

Working Paper No. 120

TRAINING EXPERIENCE IN DOMICILIARY INJECTABLE CONTRACEPTIVE SERVICES IN THE NATIONAL FAMILY PLANNING PROGRAMME

MCH-FP Extension Project (Rural)
Health and Population Extension Division

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ABSTRACT

The experience of ICDDR,B in Matlab, Abhoynagar and Sirajganj shows that injectable contraceptives can be provided safely by the female family planning field workers (FWA) in the homes of clients. This has led to a two- to three-fold increase in the use of injectables which has resulted in a substantial increase in the contraceptive use rate. This successful intervention led to the decision by the Family Planning Directorate of the Government of Bangladesh to expand and test the home-delivery of injectables in rural *thanas* at the static delivery sites: Family Welfare Centres and Satellite Clinics by female paramedics, known as Family Welfare Visitors (FWV).

This study was conducted to assess the training, logistics and management needs of the door-step injectable programme in the government setting for further expansion.

For the implementation of door-step injectable services by the field workers, training is one of the most crucial components. The field workers and their supervisors must be well trained in all aspects of door-step injectable services. The concept of bringing trainees individually to the training centres for training needs to be revised. The scoring system used for judging the quality of training is very important in this regard, and thus, needs to be further improved.

For implementing and expanding the domiciliary injectable programme, training of managers and field workers can be conducted in districts. These districts can serve as a basis for further training in new areas.

INTRODUCTION AND BACKGROUND

The injectable contraceptives, Depot Medroxy Progesterone Acetate (DMPA) and Norethisterone Enantate (NET-EN), have been found to be effective contraceptive methods which are used by women all over the world. The failure rate for injectable contraceptive is less than 1 per cent which is comparable only to sterilization (1-3). In rural Bangladesh, injectables are offered to women at the static delivery sites: Family Welfare Centres and Satellite Clinics by female paramedics, known as Family Welfare Visitors (FWV) (4). Although this method is gaining popularity, its use still remains low in the government programme; less than six per cent of the women use injectables (5-6).

The experience of ICDDR,B in Matlab, Abhoynagar and Sirajganj shows that injectable contraceptives can be provided safely by the female family planning field workers (FWA) in the homes of clients (5,7,8). This has led to a two- to three-fold increase in the use of injectables which has resulted in a substantial increase in the contraceptive use rate in these areas (7). This successful intervention led to the decision by the Family Planning Directorate of the Government of Bangladesh to expand and test the home-delivery of injectables in rural *thanas*.

The ICDDR,B's MCH-FP Extension Project (Rural) offered technical assistance to the Directorate of Family Planning in planning, monitoring and evaluating this test expansion in eight *thanas*.

Objectives of Test Expansion

The objectives of the test expansion were as follows:

1. To understand the capacity of the government programme to handle this new mode of service delivery with minimum support from an outside agency.
2. To understand the training, logistics and management needs of the door-step injectable programme in the government setting.
3. To create training bases for further expansion.

Mechanism of Implementation

The mechanism of implementation was as follows:

The district and *thana*-level officials of the Family Planning Directorate were first trained as trainers in the *thanas* where the ICDDR,B's MCH-FP Extension Project (Rural) has field sites. In the two Project sites, Abhoynagar and Sirajganj, ICDDR,B works in collaboration with their government counterparts. The government field workers, Family Welfare Assistants (FWA), have been providing injectable contraceptives in the homes of clients for over a decade. The purpose of providing training in these two *thanas* was to allow the *thana* managers of the eight test sites to get acquainted with the practical aspects of the service-delivery mechanism. The *thana* managers of Abhoynagar and Sirajganj themselves could describe their experiences.

The managers once trained went back to their respective *thanas* and started training their field workers. The training of the field workers was held in their own *thana* to enable them to raise their problems, discuss the situation in groups, and identify practical solutions. This implementation process is different from the existing training mechanism whereby workers are brought individually to a regional training centre for training.

Once the training was completed and supplies were ensured, the programme implementation started immediately. The domiciliary injectable programme was designed to allow the field workers to provide injectables in the homes of clients, so that women can have a wider choice of contraceptives. The screening for the selection of injectable clients was done by the paramedics at the Family Welfare Centres or at the Satellite Clinics. The subsequent doses of the contraceptives could be provided by the field workers at the homes of the clients.

Objectives of the Paper

This paper presents the findings of the training activities needed for implementing domiciliary services of injectable contraceptives in the National Family Planning programme. The paper is divided into three main sections: The first section briefly outlines the categories of training provided and the second section describes and discusses each category of training. The final section concludes the paper, highlighting the main recommendations.

TRAINING SESSIONS

This section presents a brief description of the training sessions which were conducted for implementing domiciliary injectable services. These sessions were based on the experience of the MCH-FP Extension Project (Rural) of ICDDR,B (9).

Orientation Session of Divisional Directors and Deputy Directors

The Divisional Directors and the Deputy Directors of the concerned eight districts were provided a one-day orientation on door-step injectable services and the training and implementation plan during a workshop at the MCH-FP Extension Project (Rural) sites. The orientation session also included a field visit to observe the injectable programme at the site where the domiciliary programme has been going on. Thus, the officials were given practical experience with the service-delivery mechanism.

Training of Trainers

The Family Planning Directorate and ICDDR,B jointly organized a **5-day Training of Trainers (TOT)** on door-step service delivery of injectables in Abhoynagar and Sirajganj for the officials of the eight test sites. The participants of the TOT session were: *Thana* Family Planning Officer (TFPO), Medical Officer, Maternal Child Health (MO-MCH), Senior Family Welfare Visitor (Sr.FWV), Assistant Family Planning Officer (ATFPO) of the concerned *thanas* and Assistant Director, Clinical Contraceptives (AD-CC), Medical Officer, Clinical Contraceptives (MO-CC), and Assistant Director, Family Planning (AD-FP) of the concerned districts (Annexure 1). The *thana* officers did not all come at the same time. One officer remained at the *thana* to run the *thana* activities and joined the next training session. Twelve officials - six from each of the two *thanas* - received training in one session.

Training of Field Workers

After attending the TOT workshop, the officials returned to their respective *thanas* to train the members of their field staff: the field workers, Family

Welfare Assistants (FWA), the supervisors of the field workers, Family Planning Inspectors (FPI), and the paramedics, Family Welfare Visitors (FWV). The training sessions were conducted in the *Thana* Health Complex. The duration of the training was 4 days. Training in each *thana* was completed in 3 sessions with 20 to 25 participants in each session. These training sessions were arranged within one month of completion of the training of trainers, so that the trainers could retain and impart the lessons learned to their trainees.

The *thana* officials were responsible for organizing, monitoring and evaluating these training sessions with the assistance from ICDDR,B. Training materials were designed by the collaborating partners, while the injectable manual for field workers was provided by ICDDR,B.

Refresher Training of Trainers

A mid-term evaluation was carried out six months after the initiation of the intervention. The results of the mid-term evaluation showed that although women were accepting injectables as a contraceptive method, there was a sharp decline in the continuation rate after six months of use. This indicated that the users were dissatisfied with the method and hence discontinued its use. The evaluation also showed that the dropouts occurred due to side-effects complained by the users.

To refresh the memories of the trainers, particularly on side-effects and their management, a refresher training was organized in the eight districts after the completion of six months of the implementation phase. It was expected that the trainers would go and train their field workers on the deficiencies raised in the workshop. The one-day TOT workshop was attended by the Deputy Director, Assistant Director, Clinical Contraceptives (AD-CC), Assistant Director, Family Planning (AD-FP), Medical Officer, Clinical Contraceptives (MO-CC), *Thana* Family Planning Officer (TFPO), Assistant *Thana* Family Planning Officer (ATPFO), Medical Officer, Maternal Child Health (MO-MCH), Medical Officer Family Welfare (MO-FW) and Senior Family Welfare Visitor (Sr. FWV). The main focus of the training was to refresh the knowledge of the participants on participatory learning methodologies for training sessions on door-step injectable services. Role

plays were conducted by the trainers on various teaching situations needed for training the field workers on injectable contraceptives. A display of results on the quality of care of door-step service was also shown to inform the participants about the problems noted in the field. Discussions were held on common misconceptions at the field level.

Refresher Training of Field Workers

A one-day refresher training of the field workers was conducted in eight *thanas* after the completion of 6 months of the implementation phase. The trainers who received TOT conducted these sessions. Each session, attended by the field workers, their supervisors, and the paramedics, was limited to 15 participants to ensure better communication among the trainers and trainees. It is to be noted that in these training sessions, the male paramedics, Medical Assistants (MA), were included for the first time in the door-step injectable programme. Their inclusion was based on the fact that MAs provide injectable contraceptives to clients from FWCs, especially on days when FWVs attend the Satellite Clinics. Training of MAs on injectables was also a recommendation of the mid-term evaluation on door-step injectable services conducted earlier (10).

Training of NGO Staff

At the request of the Directorate of Family Planning, training on door-step injectable services was also provided to the colleagues of NGOs. Two medical officers of Pathfinder attended TOT for the government officials as observers. In addition, two sessions of TOT for Family Planning Management and Development (FPMD) were also conducted in the month of April 1993. Furthermore, a two-day TOT for the Clinical Master Trainers was provided in October 1993 which included a field visit to Sirajganj to actually observe the service-delivery mechanism. The trainers of the Bangladesh Rural Advancement Committee were oriented in September 1994. In addition, during the refresher training of the government *thana* and district trainers, members of the NGO staff were also invited to attend the training sessions.

DESCRIPTION AND DISCUSSION OF TRAINING SESSIONS

This section presents the results and discussions of various sessions of training provided for testing and implementing the door-step injectable programme. Instead of providing a detailed description of the individual training sessions, the salient features of each category of training are discussed here, followed by recommendations.

Orientation Session of Divisional Directors and Deputy Directors

As the name implies, this session was not a training session in the traditional sense. The session for the divisional directors and deputy directors was meant to be a discussion session to make the senior managers of the programme aware of this new mode of service delivery. This step is essential to begin any new initiatives, so that the full support and cooperation of the leaders can be obtained. Support of these senior managers is critical for supervision and for reinforcing the activities among the mid-level managers and the field workers. In addition, their participation is needed to ensure the provision of logistics needed, such as supply of DMPA, NET-EN, cotton, spirit, syringes, etc. Discussion of the injectable contraceptives, DMPA and NET-EN, also helped communicate the latest information available on this topic and to clarify misconceptions.

The participants were able to ask critical questions, such as: What types of problems are encountered in offering door-step injectable service? How can these problems be solved? How many injectable users have switched from other methods due to the availability of door-step service? What is the continuation and dropout rates of injectables when they are provided in homes? How do FWAs manage side effects?

These questions were discussed in detail, so that a clear picture of the situation could be drawn. Various publications on these issues were provided, so that source of information could be validated (11). A detailed implementation plan was presented to the participants, including the responsibilities of the managers and field workers. Discussions were also

conducted on the dangers of re-use of the used injectable syringes and needles (12). A circular sent by the DG (FP) on this issue was noted. Monitoring issues were also raised as it was critical that the pilot study be monitored continuously.

Proposals were made to send projected supplies needed for injectables to the Central Warehouse, so that necessary arrangement can be made for logistics and supply. Recommendations were made to send a special request to the Central Store for procurement of injectables, so that a regular supply and bufferstock could be maintained at the *thana* level.

The participants put forward their suggestions for making the door-step service successful. These suggestions include: provision of one type of injectable in each *thana*, ensuring proper supply and logistics in door-step injectable areas, maintenance of a bufferstock, allowing FWAs to administer first and subsequent doses, and proper monitoring, evaluation and allocation of spirit and cotton for the door-step injectable programme.

Recommendations

1. The orientation session for Divisional Directors and Deputy Directors should be held in each district to create awareness among the participants about door-step service and to seek their cooperation in implementation.
2. Published articles, journals, etc. should be provided to the participants to validate the sources of information.
3. Discussion on the regular supply of injectables, disposable syringes and needles, cotton, spirit/savlon should be conducted in the orientation session, so that the supply does not pose a problem in future.
4. For maintenance of a regular supply of logistics, the Supply Officer of the Regional Warehouse should be invited as a participant.

Training of Trainers

The objectives of the training of trainers were to:

1. Acquaint the participants with training methodology.
2. Encourage participants on effective techniques for participatory learning.
3. Discuss the basic concepts of injectable contraceptives.
4. Discuss the record-keeping, supply, logistics and supervision needed for door-step injectable services.
5. Arrange practice teaching sessions on door-step injectable services.
6. Discuss barriers and probable solutions of providing door-step injectables.

Course contents

The following contents were covered in the 5-day TOT sessions:

- Training methodologies
- Responsibilities of trainers
- Basic concepts of injectable contraceptives
- Record-keeping
- Motivation, counselling and screening
- Supply and logistics
- Reporting
- Monitoring
- Discussion of Hand Book on Injectable Contraceptives
- Discussion of Field Workers training
- Problems and probable solutions

After discussion, the participants offered various suggestions for the successful implementation of door-step services of injectable contraceptives. These suggestions include: provision of one brand of injectable, ensuring regular supply and logistics, allocation of spirit and cotton for the door-step injectable programme, destruction of used disposable syringes at the FWC level in presence of FPI, MA, and FWV, provision of injectable client cards, incorporation of training methodologies and latest information in the injectable manual and injectable hand book, filling up vacant positions, and a policy to restrict transfer of the concerned thana and district officials from the eight test sites.

These issues were discussed at the Injectable Steering Committee meeting, and most of them have been resolved.

Resource persons

The resource persons were the government *thana* officials of the Rural Extension Project sites, Sirajganj and Abhoynagar, ICDDR,B officials, and a few guest speakers, including professional trainers.

Training materials

The following materials were used for TOTs:

- TOT manual
- Handbook on injectable contraceptives
- File and rule pad
- Handouts and posters on injectable contraceptives
- Black board, brown paper, white board

The Trainer's Manual and the Hand-Book on Injectable Contraceptives have been revised based on the recommendations and suggestions received at the training sessions. The recommendations put forward include more information on training methodologies, preparing training schedules, new government circulars, latest technological updates, etc. The Trainer's Manual and the Hand-Book have been combined and

revised, which allows the trainers to prepare the teaching sessions for the field workers more efficiently. The Trainer's Manual provides comprehensive guidelines for conducting training on injectables. Training methodologies needed schedules, contents, practical sessions, etc. have all been incorporated. New topics, such as disposal of used syringes and needles, client cards, etc., have been added to the revised manual. Sections on client motivation, communication skills, etc. have been elaborated in the latest version.

Pre- and post-tests

Pre- and post-tests were conducted in each session to assess the effectiveness of the training sessions. The same questionnaire was used for both the pre- and post-tests. A standard answer sheet was used for calculating the scores. The questionnaire contained both structured and unstructured questions. The question sheet was provided to the trainees in the first session. The same questionnaire was used again after the end of training before closure. The results of the pre- and post-tests are presented in Fig. 1 and Annexure 2.

The pre-test results of the trainers show that although injectable contraceptives have been available in the programme for more than a decade, none of the district and thana managers could score more than 45%. The pre-test also included questions on training methodology. The average pre-test score was 33. ATFPOs scored 22% and Senior FWVs 25%, the lowest score among the trainers. AD (CC) had the highest score at 45%. These results indicate a need for training of the mid-level managers on injectable contraceptives for all types of service-delivery mechanisms, both for door-step and for static clinic systems.

After the training, the average score almost doubled from 33% to 61%. ATFPOs benefitted most from this training as their scores increased more than two-folds. However, the average of the participants score was less than 70.

Discussion

The experience of conducting training of trainers raises many critical issues related to training in the government family planning programme. In the existing set-up, the capacity of *thana* managers has not been developed into trainers. There is no system of training field workers in their own *thanas*. After the initial training, the field workers and paramedics are sent to the central training institute (NIPORT) or to the Regional Training Centres in districts (RTC) for refresher training. Trainees are brought individually for training sessions.

The training process implemented during the introduction of domiciliary injectable contraceptives has shown that *thana* managers can be trained to provide training to their field workers. This mechanism is very useful in developing need-based curriculum. Although cost analysis has not been done, it is expected that training field workers within their own *thanas* can be less expensive than bringing workers to other districts. Furthermore, the *thana* managers can provide training on different topics based on the needs of the workers. New topics, such as introduction of domiciliary injectable services by the field workers, could be introduced more easily to workers in their own *thanas* than to individual workers at the district level training centres.

The mechanism raised above needs further discussion. The test scores indicate that the training methodologies used for training of trainers may need further improvement. This also raises another important issue: whether all officials can develop necessary skills to be an effective trainer. If the answer is no, then we need alternative solutions for providing training. One solution may be the formation of a group of core trainers in each district under the Directorate of Family Planning who could provide training on any aspect of family planning service when needed in the district. This would also be very useful for dissemination of new information to providers in *thanas* and districts as a team, instead of calling them to the capital city individually.

Recommendations

The following recommendations are made for training of trainers on door-step injectable contraceptives:

1. Thana managers should be trained as trainers, so that they can conduct training within their own thanas.
2. The district and thana managers should be trained on injectable contraceptive irrespective of the type of service-delivery mechanism (for both door-step and for static clinic service).
3. Training of trainers must be conducted for five full days and must include field trips, teaching sessions, and adequate training materials.
4. Participants should not exceed 15 members per session as free interactions between the trainer and trainee are essential for effective teaching. Emphasis must be placed on the participatory teaching methodologies.
5. The trainers must be encouraged to design their own training materials which they can use at the thana level. Use of black board and brown paper needs to be encouraged.
6. Published documentation must be supplied to validate and offer the latest information on the topics concerned.
7. Pre- and post-tests must be conducted, so that the trainers and the trainees know if information has been well received. The trainers must have discussions at the end of each day to clarify and provide further information to the trainees in the next session.
8. A group of officials from different thanas of a district who have the ability to train may be developed as core trainers in each district. This team will provide training on any topic of family planning service delivery in the district. They can also offer refresher training when needed. This will save money and time for the thana and district officials, as well as keep the providers informed of latest information.

Training of Field Workers

Field workers were provided a four-day training in their respective thanas. The list of the participants is attached in the Annexure 3.

Resource persons

The *thana* and the district managers trained as trainers on domiciliary injectable services were the trainers. The ICDDR,B officers also assisted the government officials. The training of the field workers was conducted in their own *thanas* by their managers.

Injectable handbook for field workers

The injectable handbook for the field workers was provided to the trainees. The handbook includes essential information for the field workers needed for provision of injectables. The topics are: basic information on injectables, motivation, counselling, screening, side-effects management, supply, record-keeping, etc. Following discussion with the field workers and the trainers, it was decided to revise the manual and make it more user friendly and include the latest information available. New chapters on client cards and disposal of used syringe and needle have been incorporated.

Pre- and post-tests

A questionnaire was designed to conduct pre- and post-tests. The same question sheet was used for pre- and post-test. A standard answer sheet was used for calculating the marks of pre- and post-tests. The average scores obtained by the field workers is presented in Fig. 2.

Of a possible of 100, the average pre-test scores attained by all cadres of field workers were less than 40 points. The mean score of the FWAs was less than 25. An alarming figure is the poor pre-test scores of FWVs (less than 40) who have been providing injectables to clients for over a decade from FWCs and Satellite Clinics. This indicates that FWVs must be trained on injectables, irrespective of the mode of service-delivery mechanism.

Compared to their trainers, the field workers appeared to have benefitted more from the training. Although their knowledge increased more than two-folds, the average post test score of FWA was 55, while FWVs was over 65 and FPI 60. The questions which had the poorest scores both before and after training were those related to side-effects and their management.

Preparation for training

Experience of the field workers training showed that the preparations needed for conducting of training were not adequate. Training dates were not always well planned and, as a result, different training schedules or other events often coincided with the training. The trainers sometimes did not prepare training materials or prepare themselves before training. If the planned time schedule is not carefully adhered to, important issues and discussions may not be covered due to lack of time. An early start in the morning, however, may not be a good idea as many field workers and trainers come from remote areas which have poor transport facilities.

Discussion

The training of field workers can be conducted by managers within their own *thanas*. This has many added advantages. Since the workers are from the same area, they can seek solutions and discuss with the supervisors who are their trainers. Spending four days in the training allows the managers to get to know their workers well. However, pre- and post-test scores of the field workers are not very high. This raises questions about the scoring system adopted here. The scoring was based on a questionnaire completed by the participants before and after the training. Many of the questions were unstructured, which causes scoring ambiguity. This limitation prevents objective judgement of the trainees. Other mechanisms of assessing the quality of training, such as responsiveness of the trainees, training methodologies adopted, quality of the trainers, etc. need to be examined further. The quality of trainers is an essential component of training. As discussed earlier, not all the managers who received TOT can be good trainers.

Another issue regarding implementation of the programme is what must be the minimum score of the trainees before they can be allowed to offer injectables at homes of clients. This issue cannot be resolved in the current methodology. However, to further increase the knowledge of field workers, improved training methodologies need to be used, and refresher training has to be organized. It may not be possible to assimilate too much new information at one time. Thus, in-service training and spot training by the supervisors can enhance the level of knowledge.

Results of discussions during and after the training as well as with the staff of NGOs suggest that a four-day training is not sufficient for training the field workers. A minimum of five days is required with more time for practical sessions on administering injections for the field workers.

At the training sessions, the trainees and the trainers made several suggestions, including filling vacant positions, avoiding transfers of master trainers from eight injectable *thanas* and providing adequate supply of logistics.

Recommendations

The experiences of conducting field workers training in eight *thanas* lead to the following recommendations:

1. Field workers should be trained on injectables within their own *thanas*.
2. Field workers should have five days' training with more time for practical sessions.
3. The field workers manual should be carefully followed by the trainees and the trainers.
4. Training schedules should be prepared well ahead of time in consultation with all concerned *thana* officials. For each session, more than one trainer should be present.

5. Training materials must be well prepared before starting the training programme. Materials should be made with whatever is available at the thana or union level, such as brown paper or black board, chalk, etc. It may be useful to prepare training materials centrally for distribution among the trainers of thanas.
6. A standard answer sheet should be prepared and circulated among the trainers to analyze the pre-/post-tests.
7. Practical sessions must be well conducted, so that the field workers can practise administering injections. Injections can be practised on vegetables. Trainers must prepare a check list of each of the steps necessary to administer an injection and grade the trainees on the basis of their performance. Errors must be discussed in the class.
8. Training dates must be planned well ahead of time, so that different training schedules or other events do not coincide with the training. As many field workers and trainers come from remote areas which have poor transport facilities, training sessions should not begin early in the morning.

Refresher Training

A one-day refresher training was held after six months of implementation of door-step injectable services. Many of the trainers had been transferred and, hence, the one-day training may not have been very useful to them. The difference in the knowledge of the participants who had received basic training compared to those who did not was obvious. This gap also made the session very difficult to conduct.

Based on observation conducted during the six months of door-step services, emphasis was given to side-effects management, counselling and follow-up in both field workers training and training of trainers. However, it became evident in the training sessions that a one-day refresher training was not sufficient. The participants also suggested a minimum of two days' training session.

Recommendations

The following recommendations are made based on the experiences of training in eight thanas:

1. Every six months, a minimum of two-day refresher training should be provided for trainers and for field workers.
2. Like the basic training, refresher training should also be held for teams instead of individuals.
3. Emphasis on follow-up, counselling, and side-effect management is essential.
4. Transferred staff who had not received basic training must be first oriented by other trainers before they attend a refresher training.
5. There must be sessions to discuss field problems.

CONCLUSIONS

The paper attempts to document the training activities undertaken for the implementation of domiciliary injectable contraceptives. It does not, however, relate the training activities to the performance of the field workers in implementing the programme.

For the implementation of door-step injectable services by the field workers, training is one of the most crucial components. The field workers and their supervisors must be well trained in all aspects of door-step injectable services. The field workers and the *thana* trainers must receive five full days of training. The duration and the quality of training cannot be compromised. Schedules and detailed content of training have been documented in the TOT manual and in the Basic Book on Injectables which can be followed to implement door-step injectable services.

The concept of bringing trainees individually to the training centres for training needs to be revised. The *thana* managers can be trained to conduct training of their field workers. However, to do so the training of trainers must be well conducted with practical sessions and field visits to observe the actual service-delivery mechanism. This can be done by conducting the trainers' training in those districts which already have domiciliary injectable programmes. The trained managers would then prepare and train their workers in their respective *thanas*. Although this mechanism is very useful and practical, it has a few limitations. Not all the managers can be good trainers, and hence support from the district is essential. The scoring system used for judging the quality of training is very important in this regard, and thus, needs to be further improved.

For implementing and expanding the domiciliary injectable programme, training of managers and field workers can be conducted in districts which already have domiciliary programmes. These districts can serve as a basis for further training in new areas.

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Annexure 1

Participants of the Training of Trainers Session

Name of district and thana	No. of participants							Total (n=41)
	AD-CC (n=7)	MO-CC (n=1)	AD-FP (n=2)	MO-MCH (n=7)	TFPO (n=8)	ATFPO (n=8)	Sr. FWV (n=8)	
Rajshahi Charghat	1	1	1	1	1	1	1	7
Joypurhat Akkelpur	1	-	-	1	1	1	1	5
Norshindi Monohardi	1	-	-	1	1	1	1	5
Mymensingh Bhaluka	1	-	-	1	1	1	1	5
Comilla Nangolkot	1	-	1	1	1	1	1	6
Feni Chagolnaiya	-	-	-	-	1	1	1	3
Jhenaidah Kotchandpur	1	-	-	1	1	1	1	5
Sathkhira Tala	1	-	-	1	1	1	1	5

Annexure 2

TOT Results of Pre- and Post-tests

Designation	No of parti-cipants (n = 41)	Average		Lowest		Highest	
		Pre	Post	Pre	Post	Pre	Post
AD (FP)	2	39	66	29	50	49	81
AD (CC)/MO (CC)	8	45	64	35	44	52	81
TFPO	8	39	65	23	50	45	77
MO (MCH-FP)	7	36	65	23	52	48	76
ATFPO	8	22	54	00*	34	31	69
Sr. FWV	8	25	56	14	45	33	65

- * A newly recruited ATFPO joined the TOT session. Although he scored 0 in the pre-test, he achieved 50 in the post-test.

Annexure 3

Names of Thana

	Kotchandpur	Tala	Akelpur	Charghat	Nangolkot	Monohardi	Bhaluka	Chagolnaiya
Training started	20.1.93	26.1.93	13.2.93	13.2.93	10.4.93	19.4.93	25.4.93	21.6.93
Training ended	28.1.93	20.2.93	20.2.93	20.2.93	28.4.93	12.5.93	12.5.93	30.6.93

Number of Participants

FPI	6	12	5	5	12	11	9	6
FWV	5	12	6	6	12	11	9	6
FWA	23	63	36	36	62	62	56	34

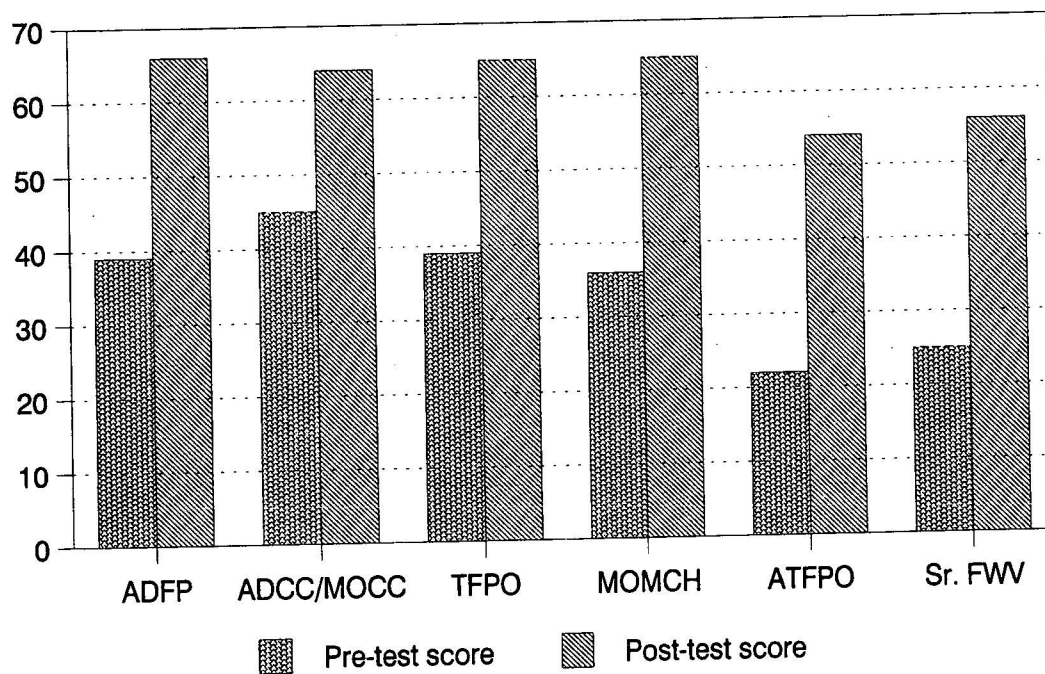


Fig. 1. Pre- and post-test scores: Trainers of door-step injectable service
- Results from 8 thanas

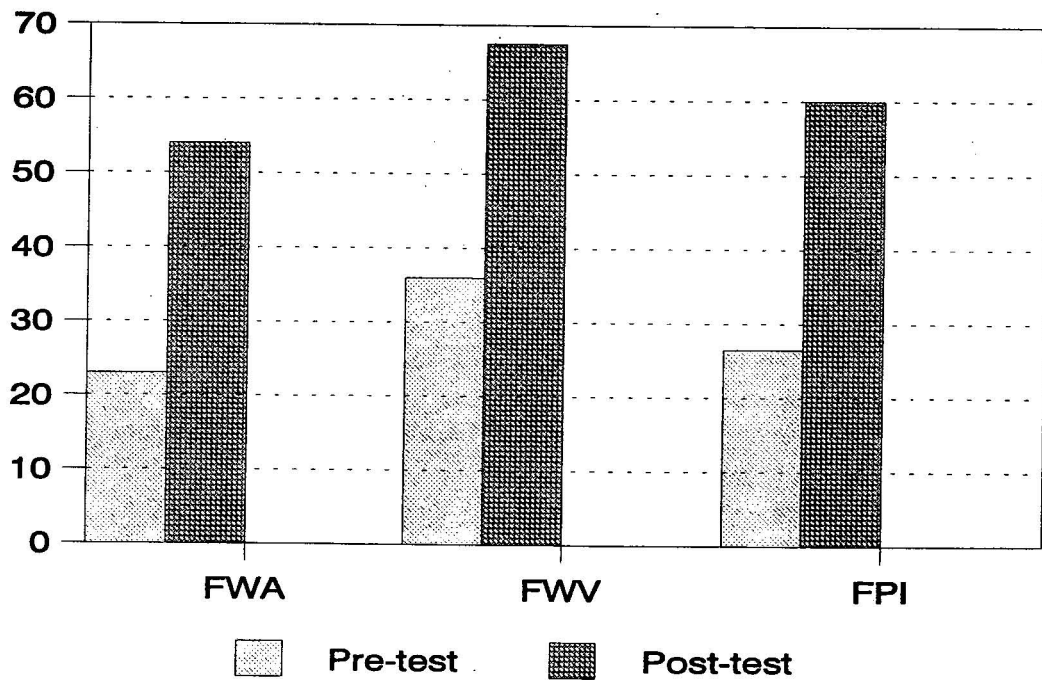


Fig. 2. Average training scores of field workers - FWA, FWV and FPI: Pre- and post-test scores from 8 test thanas

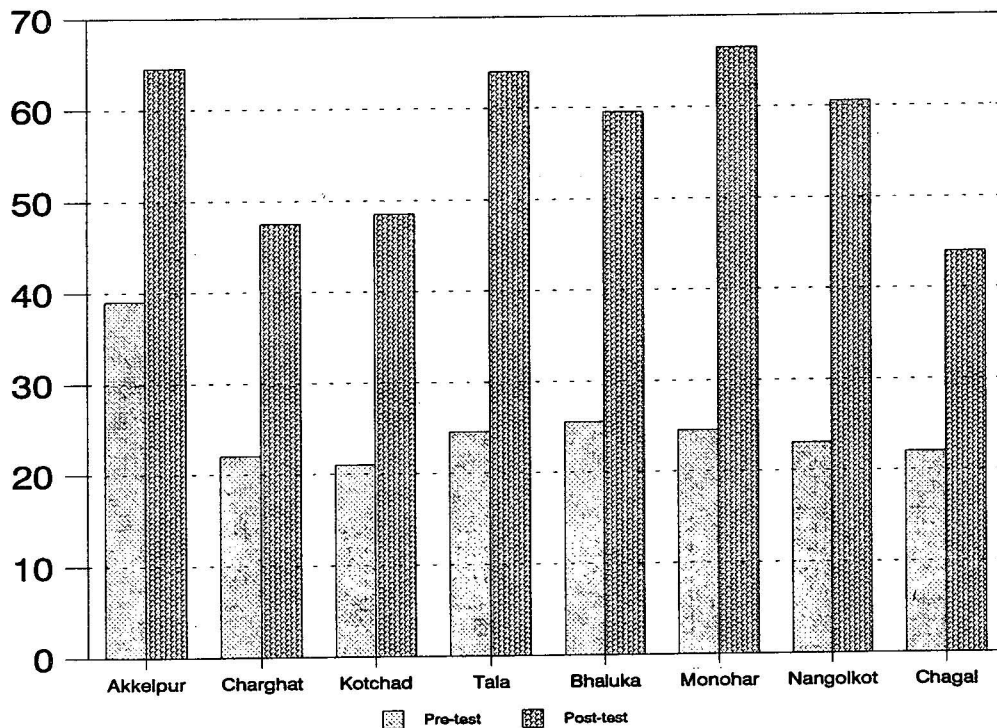


Fig. 3. Comparison of training scores of 8 thanas: Pre- and post-test scores of field workers

MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of government Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

In 1994, the Centre began an Urban MCH-FP Extension Project in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers.

The Centre, USAID, in consultation with the government through the project's National Planning Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Division has a long history of accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.



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