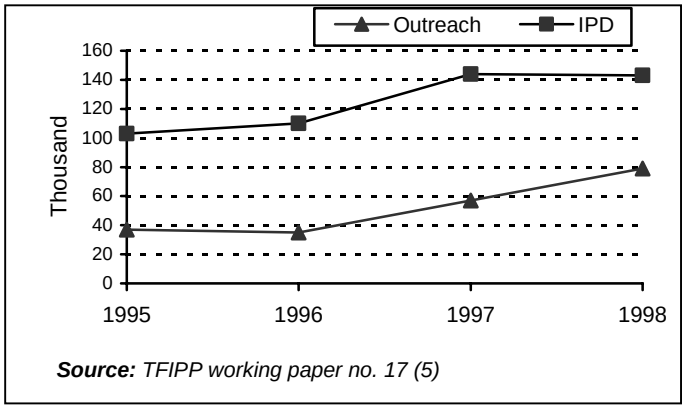
increased from 49% in 1995 to 55.6% in 1998, while the TT2 coverage increased from 45.7% to 53.2% in the same period. In the TFIPP areas, about 20% of the total expected pregnant women were assisted by the trained personnel, including traditional birth attendants (TBAs), during delivery in 1998 compared to about 14% in 1995. The number of deliveries at the THC had increased from 3,715 in 1996 to 6,493 in 1998 in the TFIPP areas.



***Source**: TFIPP working paper no. 17 (5)*

Fig. 6. Coverage of BCG and CAR in TFIPP areas, by

The BCG coverage increased from 94% in 1996 to 100% in 1998 (Fig. 6). The contraceptive acceptance rate (CAR) was 66% in 1998 compared to 63% in 1996 (Fig. 6). Clients at the peripheral facilities (UHFWC, RD, SC) increased by about 60% (Fig. 7). Again, the number of clients of in-patient department at the THCs in the TFIPP areas increased by 40% from 1995 to 1998 (Fig. 7). The actual number of combined satellite clinics increased from 25,100 in 1995 to 69,350 in 1998.



***Source:** TFIPP working paper no. 17 (5)*

Fig. 7. Total number of clients at outreach facilities and in-patients department in TFIPP areas, by year

Perceptions of thana managers on FIAP

FIAP for thana level: Eighty-three percent of the thana managers were associated with the FIAP development of 1998-99. Most thana managers informed that other thana-level staff, UP chairmen, and local leaders were also involved in the preparation of FIAP in various thanas. According to thana managers, the NGO representatives did not take part while preparing the FIAP. Ninety-three percent of the thana managers thought that the preparation of FIAP was an appropriate mechanism for improving health and family-planning services.

The thana managers mentioned that priority activities of FIAP were determined mostly by the THFPO, followed by TFPO and other THC staff. In a few cases, local leaders and MPs also contributed to priority setting.

FIAP for union level: Twenty-three thana managers participated in the preparation of 80 FIAP at union level, with an average of 3.5 per union. The thana managers also mentioned that the union *parishad* Chairmen, women representatives, school teachers, union *parishad* members, and local elites also took part in the activity at the union level.

Forty-three percent of the respondents reported some problems with the UFIAP development and implementation of which included: delay in releasing funds, lack of interest of some thana managers, inadequate funds, political pressures, and tussle of staff of health and family planning directorates. The perceived strengths and weaknesses of FIAP at the thana and union levels are summarized in Table 3.

Table 3. Strengths and weaknesses of FIAP perceived by thana managers

Strengths of FIAP	Weaknesses of FIAP
- Planning can be done according to specific need of an area - Local problems can be solved quickly - People's representation can be ensured - Easy monitoring and evaluation - Quality of services can be improved - Target for services to be offered - Opportunity to exchange views - Power is decentralized - Honour for local leadership	- FIAP could not be implemented within the time frame due to insufficient funds and delay in releasing funds - Difficulties to involve community representatives - Difficulties in implementation of FIAP due to the large committee which is often politically motivated - Unexpected influence by local leaders through the tender committee - Inadequate training on FIAP preparation - Thana managers are transferred outside the project areas - Centralized mechanism for expenditure - Inadequate guidelines - Inconsistencies between planning and implementation

Recommendations of thana managers toward development and implementation of action plan

The thana managers made some suggestions for improvement of action plan and its implementation. The major recommendations forwarded by the thana managers on better implementation of FIAP are summarized below:

- Timely approval of FIAP and placement of budget
- More training for those who prepare FIAP
- Clear guideline for preparation, implementation, and monitoring of FIAP
- Regular support of FIT officials to identify project problems, and resolve them
- Increase of supervision by district managers
- Provision for scholarships and arrangement of foreign tours for thana managers
- Reduced size of TPC for better planning
- Organization of workshop at the thana level for preparation of FIAP
- Involvement of workers at the union and thana levels
- Identification of strategies to ensure more participation by the community
- Involvement of district managers in the local-level procurement process
- Conduct of activities relating to FWC through MO-MCH-FP
- TMs should not be transferred outside the Project areas

Perceptions of thana managers about Functional Improvement Team

Most (96%) thana managers perceived that the FIT played a vital role in development of FIAP and in its approval. Eighty-nine percent of the thana managers thought that the FIT successfully performed its role in terms of supervision and monitoring activities of the Project. They also mentioned that the FIT played a vital role in making liaison with the local MP and in keeping him involved with the Project activities. However, most thana managers also thought that such external facilitation was mandatory for the performance of the Project, and this sort of support could be provided by district manager's absence of FIT.

Perceptions of thana managers on community involvement

Ninety-six percent of the thana managers thought that imparting orientation and training to the community leaders and volunteers was useful for their involvement in the Project activities. They expressed that, for better involvement of the community representatives, there should be a provision of honorarium for attendance in meetings and arrangement of regular refresher's training/workshops for them. They suggested for issuing a government order for the community leaders for extending their cooperation and acknowledged the need of strong IEC activities.

Perceptions of thana managers on sustainability issues relating to TFIPP

Sixty-six percent of the thana managers thought that the TFIPP was a sustainable Project. Perceptions of the thana managers on opportunities and constraints regarding the sustainability of TFIPP project are given in Table 4.

Table 4. Perceptions of thana managers on opportunities and constraints regarding sustainability of TFIPP

Opportunities	Constraints
▪ It is possible to do minor construction and purchase of furniture with local resources if it is mobilized ▪ Many emergency needs could be met by stopping wastages ▪ Fake patients can be controlled by introducing a service charge ▪ The Project has increased awareness among the people, so that they can demand for services ▪ Drug revolving funds can be used	▪ Cost-sharing mechanisms are not fully established ▪ There are less initiatives to mobilize local resources ▪ There is a wastage ▪ Expenditure is much higher than input ▪ There is a lack of transparency in expenditure

Perceptions of thana managers on introduction of service charge

Table 5 shows the status of various service charges by category of services. All the thanas introduced service charges but not for all types of services. Laboratory is one of the most important departments where all thanas, except Mithapukur, were receiving service charges. Service charges were not introduced in Mithapukur and Piranha for out-patients and in-patents departments. However, most thana managers perceived that the introduction of a service charge was a positive initiative for which the number of false patients decreased, patient's right has been established, general patients were getting more medicine, doctors could pay more time to patients, and, above all, the quality of services improved.

In few thanas, it was reported that pricing was not encouraging in some departments, such as OPD and laboratory, because clients do not want to pay for the services as they used to get it free, and many clients are too poor to pay.

Table 5. Introduction of service charge by category of services and areas

Thana	OPD	IPD	Emergency	Laboratory	Ambulance	X-ray	Drug	UHFWC
Dimla	✓	✓		✓				✓
Joldhaka	✓	✓	✓	✓		✓		x
Mithapukur					✓			x
Peergacha				✓	✓			x
Barura	✓	✓		✓	✓	✓	✓	x
Laksam	✓	✓	✓	✓		✓	✓	x
Daudkandi	✓		✓	✓	✓		✓	x
Chandina	✓	✓	✓	✓			✓	x

Perceptions of thana managers on use of revenues generated

The thana managers mentioned that they were not authorized to spend the revenue generated through service charges. However, some thana managers recommended to spend the revenue for the following areas:

- Improvement of services at THCs and UHFWCs
- Ensuring of cleanliness of hospitals, purchase of reagents for laboratory, medicines, gauge, bandage, and emergency patients X-rays, maintenance of privacy, safe-water supply, and sanitation
- Minor repairing
- Improvement of particular service for which it earns
- Emergencies

Perceptions of thana managers on possible effects after withdrawal of TFIPP support

Forty percent of the thana managers thought that activities, carried out by the TFIPP, could be continued through the increased involvement of the community, pricing for services, and use of revolving funds. The other thana managers (60%) thought that there would be some negative effects after the withdrawal of TFIPP support. They stated that the withdrawal of TFIPP would bar the continuity of current activities, decrease community involvement, hospitals would not be kept neat and clean, and maintenance of equipment would be difficult. One manager from Joldhaka thana commented,

> "There will be no fund to procure fuel for generator, and nobody has any idea about the source(s) of fund for printing outdoor tickets. The copying machine of THC went out of order for last six months, and could not be repaired until TFIPP fund committed. There is no source of fund for maintenance of five motorcycles provided by the TFIPP."

He further questioned,

> "How a blood pressure machine could be repaired if it goes out of order?"

Perspectives of Supervisors on TFIPP Interventions

Perceptions of thana supervisors on training

The thana supervisors, senior staff nurse, senior FWV, HI, and AHI received a five-day in-service training. Most of them felt that the training would be more effective if it was for a longer period, such as two weeks. One comment was:

> "Most of us are elderly persons. We can not concentrate now in learning as we could do before when we were younger. Therefore, it was sometimes difficult for us to pick-up things so quickly."

They, however, felt that the subjects covered in the training fulfilled their expectations, and found it relevant to their work. Some expressed that:

> "It was like a change or a good break in the monotony of our regular job, so it was enjoyable."

Many of them mentioned that the method of teaching was participatory in nature, and they felt comfortable with the training instructors while asking any questions during the training period. During the training, the participants were often asked to raise practical problems relating to their work and identify possible solutions through group work. The participants found that these types of exercises were the most useful component in the training. One participant reported that she was sick during her training, but still did not refuse to attend the training, because she had heard from her other colleagues about the usefulness of the training. In general, they felt encouraged to perform better in their work places after attending the training. Some participants qualifying the training stated, "We were brain-washed." Many of them trained their subordinates after returning back to their work places, thereby playing the role of a teacher. That was very challenging to them. They said,

> "We learnt from the training how to set plans before working."

However, they as well pointed out some weaknesses of the training. Sometimes, one instructor conducted the entire training, which was boring to some of them. Many participants reported that the issues relating to a new record-keeping system were less emphasized in the training, so they found it difficult to adopt a new set of record-keeping and reporting formats for this Project.
They said,

> "We learnt to use the new formats by making mistakes."

Some of them complained that they did not receive any refresher training after the initial training.

Perceptions of supervisors on TPC performance and implementation of annual plan

The supervisors reported that, during the first two years of the Project, the meetings were held regularly, but presently the meetings are being held irregularly. However, some participants who attended the TPC meetings could express about their concerns and needs. One AHI from Pirgacha thana of Rangpur district mentioned that, in 1998, there was an epidemic of diarrhoea in his working area, and there was a scarcity of oral saline. He then raised this issue in the Project committee meeting, and the local MP took prompt action to resolve it. They demanded motorcycles, bicycles, furniture, and other utility articles, such as bags and umbrellas, and some of them received those items. For motorcycle, no maintenance or fuel cost was provided. There was a common complaint about the low quality of some supplies, especially the bicycles were out of order within a very short time. In general, the participants were confused about the process of procuring these materials. Most of them believed that the items were procured centrally. However, there was no complaint about the quality of clinical equipment which they received.

Perceptions of supervisors on UFIAP and FIAP

The union-level action plan was supposed to be introduced since 1998. In most places, plans were prepared but not implemented, because allocations arrived just at the end of the respective financial year. Some supervisors were very much concerned about this situation, because the local representatives and leaders were involved in the process of preparing the union-level plans, and they were creating pressure for their implementation. Some supervisors were directly involved with the preparation of the thana-level action plan (FIAP). They commonly said about the action plans that:

> "They themselves (TH&FPO and TFPO), did and then shared it with others (TPC members)."

In a few exceptional cases, the TPC members identified the needs and problems of a respective thana in groups in a meeting, pointed out the priorities, and then came up with plans. But even then there was a lack of follow-up and monitoring by the TPC on the process of implementation. Some participants were aware that the FIT members were supposed to monitor the progress of implementation. They also believed that, since the FIT members were not within the administrative structure, they could not influence the thana managers in monitoring the progress. Therefore, the suggestion came for more involvement of the district-level officials, such as Civil Surgeon and Deputy Director, Family Planning, to monitor the implementation process. In general, some plans had been implemented in the initial phase of the Project. But, presently nothing significant was happening due to the delay in releasing funds.

Perceived changes since introduction of TFIPP

Management-related changes

Most participants received guidance from the TFIPP on how to perform their existing work in a systemic manner. It was said,

> "We are doing the same work that we are used to do before but in such an organized way that presently we do not have any pending jobs."

They informed that it was possible because of increased supervision and a regular record-keeping system in the Project. They were aware of the use and implications of a good record-keeping system as they commented:

> "Now we can compare our performance to that of the previous month at a glance, and can find out the drawbacks, if any."

They reported that their workload has increased, because they need to fill out large reporting formats, and supervisory work has been increased.

Service-related changes

The supervisors reported that the hospital bed occupancy has increased since the Project was introduced. Misuse of medicines in out-door patient clinics decreased due to the introduction of fees. They viewed that the referral system has improved by several means as follows:

- The trained TBAs brought the complicated delivery cases before they reached a very critical stage
- In some places, the Project provided ambulances
- The community leaders and volunteers sent patients from their localities

The supervisors also admitted that there was a remarkable improvement in terms of cleanliness, privacy for examination of patients, supply of clinical equipment, toilet facilities, and hospital decorations with posters. The rural women, even those who were illiterate, tried to understand the meaning of posters and asked questions about them. In some places, small parks were established for children within the hospital campus. However, some of them thought that the establishment of parks at the expense of Project was a wastage of money, and it would be more beneficial for the poor people if that money was spent for buying medicines. It was also said,

> "We have seen that some people were making money from this Project. This is their personal dishonesty, and there is no scope to complain directly to the highest authority."

The Project emphasized on health education, and arranged regular sessions for clients at the out-door clinics, in-door clinics, satellite clinics, and H&FWC. The Project introduced ORT corners at the thana level through which diarrhoea-related dehydration was assessed and managed accordingly. In the

present system, nobody provides oral saline without assessment of level of dehydration, resulting in reduced misuse of oral saline. They informed that previously the schoolboys and girls were used to come to collect ORT packets without any problem or complaint. Since relevant hospital staff received special training on clinical methods of family planning, provision of clinical methods increased in some places.

Coordination between health and family planning staff

One of the strategies of TFIPP was to strengthen the team approach of staff belonging to health and family-planning wings. The supervisors claimed that the union-level coordination meetings with the health and family-planning staff were being held regularly (even without funds). They had to produce joint reports, and, thus, there was a better understanding between the two sectors at the field level. However, they suggested that joint field visits should be planned. It was said,

> "Staff from two sectors (health and family planning) visit the same client at two different times, making two separate rounds. This is inconvenient for the client. It would be better if the entire field plan was prepared by a 'joutho' (joint) efforts."

Perspectives of Providers on TFIPP Interventions

Profile of union-level providers

Thirty-one service providers in 18 H&FWCs were interviewed. Of them, 17 were FWVs, 9 SACMOs, and 5 Medical Assistants. About 60% of them served at the particular centre for more than 5 years (beyond the Project period), and 54% served for 1-5 year(s).

Perception of union-level providers on training

Ninety-four percent of the union-level providers received training from the TFIPP. The training included the topics, such as diarrhoea, immunization, acute respiratory tract infections, antenatal care, reproductive tract infections, and general health. Ninety-six percent of them reported that the training was useful. However, 79% felt that the length of the training should be extended. Some suggestions were forwarded by them to make the training more useful. For example, they thought the practical sessions should be incorporated into the training programme, including ARI case management in wards.

Perceptions of union-level providers on changes during the Project period

Eighty-seven percent of the union-level providers thought that their responsibilities increased since the introduction of the Project. They reported that, after the TFIPP was introduced, they had to fulfill more targets (66%). However, 81% observed that supervision by the upper-level authority had

increased. Ninety-six percent thought that, at their level, they got some resources/benefits since the TFIPP was introduced, such as more supply of instruments (32%), development of personal skills (27%), supportive behaviour from supervisors (23%), more supply of medicines (15%), and development of volunteers to help them (3%).

Ninety-six percent of the providers believed that client flow increased during the Project period. Thirty percent believed that they could provide better treatments for ARI and diarrhoea; 39% believed that awareness was raised at the community level; 12% believed that more medicines were available at the FWC; and 14% believed that they could provide better care for pregnant women. However, 4% providers believed that there was no change in client flow, because they did not get anything new from the Project to provide to the clients. Eighty-seven percent thought that the quality of information (MIS) was much better since the introduction of the Project.

In response to a question what type of emergency patients come to them for treatment, the providers informed that the categories of emergency cases included: accident/injury (27%), ARI/pneumonia (24%), acute abdominal pain (22%), delivery with complications (16%), pregnancy with complications (7.4%), high fever (1%), and complications with family-planning methods (1%). Seventy-four percent believed that the village health volunteers and community leaders might have sent some of these emergency patients to them. If needed, the providers referred most cases, except delivery-related complications, to the THCs. The delivery-related cases were referred directly to the district hospitals. Seventy-four percent reported that the union-level monthly meetings that included both health and family-planning staff were held regularly. The providers who told that the meetings were not held regularly cited the reasons as follows: HIs or FPIs were absent (56%), and allocation for meetings stopped (44%).

Involvement of union-level providers in development and implementation of UFIAP

Seventy percent of the providers were actively involved in the preparation of UFIAP and all believed that this approach was an effective one. They thought that the process of preparation and implementation of an action plan might ensure discussion of different problems in groups, decrease misusages, improvement in the quality of services, monitoring of progress of the Project, taking of quick decisions, and running of programme systematically. Fifty percent reported that the UP chairmen/members were involved in the preparation of this plan. Of the 31 providers, 7 experienced some problems in implementing the task. Six of them made written complaints about these problems to the higher authority, and the higher authority took required steps to solve the problems of only two cases.

Perceptions of union-level providers on possible changes after withdrawal of the Project

The providers thought that there might be some changes at their workplace if the Project is closed. They anticipated that the supply of equipment would stop; the quality of services would fall (16%); training would stop (13%); supply of medicines would decrease (12%); motivation of workers would decrease (7%); there will be less supervision by the higher authority (7%); client flow would decrease (6%); monthly meetings would cease (3%); and cleanliness could not be maintained.

Perspectives of Clients on TFIPP Interventions

Profile of clients interviewed at the H&FWC level

Of 72 clients interviewed, 55 (76%) were females and 17 (24%) were males. Most of them were married (86%). About 21% were aged less than 20 years.

Health-care seeking behaviour by clients at H&FWC

The clients came for services, such as general health problems (31%), family-planning (8%), and child health, including immunization (25%), ante- and postnatal care (7%), and women's health problems (29%). In response to the question about how they came to know that such services are available at these centres, 49% mentioned that, since they reside very close to the centre, they came to know about it. Thirty-three percent heard of it from the FWAs, 17% from the relatives and neighbours, and 1% from the TBAs. However, 72% lived nearby the centre, within less than half an hour-walking distance. Another 25% would require half an hour to one hour walking, and only 3% resided at a distant place. Eighty-three percent of the clients previously visited the same centre previously. In addition to the present visit, in last six months 18% of the clients visited the centre once, 37% visited twice, and the rest three times or more.

Quality of services at H&FWC

Most (83%) clients had to wait less than half an hour to meet the providers. Whereas, 11% had to wait for more than one hour, and 6% waited for half an hour to one hour. While waiting, 93% got a seat, and 19% could show that they received prescriptions. Most (98%) clients could mention about a number of services provided from the centres. Forty-six percent reported that the providers performed some physical examinations. Most (90%) clients received counselling from the providers on medicine (72%), general cleanliness (5%), food or nutrition (12%), and side-effects of family-planning methods (11%).

Forty-three percent were told to come again for follow-ups, and three clients were referred to THC or to district hospital.

Perceptions of clients on quality of services

Table 6 presents the perceptions of clients on the quality of services at the H&FWCs. It shows that 26% perceived that the quality of services was very good, and 69% perceived that it was moderately good. Five percent who were dissatisfied, cited the following reasons: "Without money, the providers did not provide good services or medicine;" "They did not examine properly or did not provide prescriptions;" and "Long waiting times." There were some other expressions, like "Provider's behaviour was not good;" "Provider did not allow me to say what I wanted to say;" "Provider did not hear about details of my illness;" and so on. However, 96% also reported that the providers were friendly and attentive.

Table 6. Perceptions of clients on quality of services

Level of satisfaction	Percentage of clients
Very good	26
Moderately good	69
Unsatisfactory	5

Perceptions of clients on changes at the H&FWC during the Project period

Most (86%) clients observed a positive change at the FWC since the introduction of TFIPP (The clients termed the Project as FIT, and recalled five years back without such changes). The perceived changes included provision of good medicines (27%), new seating arrangement (12%), new equipment (12%), better treatment (12%), better cleanliness (11%), new posters and pictures (8%), good behaviour of providers (6%), and building repair (6%). One client mentioned about the introduction of fees as an important change.

Perspectives of Community Leaders on TFIPP Interventions

Training

The leaders who were interviewed could recall a number of topics that were covered in the training, such as services provided at the satellite clinics, various temporary and permanent family-planning methods, preparation and administration of ORS, first aid, importance of sanitation and hygiene, pregnancy care for mothers, vitamin A, child care, and EPI.

Although some community leaders viewed that the training should have been of longer period to enable them to carry out their responsibilities better; most of them felt that one day was adequate. Most of them received nominal remuneration of Tk.50.00-100.00 for attending the training programme, and were offered refreshments and food.

Perceptions of community leaders about their roles in TFIPP

Most responding community leaders acknowledged that, after the training, they were given certain responsibilities to help their communities. The tasks included:

- Holding group discussions with people to teach them everything they have learnt from the training
- Talking to people and encouraging them to avail of clinical help in case of medical crisis and sending them to the hospital, if necessary
- Convincing people to adopt family-planning methods, if they have two or more children
- Motivating them to adhere to hygiene rules and sanitation
- Assisting pregnant women to get antenatal/postnatal care
- Assessing the family-planning situation of their areas
- Motivating and helping people to get vaccination and proper care from EPI spots and satellite clinics
- Teaching people about management of diarrhoea and preparation of ORS
- Preventing environmental pollution

However, some of them could not recall any responsibility that was specifically assigned to them. They said that they tried to use what they have learnt from the training by motivating people to make the right health decisions.

Some of them mentioned that they visited the satellite clinics and EPI spots regularly. One respondent adopted the permanent family-planning method herself to convince others. Some of them reported that they took part in seminars for promoting health issues, such as management of diarrhoea, nutrition and home gardening, etc. Some of them even tried to quantify their success rate by grading their performances as 60%, 70%, 80%, etc. The reasons for not being able to perform at the expected level were usually

attributed to their jobs, family, and other social obligations that they have to carry on. Some respondents stated that so far no government workers came to obtain their assistance in any public crisis. They assumed that the government workers were not aware that the community leaders have been trained to assist them if necessary. One respondent said,

> "We are only called when any high-level official visits."

However, the government field workers consulted some community leaders to arrange awareness programmes in the village about maternal and child healthcare, family planning, management of diarrhoea, etc. In some occasions, representatives from the government health facilities encouraged the community leaders to be present at the satellite clinics and EPI spots. However, they did not provide any assistance to the community leaders in any way.

Motivational factors for community leaders

The factor that motivated most respondents to participate in the training programme was that it helped them learn about how to help people in need and handle a crisis situation. They also admitted that, being involved in the TFIPP activities, their public image had brightened, and they have won people's respect and social contacts. One such participant expressed,

> "Helping people is the only way of gaining others' respect."

Many of them reported that they were providing free services for self-satisfaction. Some UP Chairmen and members said that they had been elected to serve people, and it was their duty. Some also stated that it was the moral obligation of the few literate people like them to make uneducated people conscious about their health. One woman UP member remarked that this training had increased her popularity substantially. Her voters used to say,

> "We don't need a man to be our UP member, we can do well with a woman."

Issues relating to continuation of work

Most respondents stated that they did not expect to be benefited financially for working for people, but they wanted some linkage with the government workers. They suggested that the government workers might keep regular liaison with them either through meetings or through regular training sessions. Some felt that they should keep a stock of common remedial drugs, such as ORS, vitamin A capsules, etc. Some emphasized that they could circulate an illustrated handbook, posters, etc. to the people for health education. One respondent pointed out that the target group for this kind of orientation sessions, which they attended, should be the common masses.

One respondent questioned the quality of services provided by the government hospitals. She said that, as part of her responsibility, she advised people to go to the hospital for health-related problems. But she lost credibility every time some one had to come back from the hospital, because of non-availability of drugs.

Some community leaders emphasized on payment of honorarium for their services. They said that, without cash incentive, no one would go for working for others indefinitely; if not possible, then there should at least be weekly or fortnightly meetings for them and arrangement of refreshments with possible sanction of travelling and daily allowances.

Most (80%) respondents were willing to continue their social work, even if the TFIPP programme closes down. Some pointed out that they had started rendering their services to the common people even before they were oriented/assigned by the TFIPP. So, they would not stop working, because the TFIPP might be withdrawn. A number of respondents showed concerns about the possibility of TFIPP being shut down. They feared that the drug supply would be reduced, and believed this might cause substantial damage to the local health situation.

Perspectives of Volunteers on TFIPP Interventions

Training and its parameters for volunteers

All the volunteers interviewed had undergone a TFIPP training within the last 1-12 month(s) lasting for 4 days. However, many volunteers did not know clearly what the TFIPP stands for. In Comilla, there was no such training for the volunteers. The participants could recall the following topics covered during the training:

- Mother and child healthcare
- EPI
- Family planning
- Management of diarrhoeal diseases and preparation of ORS
- Pregnancy care
- Management of diseases, such as cold, fever, etc.
- First-aid

Most volunteers reported that the training was useful to them. All the respondents reflected positively about getting the opportunity to take part in the training. They said that books, posters, and colourful illustrations were used for making the learning easier during training. All the respondents vouched for the training instructors to have pleasant and warm behaviour. Most of them have received some other training and experiences regarding social work. Many of them had worked as depot-holders or local *dai*s. Most respondents lived within a 5-30-minute walking distance from the premises of the training centre, and

used to walk to the training spot. None of them received any travel allowance for attending the training. However, few of them lived more than half a kilometer away from the training center, and used either rickshaws or vans to come to training place. The volunteers received daily allowance amounting to Tk. 200.00 and refreshments during the training. Many of them stated that more training like this is needed to comprehend the various health-related issues properly and to clarify things that they did not understand for the first time.

Motivational factors for volunteers and expectations of volunteers

Some volunteers hoped that such a training experience would help them find better employment elsewhere. Some respondents strongly stated that they do not want to work too much without pay, and pointed out that cash incentive would help boost their dedication. One said that utility items, such as bags, umbrellas, etc., should be given to the volunteers to make them interested to work. One respondent reported that she puts her own work on hold to serve others. If she was paid for her services, she could have told her husband that her work was worth something. However, despite such problems, she would continue her work, because it might help her find real employment someday. Some needed to walk a long way to work as volunteers, but did not receive any travelling allowance.

However, the majority reported that they were rendering voluntary services without any cash incentive or any benefit from the government or NGOs. They informed that they felt good to think that other people were being benefited from their work. One respondent recalled that once she was used to be driven out of people's homes. Today, she is warmly received and sought after helping them. Some believed that their voluntary work has increased their popularity and gained people's respect.

They also expressed the hope that the government would consider their economic restraints, and arrange for them a monthly salary package in future. Some felt that more training programmes would enhance the efficiency of their services. One suggested that they should be given a stock of common remedial drugs for helping people. All felt that the current size of the volunteer groups is enough to do the work. The volunteers also said that, if they were paid for their work, they could work as field workers.

Role, responsibilities, and achievements of volunteers

All the volunteers believed that they were effectively using the training in their locality by mobilizing people to adopt family planning, immunize their children, and themselves (TT), manage diarrhoeal-related complications at home in the correct way, maintain hygiene, drink boiled water, etc. Some regularly visited the satellite clinics and EPI spots, while others encouraged and accompanied

people to go to the FWCs. They said that attendance level of these facilities has risen, since they have been trained to advise people to take the right health decisions. They said that, as part of their responsibilities, they accompany the local people if they need to go to the hospital for any health problems. The participants were familiar with at least one of the government health workers, such as FWA, FWV, MA, HI, etc.

The respondents reported that as trained volunteers they mostly served poor people, because well-off families would not come to them for any help, they would rather go directly to the private practitioners. They reported that they did not face any social or familial obstacles in carrying out their duties as social workers.

Supervision issues for volunteers

Many volunteers informed that they had no further meetings or group discussions with the authority after the training but felt that such gatherings were needed to reach unanimous solutions to problems they face in their line of work. Some respondents reported that they attended monthly meetings with representatives from the THC. In these meetings, they discussed their problems, and usually they were able to reach some solutions.

Content Analysis of Minutes of TPC Meetings

The TFIPP had a 25-member TPC to (a) endorse the FIAP at the thana level, (b) monitor and oversee programme implementation, (c) ensure community mobilization and participation, and (c) mobilize local resources. The TPC was scheduled to hold one meeting each month during the first year and once every quarter thereafter. Content analysis of the available minutes of meetings revealed the following:

TPC and its members: Of the 25 committee members, 7 were community leaders, including the local MP as its chairman, 3 UP chairmen, and 3 other local elites. The other members of the committee included health and family-planning staff, GoB officials of other departments, and NGO officials. Table 7 shows representation of different categories of members in TPC meeting.

Table 7. Participation in TPC meetings by category of members

Category	No. of representatives in TPC	Average attendance in TPC meetings
Community leader	7	4.5
Health and FP officials/staff	10	8.8
Other GoB officials	6	2.9
NGO	2	0.7
Total	**25**	**16.9**

On an average, 4.5 leaders attended meetings. Of the community leaders, the role of UP chairmen was very encouraging. About two of three UP Chairmen in each committee attended all the meetings. Their attendance was comparatively better than the members of other categories, i.e. other GoB staff and NGOs (Appendix 3).

TPC meeting by thana and district: The TPC meetings were planned to be held monthly during the first Project year and once every quarter thereafter. Table 8 shows the number of TPC meetings planned versus the number of meetings actually held by thana.

Table 8. TPC meetings held, by thana and district

Name of thana	Name of district	Year of project inception	No. of meetings scheduled	No. of meetings held[1]	Average number meetings per year/district
Dimla	Nilphamari	1995	23	8	1.7
Joldhaka	Nilphamari	,,	23	6	
Mithapukur	Rangpur	1996	19	8	2.3
Peergacha	Rangpur	,,	19	6	
Barura	Comilla	,,	19	7	1.5
Laksam	Comilla	,,	19	4	
Daudkandi	Comilla	,,	19	3	
Chandina	Comilla	,,	19	4	
Total			**160**	**46**	

Community leaders in TPC: The role of MPs is pivotal for the performance of TPC. In his absence, one of the three UP Chairmen was supposed to preside

[1] The number of meetings was determined on the basis of available meeting minutes and attendance records

over the meetings. Of targeted 160 meetings, 46 were held. Half of the meetings were presided over by the local MP and others by the UP chairman. Table 9 shows the category of members who presided over the TPC meetings by thana.

Table 9. Meetings presided over by different categories of members

Name of thana	Name of district	No. of meetings held	Meetings presided over by			
			MP	UP/UZ chairman	Others	Not specified
Dimla	Nilphamari	8	4	4	-	-
Joldhaka	Nilphamari	6	4	2	-	-
Mithapukur	Rangpur	8	3	4	-	1
Peergacha	Rangpur	6	1	3	1	2
Barura	Comilla	7	5	1	-	1
Laksam	Comilla	4	-	1	2	2
Daudkandi	Comilla	3	3	-	-	-
Chandina	Comilla	4	3	1	-	-
Total		**46**	**23**	**16**	**3**	**6**

TPC meetings held by year by district: Table 10 shows that the TPC meetings were held frequently in the initial part of the Project period, and the number gradually tended to decrease.

Table 10. TPC meetings held, by year

Name of thana	Name of district	Number of meetings by year				
		1995	1996	1997	1998	1999
Dimla	Nilphamari	1	4	2	1	-
Joldhaka	Nilphamari	-	2	2	2	-
Mithapukur	Rangpur	-	6	1	1	-
Peergacha	Rangpur	-	2	3	1	-
Barura	Comilla	-	4	2	1	-
Laksam	Comilla	-	4	-	-	-
Daudkandi	Comilla	-	1	2	-	-
Chandina	Comilla	-	-	4	-	-
Total		**1**	**23**	**16**	**6**	**0**

Agenda of TPC meetings*:* Content analysis of the meetings revealed that most agenda focused on formation of TPC, tender, procurement, construction, and renovation work. Other programmatic issues, such as supervision, monitoring, performance review, were not discussed (Appendix 4).

Factors Affecting Community Participation

Box 1 shows some factors affecting community participation.

Box 1. Factors affecting community participation

Status of thana managers: An invitation from the thana manager is not adequate motivation for many participants to attend a meeting. This is discouraging for the organizers.
Ambiguity in responsibility: The community representatives were not assigned any specific task to accomplish, and do not see any role for themselves in the forum other than just to 'attending the meetings.' So, they think that the thana managers can do everything, and can avoid attending meetings.
Political pressure: In general, the thana managers showed lack of interest in organizing meetings, because (a) MPs were not available to chair the meetings (as they were busy and seldom reside in the vicinity of their constituency); (b) they thought that MPs are powerful, and can take punitive measures against anyone; thus, the thana managers avoid communicating with MPs; (c) they thought that MPs tend to give undue benefit to men of their own party, but do not take the responsibility for these decisions during audit.
Lack of understanding between thana managers and other representatives: The thana managers' perception of the UP chairmen is that they often misuse funds provided to them by the government for different development activities in their locality. Thus, the thana manager do not want to involve UP chairman in financial issues.
Cost to participants: There is no provision for reimbursement of transportation costs for attending meetings. Members from far-reaching areas do not come to attend meetings at their own expense.
Lack of ownership by family planning staff: The TFIPP is a project of the Directorate General of Health Services. Under the present administrative set-up, the family-planning department at the thana level is under the supervision of THFPO who is a staff member of the health department. As a result, the family planning staff felt that they did not own the initiatives under the TFIPP.
Attitude of community representatives: In most meetings, agenda focused on the THC-related issues, particularly on procurement. Therefore, some community representatives lost their interest to participate in the meetings.

Discussion

The FIPP dealt with alternative management approaches, various modalities of participation of stakeholders, and large-scale experiments on local-level planning. A local-level planning is meant to convey the understanding of a planning process prepared, implemented, monitored, and evaluated at the level where the community and other stakeholders implement it. In the context of TFIPP, local-level planning was practised at the thana level in the name of FIAP, where an operational plan along with budget was developed and implemented in a participatory method. The process further percolated down to the union level in the name of UFIAP to ensure the participation of stakeholders at the grassroots level. In the HPSP, 12 thanas have been targeted as pilot sites for decentralization, and two districts have been chosen--one is a former TFIPP district, Nilphamari, and the another is a non-TFIPP district, Khustia (6). Under this pilot initiative, six thanas from each district were selected; a detailed situation analysis was carried out in each site; and a work plan, covering both short- and long-term was formulated.

Results of the study showed that, in the TFIPP project areas, all levels of staff had positive attitudes toward preparation of an annual action plan (FIAP). However, in many places, the thana managers reported that the implementation of action plan was hampered due to the delay in releasing funds. The thana managers anticipated to get more assistance from the FIT in the implementation of action plan. The thana managers also believed that, since the FIT members were not within the administrative structure, it was difficult for them to provide an expected level of assistance to the thana managers. The thana managers suggested for more involvement of district-level officials, e.g. CS and DDFP, in implementing and monitoring the action plan.

However, the study found that, in many places, the TPC meetings were not regularly held. The frequency of meetings held varied across thanas and districts. Although there was a target of 6 meetings, on an average, per year, the average number of meetings held per year ranged from 1.4 in Chittagong division to 2.3 in Rajshahi division. Sometimes the thana managers felt the difficulty in ensuring the continuous participation of community leaders, and feared getting involved in local politics. The UP chairmen did not often attend meetings which negatively influenced the participation of other members. Lack of orientation, motivation, and decision-making power and perceived less-important role in TPC meetings by the community leaders resulted in their low participation.

The community leaders often felt the need of more training on the health issues. The TPC members in the study thanas received orientation during the inception of Project. The members, who joined later, received no orientation.

Besides, the members did not receive any refreshers' training. A single one-day orientation might not be sufficient to motivate the community members to attend TPC meetings regularly and enable them to participate fruitfully in meetings. However, the experience of Pathfinder shows that well-planned orientation can contribute to activating the community representatives (7). In this initiative, the union population control committee members of 70 unions were oriented on the impact of population growth on land, housing, food, and on family-planning performance of their unions. Most of these union population control committee meetings held on a regular basis (7). For better functioning of TPC, the thana managers suggested for a smaller committee.

Analysis of the minutes of TPC meetings also revealed that attendance of some categories of members, such as NGO representatives and thana-level GoB officials, such as thana education officer or engineer, were very poor in each place. Therefore, selection criteria for members and size of the committee both are equally important. A smaller local committee could exhibit better performance. Assessment of the functional effectiveness of TPCs in the Project areas also suggested for a smaller committee (8). However, the study further reported that, in most places, documentation of meeting minutes was very poor, and the meeting agenda focused on renovation of the healthcare facilities and on the financial and logistic issues rather than on programme performance.

Training at all level is the most important component of the Project. Most managers, supervisors, thana and union-level service providers expressed that the training was relevant to their job, and were benefited from their respective training. Some of them received TOT training and trained others, which was a new experience for them, and enjoyed very much such a new role as teachers, which raised their confidence. The participatory methods followed in the training were highly appreciated by the participants. However, some participants thought that the duration of training was not enough to fulfill their requirements. The thana managers mentioned that transfer of trained staff shortly after the completion of training was a great problem in many places for which the programme suffered a lot.

In general, the service providers and supervisors appreciated the strong record-keeping system implemented by the Project. Although the union-level providers and supervisors thought that their workload increased since the inception of the Project due to increased monitoring and supervision of the higher-level authority, they could perform their activities in a systematic way due to the regular record-keeping system.

The service providers observed a number of service-related changes during the project period. The thana and union-level providers mentioned that client flow increased at the service centres during the Project period due to better supply of equipment, medicines, and provision of ambulances. They

believed that, another reason for increased client flow was better treatment provided from the service centres. For example, the family-planning staff were trained in clinical methods of contraceptives, and were providing this specific service to more clients since the Project was implemented. It was commonly mentioned that the community leaders, volunteers, and trained traditional birth attendants performed as the link persons between the community and the service-delivery centres who used to refer clients from their locality, and thus, client flow increased at the centres. They thought that the introduction of user fees at outdoors reduced the misuse of medicines by decreasing the number of false patients. Another common observed change in indoor, outdoors, FWCs, and satellite clinics was the arrangement of regular health-promotion sessions for the clients and the attendants of patients. The thana-level service providers believed that hospital delivery increased during the project period by many means. The TFIPP was increasingly promoting hospital for complicated deliveries, and due to establishment of a referral mechanism, people became aware of complications resulting in increased hospital deliveries. Both service providers and clients observed noticeable changes in the supply of new equipment, building repairing, cleanliness in the centres, privacy of patients, seating arrangements, toilet facilities, and decoration of centres with posters and charts. However, some service providers complained about the wastage of money due to lack of coordination between thana and central-level management. For example, some equipment, installed in Thana Health Complexes were difficult to operate due to the non-availability of a skilled person at that level.

The issue of "team building approach" under the TFIPP was considered an important initiative. The union-level staff reported that, during the Project period, the union-level meetings took place regularly, which increased coordination between the staff of health services and the family-planning directorates. There was an increased demand for implementing the union-level action plan by the local leaders, which is encouraging from the programmatic point of view. At the thana and district levels, the team approach would also function better if there were more strong initiatives to involve the district-level authority by the TFIPP and synchronization with the GoB procedures. The ongoing legal matters of thana management relating to merging of staff from the two directorates were often barrier to coordination between the two wings.

The provision of financial and logistic supports was a key factor to ensure the formulation and monitoring of action plans. The service providers suggested a more transparent procurement mechanism and an effective feedback mechanism for all levels of staff and also a rewarding system for better performance of staff. For proper auditing mechanism, an auditing guideline for user fees should be developed. A procurement and fund-management procedure manual should also be available to spell out the procedures for supply of cleaning materials, reagents for laboratory and

radiology, medicines, formats, and registers to the different service units of THC.

The TFIPP working paper no. 10 elaborately discussed the issue of introduction of user fees at the THCs and suggested for developing a mechanism of financial management (9). There was no tradition of involving the community representatives in formulating and implementing the local action plans. If the managers and service providers lack interest, and are not sufficiently motivated in community participation, it is impossible to have local-level planning in a true sense. A review of interventions promoting local-level planning and coordination of ESP services also found that success of such interventions is mostly determined by the commitment and skills of thana managers (10). However, the involvement of the community must be genuine, not just token. Although the community volunteers intended to keep up their voluntary support to the community even if the Project activity closes down, they anticipated regular communication with the health service centres. Efforts to ensure community involvement may require clearer terms of reference for the committees and more comprehensive orientation for the community representatives and for the managers themselves.

Best Practices of TFIPP

Planning at local level: The TFIPP promoted the development of annual action plan, named as Functional Improvement Action Plans (FIAP), at the thana and union levels. The process involved identification and assessment of the areas to be improved, and implementation of necessary action through supervision and guidance of a local committee.

Involvement of community: A vital component of TFIPP was the community participation. The selected community representatives, including elected MP, UP chairman, and local elites, were involved in the activities of TFIPP. The community showed interest to be involved in such activities to enhance their social status. This process helps educate the community, sensitize them about their needs, make them aware of the local problems, and establish links between beneficiaries and providers through referral networks.

Training at all levels: At all levels, the TFIPP was one of the most important components of the Project. A Thana Training Team (TTT) was formed with THFPO, TFPO, and other thana-level staff at each THC to impart training to staff at the thana level and below. The TFIPP constructed a training centre at each thana, and equipped it with necessary furniture and equipment. It opened the scope of training for staff at the thana level and below on technical, managerial and communication skills as an alternative to rarely attainable institutional training provided at formal institutions, such as National Institute of

Population Research and Training (NIPORT) and Family Welfare Visitor Training Institute (FWVTI). Even the sweeper and guards of THC, who never thought of attending in any training, received such training. The training boosted their morale and enhanced their commitment to work.

Provision of equipment and furniture: The Project provided equipment and furniture for THC and union outlets which ensured access of the community to better facilities and to receive quality services. It also helped in proper maintenance and safe preservation of logistics, and extended comfort to clients**.**

Transportation: The TFIPP provided ambulances to THC which helped manage emergencies. Besides motor cycles and bicycles, provided to the managers and service providers, were very helpful for their mobility, which enhanced monitoring and supervision.

Local procurement and minor doable repairs: One important aspect of the project input was provision of local procurement and minor doable repairing of THC and union-level outlets.

Revolving drug fund: A revolving fund amounting to Tk.55,000.00 was provided to selected upazilas to procure drugs from retailers and sell them to IPD patients at a reasonable price. This measure ensured emergency medicines to clients, and was one of the steps attaining sustainability.

Information, Education and Communication (IEC): The TFIPP carried out extensive IEC activities. Pictorial wall painting describing health messages, services, and timing of services at health outlets was attractive, easy, and comprehensible for even illiterate persons.

Lessons Learned

- Most managers, supervisors, and thana and union-level service providers found the training they received from the TFIPP relevant to their job and useful. It establishes that the training arranged at the local level could be of great satisfaction and productive
- Transfer of the trained staff to outside the project areas was a common problem in many places for which the Project highly suffered
- Although the union-level service providers and supervisors thought that their workload increased during the project period because of increased monitoring and supervision of the higher-level authority, they believed that they could manage to do the activities in a systematic way due to a regular-record keeping system

- During the project period, both service providers and clients observed management and service-related positive changes
- All levels of staff had positive attitudes toward the preparation of an annual action plan locally
- In many places, the thana managers reported that the implementation of the action plan was hampered due to the delay in releasing funds
- The thana managers anticipated to get more assistance from the FIT in implementing the action plan, and suggested for more involvement of the district-level officials in implementing and monitoring the action plan
- The service providers suggested for a more transparent procurement mechanism and an effective feedback mechanism for all levels of staff and for a rewarding system for better performance of the staff
- The local leaders strongly emphasized quick implementation of the action plan, which reveals their interest in involving themselves with development activities
- The community volunteers anticipated regular communication with the health service centres
- Lack of adequate training and motivation, lack of decision-making power, and perceived less-important role in TPC meetings resulted in low participation by the community representatives
- Absence of follow-up training may bring slackness among all concerned
- A concrete plan for use of revenues generated by the TFIPP project has to be in place to fill-up the gap caused by withdrawal of TFIPP support.

Possible Strategies to Ensure Increased Community Participation

The following strategies are put forward for adopting to increase community participation.

- **Authority**: The representatives of the community should have authority to endorse budget, bring modifications to proposal, and examine quarterly progress reports. They should have an increased scope to express their feelings and concerns.
- **Responsibility**: The community representatives should be assigned specific task, so that they are aware of their specific roles. These tasks could be identified during the preparation of the action plan.

- **Valued role of the community representatives**: The community representatives should be invited to attend all health-related occasions, such as National Immunization Day (NID), National Population Day, or any other occasions observed at the thana level and, thus, make the representatives feel honoured.
- **Orientation and refresher training for community representatives:** Orientation of the TPC orientation should be expanded. Training curriculum should be developed to orient community representatives with emphasis on programmatic issues, i.e. objective, inputs, desired outcomes, monitoring and supervision, and responsibilities of community representatives. Refresher's training/orientation, should also be arranged for community representatives for their better performance.
- **Change of attitude:** The community representatives do not attend meetings assuming that the hospital authority does not welcome them. Therefore, the thana managers should be more accommodative.
- **Composition of committee:** A committee at the thana level should be formed carefully with members who are willing to attend meetings regularly and who are available. It was observed that MP was not always available if he does not live in the vicinity of his constituency. Under such circumstances, the upazila chairman or TNO should perform as chairman of the thana-level committee.
- **Incentive:** Provision for reimbursement of actual transportation cost for attending meetings might increase the participation of community representatives.

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Appendix 1

Members of National Steering Committee, Technical Advisory Group, and Thana Team

- **Composition of National Steering Committee**

1. **Chairperson:** Secretary, MOHFW

Members:

2. Director General, Health Services
3. Director General, Family Planning
4. Director General, National Institute of Population Research and Training
5. Director, National Institute of Preventive and Social Medicine
6. Joint Secretary, Health
7. Joint Secretary, Family Welfare
8. Deputy Chief, Health
9. Joint Chief, Planning Commission
10. Joint Secretary, Economic Relations Division
11. Director, Maternal and Child Health
12. Representative of European Union
13. Representative of World Bank

- **Composition of Technical Advisory Group**

1. Civil Surgeon
2. Deputy Civil Surgeon/MNO (Civil Surgeon Office)
3. RMO of District Hospital
4. Deputy Director Family Planning
5. Assistant Director, Clinical Conception, Family Planning
6. Executive Engineer, Directorate of Public Health Engineering
7. Executive Engineer, Construction, Maintenance and Management Unit
8. Senior Health Education Officer
9. Principal of Family Welfare Visitor Training Institute/Medical Assistant Training School in the district
10. District Public Health Nurse
11. FIT member

- **Thana Team (TT)**

1. Thana Health and Family Planning Officer
2. Thana Family Planning Officer
3. Medical Officer, Disease Control
4. Medical Officer, Maternal-Child Health
5. Residential Medical Officer
6. Other Medical Officers (MOs)
7. Thana-level supervisory staff

Appendix 2

Members of Thana Project Committee

Composition of Thana Project Committee

Chairman:	Local Member of Parliament
Vice-Chairman:	UP Chairman of Thana or Chairman of UP Council
Secretary:	Thana Health and Family Planning Officer
Members:	Thana Family Planning Officer or Assistant Thana Family Planning Officer
	Medical Officer, Maternal-Child Health or Senior Family Welfare Visitor
	Residential Medical Officer
	Medical Officer, Disease Control and Management Information System
	Senior Staff Nurse
	Health Inspector
	Sanitary Inspector
	One non-medical staff (President of 3rd/4th class employee association)
	Thana Nirbahi Officer
	Sub-Assistant Engineer, Directorate of Public Health Engineering
	Thana BRDB Officer
	Thana Engineer
	Thana Education Officer
	Thana Ansar and VDP Officer
	Three UP Chairmen
	Three NGO/Social workers
	Three local elites
	One FIT member

Appendix 3

Participation in Thana Project Committee meetings by category of members

Category of participants	Comilla district				Total	Rangpur district		Nilphamari district		Total	Grand Total	Percentage
	Daudkandi	Chandina	Laksam	Barura		Mithapukur	Peergacha	Dimla	Joldhaka			
Community Leaders												
MP	3	3	0	4	10	3	2	4	4	13	23	3
Chairman	8	9	5	9	31	12	17	10	18	57	88	11
Others	14	5	8	14	41	25	6	5	22	58	99	13
Total	**25**	**17**	**13**	**27**	**82**	**40**	**25**	**19**	**44**	**128**	**210**	**27**
Thana Manager	12	10	11	20	53	27	17	21	17	82	135	17
Thana Supervisor	21	12	20	32	85	38	17	37	20	112	197	25
Officials (others)	10	11	12	21	54	23	16	27	14	80	134	17
NGO representatives	2	3	2	7	14	5	3	8	6	22	36	5
Support staff	6	3	1	11	21	18	5	8	4	35	56	7
FIT member/TAG	1	5	1	2	9	4	0	3	5	12	21	2
Total	**52**	**44**	**47**	**93**	**236**	**115**	**58**	**104**	**66**	**343**	**579**	**73**
Grand total	**77**	**61**	**60**	**120**	**318**	**155**	**83**	**123**	**110**	**471**	**789**	**100**
No. of TPC meetings held	3	4	4	7	17	8	6	8	6*	28	46	29
Average attendance	26	15	20	17	-	19	14	15	18	-	-	-
Planned meetings	19	19	19	19	76	19	19	23	23	84	160	

*Excluding 5 meetings of tender committee

Number of agenda discussed in meetings of Thana Project Committee

Agenda discussed	Chandina	Daudkandi	Barura	Laksam	Peergacha	Mithapukur	Joldhaka	Dimla	Total
- TPC: formation, TOR, reorganization	7	0	14	2	1	2	1	3	**30**
- FIAP: discussion on draft, approval	1	2	1	0	0	1	7	1	**13**
- Budget: estimate, modification, approval	3	2	3	1	2	3	3	9	**26**
- Tender: formation, call tender, terms and conditions for bidders	5	1	7	0	4	5	4	4	**30**
- Construction/repair of building, facilities	6	4	1	0	5	4	6	4	**30**
- Procurement of supplies: stationeries, equipment, reagents, etc.	2	5	3	0	6	3	2	11	**32**
- Vehicles: use, maintenance, etc.	1	2	1	0	2	4	1	5	**16**
- Report on cost incurred	1	0	2	0		1	0	4	**8**
- Additional demands made to authority	0	3	1	0	0	4	0	1	**9**
- Approval of last meeting minutes	3	1	7	0	0	0	1	1	**13**
- Management/disciplinary	0	2	2	0	0	0	2	4	**10**
- Miscellaneous (gardening, banking, etc.)	0	0	2	0	1	1	2	0	**6**
- Programmatic service-related	2	2	0	1	1	3	2	0	**11**
- Training of staff and community leaders	1	1	0	1	0	0	0	0	**3**
- Supervision and monitoring of field activities	1	1	0	0	0	4	0	0	**6**
- Pricing/sustainability	0	0	1	0	1	2	6	2	**12**
Total	**33**	**26**	**45**	**5**	**23**	**37**	**37**	**49**	**255**
No. of total meetings	4	3	7	4	6	8	6	8	46
Average no. of agenda per meeting	8,3	8,7	6,4	1,7	3,8	4,6	6,2	6,1	5,7