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Interventions to Promote Local-level Planning and Coordination of Essential Health and Family Planning Services: A Review

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Glossary

ARI	Acute Respiratory Infection
ANC	Antenatal Care
AHI	Assistant Health Inspector
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
BRDB	Bangladesh Rural Development Board
CPR	Contraceptive Prevalence Rate
CWFP	Concerned Women for Family Planning
DCC	Dhaka City Corporation
DGHS	Directorate General of Health Services
DFP	Directorate of Family Planning
EPI	Expanded Program on Immunization
ESP	Essential Services Package
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FIAP	Functional Improvement Action Plan
FPMD	Family Planning Management Development
GoB	Government of Bangladesh
H&FWC	Health and Family Welfare Centre
HPSS	Health and Population Sector Strategy
HI	Health Inspector
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
LLP	Local-Level Planning
LIP	Local Initiative Programme
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development & Cooperatives
MDU	Management Development Unit
MO-MCH	Medical Officer-Maternal and Child Health
MR	Menstrual Regulation
MIS	Management Information System
NGO	Non-Government Organization
NIPHP	National Integrated Population and Health Program
ORP	Operations Research Project
PSTC	Population Services and Training Centre

Glossary *(Contd.)*

PHC	Primary Health Care
PSKP	Progati Samaj Kallan Prothistan
TH&FPO	Thana Health and Family Planning Officer
TFPO	Thana Family Planning Officer
TFIPP	Thana Functional Improvement Pilot Project
TPC	Thana Project Committee
UNFPA	United Nations Population Fund
USS	Urban Surveillance System
WHO	World Health Organization

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Abstract

Background: Significant variations in the coverage and availability of comprehensive quality health and family planning services still exist in Bangladesh. Evidence shows that the current lack of planning and coordination among the providers at the local-level contributes to the inadequate distribution of services, to inefficient management of resources and perhaps to differential quality of care. There is a need, particularly in low performing areas, to develop capability at rural and urban areas so that managers are able to identify problems, and plan and act locally to solve them in a cost-effective manner.

Objectives: This review was undertaken to examine current local-level planning and coordination interventions and experiences of government and NGO agencies in urban and rural settings. This exercise was carried out to identify ways of increasing the effectiveness of interventions to improve local-level planning and coordination.

Methodology: Data on the existing local-level planning process, in both rural and urban settings, were collected through discussions with programme managers and supervisors, observation of field activities, analysis of organized meetings, and review of literature.

Findings: There was no systematic local-level planning process in the government programme. Managers distribute targets issued by the national level among field workers. The government has established committees at the district and thana levels and below which are supposed to meet every month to plan programme activities and review performance. The available evidence showed that the majority of these committees were inactive. Local-level planning interventions, undertaken by the MCH-FP Extension Projects of ICDDR,B, revealed that the systematic introduction of the process of performance review helped managers and supervisors to diagnose problems and find solutions in rural areas. However, the success of the interventions was largely based on the commitment and skills of thana managers. Interventions in urban areas were effective in establishing a forum for service providers to discuss and resolve common health issues and problems. In both urban and rural settings, the role of external facilitators was critical. Other interventions conducted by ICDDR,B projects, national NGOs and special projects to support the government health and family planning programs at district and thana level, have shown promising results in small areas. The effects of these interventions are still being monitored. Among others, these local-level planning interventions have been introduced by the Thana Functional Improvement Pilot

Project, BRAC, Swanirvar Bangladesh, Pathfinder International, Population Services and Training Centre, CARE and Concerned Women for Family Planning. The replicability of these interventions is yet to be established.

Conclusion: Interventions to promote local-level planning and coordination of health services in Bangladesh need to identify mechanisms to motivate and train local managers and supervisors. Up to now, most interventions seem to require external facilitation. New interventions must recognize the transition to the full range of ESP services and the shift in emphasis from doorstep to static clinics. Realistic ways of obtaining a meaningful involvement of community representatives could enhance the availability of additional local resources.

Background

The health and family planning programmes of Bangladesh have made remarkable progress over the past two decades. The progress in the coverage of child immunization and use of contraceptives is most impressive. Currently, 54 percent of children 0-2 years old are immunized against six infectious diseases. The contraceptive prevalence rate is about 50 percent and the fertility rate has declined from 6.3 in 1971-1975 to 3.3 in 1994-1996. The under-five mortality rate has declined from 133 for the period 1989-1993 to 116 for the period 1992-1996, and during the same period, infant mortality has also declined from 87 to 82 per 1,000 births [1].

Despite the recent overall successes, however, there are still significant variations in the coverage and availability of health and family planning services. In some areas, like the districts of Chittagong and Sylhet divisions, the key indicators of health and family planning services, such as immunization coverage, contraceptive prevalence rate and antenatal care (ANC) contact are considerably lower than the rest of the country. Sixty-two percent of the married women in Khulna division and 59 percent of those in Rajshahi division are using a family planning method, compared to only 20 percent of the women in Sylhet and 37 percent in Chittagong divisions. The highest level of EPI coverage was reported in the children of Rajshahi and Khulna divisions, while the children of the Chittagong and Sylhet divisions were the least likely to have received all of the basic immunizations (BDHS, 1996-97).There are also significant intra urban differentials in health and family planning status. For example, immunization coverage rate in the slums of Dhaka City Corporation (DCC) is 38 percent, while in the non-slum areas it is 69 percent [2].

The persistence of these differentials in coverage and service utilization is not only due to a lack of awareness about the availability of services, but is also conditioned by other factors. These include the suitability of service delivery strategies to local conditions, i.e. similar strategies are used in high and low performing areas. Poor planning and management of health resources and the degree of coordination among service providers are also important predictors for low coverage [3].

The health and family planning infrastructure in rural Bangladesh includes doorstep services, regular satellite clinics at the village level, and a Health and Family Welfare Center (H&FWC) in every union. In practice, however, most services are not linked, especially at the periphery, and therefore, are of limited effectiveness [4]. In contrast, the urban situation is characterized by the presence of multiple providers. Usually, urban facilities offer a limited range of services, and

many offer only a single service, i.e. providing only EPI or only family planning or only curative services. Some urban areas have an excess of facilities while others are under served. There is also a lack of local-level coordination and cross referral, which creates duplication of services and gaps in coverage, wastage of available resources and differential quality of care. Thus, despite the existing infrastructure for service delivery, services remain largely fragmented and not organized to meet the needs of customers [5].

The health and family planning programs in Bangladesh are managed at three levels. The three levels are: the top-level (The Ministry of Health and Family Welfare and Directorates of Health Services and Family Planning), the mid-level (division and district), and the operational level (thana and below). Top management usually formulates policies and strategies, plans for human resource development, sets national and regional targets and allocates resources. The mid-level and the operational-level managers, within the prescription formulated by the top-level management, focus their planning on activities through supervision and maintenance of record-keeping, managing logistics and carrying out personnel functions, such as disbursement of salary, transfer, leave and provision of travel and daily allowances [4].

Referring to the current service delivery infrastructure of Bangladesh, a project working toward the improvement of services has concluded that "everything is there–doctors, nurses, staff, medicine, equipment, buildings, plans and programs. But why does it not reach the people for whom it had been devised in the first place? Why are children still dying of preventable diseases? Why are mothers dying during childbirth? Why are the rural people being deprived of their fundamental right to health? This situation may be due to absence of decentralization of program planning, poor management and less involvement of community with the program"[6].

In 1992, Management Development Unit highlighted the following issues regarding the absence of local-level planning at the district level and below: (i) lack of planning skills among managers, (ii) ineffective coordination committees, (iii) local-level information is not used for planning, (iv) lack of follow-up of local-level management from headquarters, (v) targets and related strategies are given from headquarters resulting in little scope for local-level planning, (vi) lack of interest from managers in the program, (vii) absence of incentive or punishment for achievement or non-achievement respectively for planned progress, (viii) no tradition of local planning, (ix) financial constraints [7].

Those involved in the health sector of Bangladesh have long felt that the services are caught up in a vortex of bureaucracy and a plethora of paper work [6]. Because of the rigidity of the policies and procedures set by the highest level,

functional planning at the middle and operational levels has become restricted to uniform and routine tasks. Programme failures in most developing countries can be attributed to top-down planning process, which leaves very little direction in the hands of lower-level officials. Except in areas with experimental or pilot projects, local-level planning is rarely undertaken because of organizational weaknesses of the public system planning process [4].

Current management systems, however, provide few incentives to improve quality of care, and respond to client need. The management culture in the sector needs to change so that the providers are motivated to serve the needs of consumers. Accordingly, the national Health and Population Sector Strategy (HPSS) recognizes that a significant aspect of the necessary reform will involve "strengthening local-level capacities to plan, implement and monitor sectoral programs" [8].

Local-level Planning and its Cmponents

For the purpose of the review, we will consider local-level planning as the organized effort of workers, supervisors, managers and community leaders to prepare plan of action, review the health status in their community, analyze the performance of existing services, identify problems and local resources and develop solutions. Interventions of health and family planning services to promote local-level planning in rural and urban areas of Bangladesh have had the following objectives:

- To introduce planning mechanism at the thana, zone and below.
- To introduce systematic review of services and activities of agencies in the health and population sector at union, thana, ward and zonal levels.
- To strengthen monitoring mechanism by supervisors through the introduction of supervisory tools.
- To enhance community participation in the health and family planning programme.
- To create linkages between union and thana in rural areas and ward and zone in urban areas.

The interventions included in this review concern thana, zone and below only.

Objectives

The objective of this review is:

- To identify the existing local-level planning and coordination practices of managers and supervisors in the health and family planning sector both in urban and rural settings.

- To identify recent interventions by various agencies to improve planning and coordination of health and family planning services at the local-level.

Methodology

The data on the existing local-level planning process, both in urban and rural settings, were collected through discussions, observation of field activities, organized meetings and review of literature. A simple semi structured questionnaire (Annex-1) was administered to all categories of providers. They were the MOHFW officials (Thana Health and Family Planning Officer, Thana Family Planning Officer, Medical Officer-Maternal and Child Health) and union-level supervisors (Family Planning Inspector, Assistant Health Inspector, Health Inspector) of Mirsarai, Abhoynagar and Patiya thana, representatives from urban service delivery partners in Dhaka (Concerned Women for Family Planning and Progoti Samajkallan Prothistan). ORP field staff were consulted regarding the current system of local-level planning in the thanas. The team members observed the government programme at Feni Sadar thana. The NGOs, such as Swanirvar Bangladesh of Feni Sadar thana, BRAC-Sherpur project, Thana Functional Improvement Pilot Project (TFIPP), Pathfinder International, Dhaka Urban Child Health Program, Population Services and Training Centre, and CARE were also visited to review their local-level planning processes. Two H&FWC meetings in Abhoynagar and one supervisory meeting in Mirsarai were observed by using an observation checklist (Annex-2). Both observations and interviews were carried out by researchers from the Operations Research Project (ORP), between October 1997 and January 1998. The literature review was also done to identify experiences gained from the local-level planning process.

The Current Situation

Planning and review mechanism

With the aim of developing local plans for comprehensive health and family planning services and ensuring effective coordination in programme

implementation and monitoring, the government initiated different committees, such as population control committees, MCH coordination committees at district, thana and union level in 1985. The main activities of these committees were to review the status of family planning and MCH activities, to review existing family planning goals and targets in order to set achievable goals and realistic targets, and to ensure effective coordination in programme planning and implementation with a view to optimize the utilization of available resources [8]. The committees were supposed to meet every month to plan and review their performance. In reality, however, these government guidelines have not been implemented in all areas [9].

Supervision and monitoring mechanism

In order to strengthen and streamline the supervisory and inspection system, the Ministry of Health and Family Welfare (MOHFW) issued circular with guidelines for supervising field activities in 1985. For example, prior to a visit to a particular area or unit, the supervisors/officers are supposed to prepare a tour programme. The supervisor/officer is also responsible for sending a monthly inspection report using a designated format to his next authority within the first seven days of the following month [8]. In reality, the supervisory guidelines are rarely known and followed. Therefore, feedback and follow-up of supervisory actions are lacking. Overall, the supervision of FWAs by FPIs is unsatisfactory. In general, weak personnel policies have been identified as affecting accountability within the system. Lack of responsibility and accountability is due to lack of clarity in job descriptions, and confusion in direct line of supervision throughout the field level health and family planning system [10].

Coordination mechanism in DCC area

In the provision of health and family planning services to the urban population, the mandate lies with the various city corporation and municipal governments under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC). One major development to improve the government infrastructure for better urban health issues is the establishment of the Inter-ministerial Urban Primary Health Care Coordination Committee and formation of zonal and ward Health and Family Planning Coordination Committees in DCC areas. These committees bring together the various urban health and family planning providers and decision makers to develop coordinated approach for the delivery of primary health care services to the urban population of Bangladesh [11].

NGO's involvement in the implementation of HPSP

The HPSS emphasizes that the NGOs will make an important contribution to the implementation of the HPSP. The current legal and regulatory framework for NGOs, however, needs to be modified. Thus, under HPSP, MOHFW plans to review its own internal procedures to determine ways and means to ensure maximum productivity from MOHFW/NGO partnerships, with particular attention to accountability and cost effectiveness. Further work will be done, in consultation with NGOs, to map NGO current capacity, suggest ways in which that capacity can be developed, and identify mechanisms for developing collaborative arrangements which maintain NGO autonomy. This work will result in the articulation of principles for expanded MOHFW/NGO partnerships. The MOHFW has established a focal point in the Ministry to coordinate this work [12].

Review of the Experiences of ICDDR,B

Review of the Work of the MCH-FP Extension Projects

Several studies have been conducted by the former Extension Projects of the Health and Population Extension Division of ICDDR,B to promote local-level planning at the district, thana and union levels, and to identify and address problems particularly those in low performing areas.

Rural Areas

A local level planning intervention was introduced in 1991 to improve programme performance planning and management capabilities. The key activities of the intervention were: a) increase use of available data to identify areas of poor performance; b) brain storming session with managers, supervisors and workers to identify factors that hinder performance, and develop solution(s) within the existing resources; c) developing work plans and reviewing performance. The strategy used by the intervention was to structure the regular staff meetings at thana and union levels and to ensure planning and performance monitoring. The findings show that the system of performance review and planning is feasible to implement in the public sector setting in Bangladesh. It can help managers identify problems, find solutions and develop local-level action plans. Furthermore, this process help to improve performance, at least in those areas in which managers and supervisors exhibit some degree of motivation and willingness to learn. The methodology follows a process aimed at improving the planning capability of supervisors and managers at the operational level. There are four distinct components of this

process: a) organizational diagnosis; b) training and workshop on performance planning for supervisors and managers; c) micro planning; and d) follow-up process [4].

Findings from Sirajgonj Sadar thana indicate that meetings between managers, supervisors and workers, if conducted in a systematic way, contribute to efficient programme management and planning and result in improved performance. During the presence of the MCH-FP Extension Project (Rural) at the Sirajgonj H&FWC, salary day and supervisory meetings were conducted regularly and systematically. Formalities of meetings in terms of recording the agenda, resolutions, issues were maintained. Also, performance was reviewed at the majority of the meetings [13].

ORP staff visited Abhoynagar, Mirsarai and Patiya thanas. The findings from the thanas related to the local-level planning process are as follows:

Union level

Meetings at two H&FWCs (Siddipassa and Mohakal) at Abhoynagar thana were observed. The local-level planning intervention was tested in both of the unions of the former MCH-FP Extension Project (Rural). Neither of the meetings used an agenda. At the Siddipassa meeting, the meeting's proceedings were not recorded. One Health Assistant (HA) was responsible for taking notes at the Mohakal meeting. Worker performance was reviewed at Mohakal, while performance was not reviewed at the Siddipassa meeting. Performance of MCH and health activities was not reviewed at the meetings although the Family Welfare Visitor (FWV) of Mohakal union, the Medical Assistant (MA) and Assistant Health Inspectors (AHI) of both the unions were present. There was little interaction between the health and family planning staff members at both of the meetings. No one from thana headquarter attended the meeting of Siddipassa, while Thana Family Planning Officer (TFPO), Medical Officer-Maternal and Child Health (MO-MCH) and the concerned Health Inspector (HI) were present at the Mohakal meeting. It was probably a combination of good road communication and our visit that encouraged such a good turnout of the officers at the Mohakal meeting.

The supervisors (FPIs and AHIs) of Abhoynagar thana reported that currently there is no formal local-level planning process in the thana. The supervisors mentioned that they basically carried out the plans/decisions made by the upper levels, which were not always feasible for them to implement. They did not use any checklist/tools to record the supervisory findings. They used their personal diaries and field worker registers to record the findings from supervision visits. Supervisory findings were used to provide on-the-spot feedback to the workers. They were then forwarded to the thana office for administrative action.

The supervisors of the local-level planning intervention area of Mirsarai mentioned that even without the intensive support from ICDDR,B for the past one year, they continued some components of the intervention (micro planning and performance review in the HFWC and supervisory meetings). The FPIs used the FPI Diary. They spent more days for supervising weak workers. Supervisory findings were used to provide feedback to the staff and to share at the H&FWC meetings.

Thana level

One supervisory meeting was observed at Mirsarai. This meeting began on time and the TFPO chaired the meeting. Discussion was held as per agenda. Minutes from the previous meeting were reviewed and one participant was assigned to prepare minutes for the meeting. Although it was a mid-level supervisory meeting, the discussion was focused on the review of performance of all ORP interventions carried out at Mirsarai using the mechanism developed for the local-level planning intervention. Two components (micro planning and performance review) of the intervention were still going on in Mirsarai without intensive support from the ICDDR,B project. Problems in the field, such as coverage of FWAs, vacant FPI areas, shifting of satellite clinics to high target areas were discussed and resolved at the meeting.

The thana managers of Abhoynagar (TH&FPO, TFPO and MO-MCH) said that they implemented the decisions of higher levels, with regard to the health and family planning programme. Performance review, they said, was done at the H&FWC meeting, but not according to the mechanism developed for the local-level planning intervention. The mid-level supervisory meetings or performance review meetings had not been held at the thana for 18 months. Neither had they developed a schedule or used a checklist for field supervision.

According to the thana managers of Mirsarai the targets set by the upper levels for their program were not feasible to implement at the field level, because the target did not take into consideration the population size of the service providers. Therefore, they emphasized the local-level planning process for better performance of health programme. They added that planning should be done locally with the involvement of workers, supervisors and thana managers which would be more realistic for implementation. The TH&FPO of the thana mentioned that the Management Information System (MIS) of the health department was weak and suggested to strengthen the MIS like EPI programme. In his opinion , this would help local-level managers to plan, monitor and evaluate the programme. The managers used neither any schedule nor any checklist for supervision. Generally,

their field visits were need based. They were not aware of the checklist for supervision issued by the Directorate General of Health Services to thana officers (Annex-3).

No formal local-level planning process existed in Patiya. Thana managers and union supervisors plan for the areas where ESP activities are going on. Like in other areas, they also simply executed the decisions of the upper levels. They felt, however, that local-level planning process was more effective than top-down planning process for overall improvement of program performance. According to the TFPO of Patiya, technical assistance in demographic issues from any technically competent agency was needed for thana managers for programme planning locally. The managers emphasized joint scheduling and field visits, especially in ESP areas. They felt that local-level planning activities work better in the special project sites where considerable amount of additional inputs, such as high salaried staff, expatriate, provision of providing transport for field workers and supervisors, fund for repairing work and special fund at union and thana levels have been provided.

Summary of Recommendations Related to Local-level Planning from GoB Supervisors and Managers

- Planning should be done locally; **field worker involvement** with the planning process is essential.
- Union and thana-level **meetings need to be strengthened**. The meetings should be used as a forum for planning and performance review.
- Development and **regular follow-up of the action plan** is a prerequisite for overall program performance improvement.
- **Support from higher levels** is needed to resolve problems which can not be solved at the local level.
- Each supervisory level should **use supervisory tools** to strengthen supervision.
- The **record keeping system** of the health wing is weak. Therefore, the health department's MIS should be strengthened.
- **Training** on programme planning technique should be offered to the workers and supervisors.

Urban Areas

A local-level planning intervention was introduced in DCC area in 1995 by the former Urban MCH-FP Extension Project. The objective of the intervention was to link all of the local level service providers and serve as a mechanism for local-level planning. It was also done to ensure effective utilization of available local resources through minimizing gaps and overlaps in MCH-FP service delivery. The emphasis of the intervention was to promote coordination between the multiple organizations providing health and family planning services with the involvement of municipal health departments.

The main activity of the intervention was the establishment of Health and Family Planning Coordination Committees at the zonal and ward levels. The zonal committees were designed to meet every alternate month and coordinate the activities of different service providers at the zonal level. The zonal committees would also responsible for developing and regularly reviewing an annual work plan of the zonal activities. They would also support implementation of the ward-level activities through the ward committees [5].

The zonal committees were found to be effective as a coordinating mechanism for service providers to discuss and resolve common health issues and problems. The ward committees, on the other hand, were found to be effective as a forum of grassroots-level service providers and community leaders for local-level planning and local resources mobilization. Committees at both levels, however, required major service providers of the zone/ward to facilitate organization of regular zonal/ward committee meetings. They also provided technical assistance in preparing agenda, schedules and minutes for these meetings, and followed-up zonal/ward activities. The ultimate objective was to motivate the CC/Municipalities to take over and continue the coordination process [5].

Study findings have shown that it is possible to redistribute health and family planning facilities through zonal committees to improve the utilization of service outlets in urban areas [14].

An assessment of this intervention revealed substantial NGO involvement and suggested the need for increased involvement of community representations and the government sector in zonal committee activities [15].

Other Activities of ICDDR,B

The most relevant experiences in local-level planning from other projects of ICDDR,B involves the Matlab MCH-FP Program and the Chakaria Community Health Project.

The Matlab programme has established health service systems at different levels. The first line providers are the "bari mothers "who act as a depot for distribution of ORS and for the initial screening for health problems. The key element of the programme is the Community Health Workers (CHWs), the second level providers. They provide services at the household level through fortnightly visits, and they also refer clients to sub centres or the Matlab hospital. CHWs also maintain a service record book and record all the services they perform. This book is reviewed fortnightly by the CHWs and supervisors at the sub centre meetings. This information sharing is useful for service delivery, particularly in connection with providing feedback to the workers and targeting specific groups at risk. Findings from the programme suggest that this process helped to improve the overall performance of the programme [16].

Bangladesh has a long tradition of community initiative in establishing schools, and building roads, markets and mosques. Most of the now nationalized schools were once built through community initiatives and were maintained by the community. Even now, most high schools are managed by communities. Thus, it would be reasonable to believe that community participation could be initiated for health and family planning related activities [17]. To discover appropriate strategies to ensure people`s participation in health matters, Chakaria Community Health Project promotes self-help for health as a strategy for indigenous organizations to improve the health situation in the villages. The self-help for health approach is based on the realization that people in rural areas already have well-functioning indigenous organizations, which carry out activities in the fields of religion, education, kinship, economics etc. These indigenous organizations show a good potential to use their existing organizational structure and management capacity in the improvement of health situation. In some places, the community members and the government HAs established EPI sessions at Village Health Posts (VHPs) because it would facilitate the establishment of an effective linkage between the VHPs and the government services [18].

Review of Other Initiatives Taken by Government and Non-government Organizations

GoB Work in Rural Areas

In order to assess the current activities on planning and coordination practices of local managers the authors visited areas where managers were receiving inputs from special project and where there was no additional inputs.

Feni Sadar Thana

The managers at Feni Sadar thana mentioned that there was no local-level planning process in the thana. The managers said that they distribute the thana target that they receive from the national level to each worker. They developed advance tour programmes for supervision visits. The MO-MCH of Feni mentioned that the supervisory system could be improved by distributing the area of work among the supervisors. Thana managers suggested that joint visits and training on supervision could be introduced to make supervision more effective.

According to the supervisors of Feni Sadar thana, the thana had no systematic local-level planning process. There was a Population Control Committee in the union which was supposed to meet every month. Practically, however, this had not happened. The FPIs used checklists (provided by the MOHFW in 1996) during supervision. Feedback on the findings was given to the FWAs in the field or at the routine meetings.

Thana Functional Improvement Pilot Project (TFIPP)

TFIPP facilitates the GoB health and family planning program in 55 thanas with a view to strengthen the existing health and family planning service delivery system in Bangladesh. In order to enable the project to accomplish the above ,a number of interventions have been undertaken by TFIPP. These are: supply of equipment and means of transport to different service outlets; training to providers in technical, managerial and communication skills; provision of additional financial resources to the thana health and family planning system, particularly for minor construction; and repair works for facilities and for operational expenditures and community participation.

The main strategy the project follows is to promote a team approach between health and family planning at both the thana and district level. The main vehicle the project uses for this purpose is the Functional Improvement Action Plan (FIAP) at thana level through which the project activities are planned and implemented annually at thana level and below. The FIAP ensures a decentralized local-level planning process with involvement of all the stakeholders, including the people for whom the project is meant for. Study findings shown that about 90 percent of thana managers believe that FIAP is an effective instrument for improving quality of services.

TFIPP formed Thana Project Committee (TPC) with representation from thana level health and family planning and other concern GoB departments and agencies as well as from the community for institutional arrangement to ensure a coordinated plan of action. Local Member of the Parliament (MP) is the chairman of the

committee. TPC is the forum where cross-sectional views and opinions are elicited for assessing needs, identifying problems and suggesting appropriate actions. There are evidence that the performance of the TPC is better where the MP is active in organizing the TPC activities than the areas where the MP's involvement is less and that needs to further study. Study findings revealed about 53 percent of the respondents mentioned that TPC is useful for implementing FIAP. [19].

Family Planning Management Development (FPMD)

As part of FPMD, the Local Initiative Program (LIP) has operated since 1987 to improve the performance of the Bangladesh Family Planning Program at grassroots level through strengthening the management capacity of government (thana level) family planning staff and local leaders. LIP does not itself deliver services. Rather, it works closely with existing Bangladesh Government personnel (FP-MCH and local government) to maximize the use of available resources. LIP provides on-going training, intensive monitoring and technical assistance to thana teams and volunteers. The thana teams are consisted of thana level family planning staff, elected representatives and community leaders. LIP uses four approaches in providing decentralized and community-based services. These are: a) family planning program staff, elected representatives, local leaders and administrators of government health and other development programmes become partners as part of thana team; b) community members are actively involved in managing FP-MCH programme; c) local women participate in family planning activities by serving as community volunteers; and d) the community helps to finance the implementation of action plans prepare by the thana teams.

These approaches have resulted in an increase in both community participation and in their feeling of responsibility for programme performance. CPR increased significantly in LIP thanas especially in those thanas where CPR was low prior project implementation [20].

Intensified Primary Health Care (PHC) Project

In Bangladesh, PHC intensification was initiated in the Gazipur and Tongi districts in 1988. To date, the project has been extended to another ten districts providing essential health care to over 12 million people. The PHC intensification approach in Bangladesh is to reorganize the components of the health and family planning infrastructure and its activities into the district health care system based on primary health care. These are: (I) extending the health care system downwards so as to provide basic health care down to the grassroots level, with community

participation and intersectoral support; (ii) developing functional integration of the health and family planning personnel and services through formation of thana PHC teams.

The modalities followed for PHC intensification were: (i) functional integration between health and family planning personnel; (ii) expansion of health care services to promotive and preventive dimensions; and (iii) development of local level planning.

Studies conducted in PHC intensified and non-intensified areas found that there was a significantly better knowledge of mothers on major PHC components in the PHC intensified thana as compared to those in non-intensified thana. The components include antenatal care, immunization, breast feeding, growth monitoring, treatment of diarrhoea, family planning and safe water. The EPI, Diarrhoea, TB, Leprosy and Malaria control programmes have been effectively implemented in all the thanas. These programmes have been well planned with adequate resources for training, implementation, monitoring, supervision and evaluation. The study revealed that in the intensified area about 90 percent and in the non-intensified area about 79 percent of children were fully immunized [21].

GoB Work in Urban Areas

The government also has a key role in the provision of health and family planning services to urban population. The mandate for this lies with the various city corporations and municipality governments that are responsible for the urban areas. The municipal bodies are under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC). Only recently has this mandate been operationalised to address MCH and FP specifically; an interministerial decision has placed the responsibility directly with the MOLGRDC. However, currently, their role in health services is limited to municipality dispensaries and EPI centers.

The Ministry of Health and Family Welfare provides some basic services in urban areas. FWAs are assigned to provide services in selected urban areas, but HAs are not posted in urban settings. Instead of H&FWCs, the Directorate of Family Planning operates Family Planning Clinics in urban areas which provide only family planning services and Menstrual Regulation (MR). The Directorate General of Health operates dispensaries and tertiary care hospitals in the cities. However, the mandate for urban health and family planning does not specifically lie with the MOHFW, although this ministry has more technical expertise in the areas of health and family planning than does the MOLGRDC [11].

NGO Work

NGOs like BRAC, Swanirvar Bangladesh, Pathfinder International, Dhaka Urban Child Health Program, Population Services and Training Centre, CARE, Concerned Women for Family Planning, and Progoti Samajkallan Prothistan were visited to review their local-level planning process. The main findings gathered from the NGOs visited, are presented below:

Bangladesh Rural Advancement Committee (BRAC)

In Sherpur, BRAC supports the GoB health and family planning program in the project area. BRAC assists in action planning for the thanas of the district. Action planing is done based on national targets. BRAC also assists unions to prepare their action plan with necessary modification of the targets they receive from the thana. BRAC involves depot holders who refer clients from the community. They are working toward establishing a linkage from district to union-levels through strengthening health and family planning coordination committee activities. BRAC organizes weekly performance review meeting with their own field staff for performance review, identification and solution of health problems. The programme, however, is yet to be evaluated.

Swanirvar Bangladesh

In Feni, Swanirvar Bangladesh organizes meetings to review program performance. They involve community leaders. The local manager's opinion is that orientation for workers and supervisors is require to improve the supervisory system. At the time of the visits there were not action plans or systematic local level planning procedures.

Pathfinder International

In an effort to involve community leaders and local influential leaders in family planning activities, Swanirvar, with support from the then Upazila Family Planning Officers and technical assistance from Pathfinder, organized about 70 workshops at union level to activate union family planning committees. Based on projected population, the workshop participants were shown the impact of population growth on land, housing, food, clothing and schooling. They were also made aware of their duties and responsibilities as members of union population control committees. Family planning performance of their unions was discussed and a plan to activate the committees was recommended. They were introduced to the FWAs and Swanirvar workers to establish stronger accountability and cultivate

cooperation. Most of these union population control committee meetings at the unions are now being held on a regular basis [22].

From January to March 1998, representatives from the University of North Carolina conducted a three-month training course for thana level officials from the Directorate General of Health Services, the Directorate of Family Planning and NGOs supported by the Rural Service Delivery Partnership of the National Integrated Population and Health Programme. The course focused on local level planning, quality issues and team work to improve management and performance in the delivery of services included in the ESP. The government officials who participated in the training activities were the TH&FPO, TFPO and MO-MCH from eight thanas. The teams prepared action plans to be implemented in their respective thanas for a one year period. A total of 29 performance indicators for ESP services, team work and quality related issues were identified. Each team will be expected to submit monthly performance reports. An advisory committee was set up to review performance on the selected indicators regularly and to provide appropriate feedback to the thana teams.

The Aga Khan Community Health Program

The Aga Khan Community Health Program has experienced set-backs in engendering community participation in project activities. The Project's self assessment report suggests that volunteerism is becoming more difficult given the present socio-economic situation in Bangladesh. Female volunteers are reluctant to work alone in the community, and social and cultural barriers prevent female and male volunteers from working together. The project also believes from experience that volunteers are not likely to perform activities in addition to immunization [23].

Population Services and Training Centre (PSTC)

As a follow-up action of the Family Planning Fortnight observed between December 6-20, 1993, PSTC organized 20 thana level workshops. The major area of concentration for these workshops was to identify and obtain a grassroot perspective on the future challenges of the national family planning and MCH programme The participants were critical stakeholders of the programme. They were thana and union level public leaders, programme managers, supervisors and service providers from both the GoB and NGOs and selected clients. The workshop participants developed action plans for their thanas. The major issues addressed in the action plans were: indicator-wise targeting of MCH-FP activities and plan for IEC activities. The action plans also identified responsible persons and set a time frame for the implementation of each and every activity. No evaluation, however, was done by PSTC to assess the impact of the process.

CARE

CARE has contributed actively and significantly in national level collaboration and monitoring of EPI throughout the past decade. CARE's Training Immunizers in the Community Approach (TICA) project took the opportunity to utilize the BRDB women's cooperatives as social mobilizers within the intensive social mobilization strategy. At the community, BRDB organizers and HAs jointly prepared a schedule for group meetings. In the group meeting, BRDB women were given lessons on vitamin-A, family planning, immunization, diarrhoea, nutrition and breast-feeding. The mothers were also given extensive knowledge about EPI related service delivery information. It was expected that health messages could be disseminated by using this organized group at the community level. The activities of women's cooperatives were found to be satisfactory in terms of providing support/advice to fellow community members regarding various health care practices. The group managers of this cooperatives also act as volunteer for providing support and help to mothers and children who need help [24].

Concerned Women for Family Planning (CWFP)

Some NGOs have introduced special local meetings. For example, CWFP unit office of DCC's Zone 3 organized two types of meetings for planning and programme implementation. The supervisor and the field workers met weekly. Another meeting took place monthly with the Unit Coordinator. At the meetings, the participants planned programme, reviewed the performance, identified problems and sought support from the upper levels. Performance of individual worker's was reviewed by looking at the CPR, immunization coverage, number of under-five children treated for diarrhoea and ARI, number of dropout cases for immunization and family planning, ANC and PNC client referred etc.

Supervisory checklists were used during supervisory visits by the supervisors of CWFP and the supervisory findings were shared with workers in their regular meetings. They sought support from headquarters to solve the problems which were not possible to solve at local level.

CWFP used prescribed formats to prepare work plans. They usually prepared a bi-monthly work plan which included activities, such as: fixing targets for immunization, CPR, clinical contraceptive use, and household visits. Other than the routine activities they also made plan for national events, such as National Immunization Day, World Health Day etc.

Meetings were organized with the officials of Pragati Samaj Kallyan Prothistan of the National Integrated Population and Heath Programme. Discussions were held on their service delivery strategies for a local-level planning

process and their suggestions about how to improve the existing planning process. The key findings from the meetings were as follows:

- The managers were supposed to establish satellite clinics (SCs) targeting slum areas. The SCs were to recover 30 percent of operational cost. The managers, however, assumed that it would not be possible to recover costs if the SCs were established in the slum areas. Therefore, they established the clinics in non-slum areas. Subsequently, the expected number of clients did not attend.
- They mentioned that there is a need to coordinate with service providers not funded by USAID.
- The respondents also added that there is no standard policy to determine the catchment area of static or satellite clinics.
- Although they have activities related to supervision and community involvement, but these are not well documented because of the other priority works.
- There is an informal local-level planning process. But to improve the programme performance, it will have to be strengthened.
- To minimize gaps and overlaps in coverage, coordination between the service providers needs to be strengthened.

The organizations also addressed some other areas related to local-level planning which are outlined below:

The involvement of community representatives in planning and progress review

Some of the organizations (e.g. TFIPP, FPMD, CARE, Swanirvar Bangladesh) involved community representatives in planning and review process. The community representatives include the elected as well as selected members of the community. For example, TFIPP involved union parished chairman and members in development of action plan at union and thana levels as well as review of progress. Similarly ORP involved ward commissioners in planning and reviewing of the zonal and ward committee activities in Dhaka City. On the other hand, some organizations, such as BRAC involve community representatives also in performance review.

Joint planning with different stakeholders

Some organizations (e.g., TFIPP, FPMD, BRAC, CWFP, Swanirvar Bangladesh) do their plan jointly with one or more government and non-government organizations. For example, TFIPP do their plan with the involvement of both Directorate General of Health Services (DGHS) and Directorate of Family Planning (DFP), on the other hand, FPMD plans only include staff for DFP.

Provision of soft fund

There is provision of soft fund for carrying out local-level planning activities in some of the organizations. This fund is mainly for organizing meetings, reimbursement of transportation cost, minor repair of facilities and logistics support etc. The range of the amount is Tk. 200.00 to 200,000.00 per year.

Incentives for good performance

There is provision for some organizations to provide incentives for good performance of the providers. The incentives may be in cash or kind. Incentives in kind include certificate, appreciation letter etc.

Community contribution or local fund generation

Some of the organizations involved community member for local fund generation for promotion of health and family planning activities and for sustainability of the programme. As for example, some of the Pathfinder supported NGOs collected contribution from eligible couples @ of Tk 1.00 per year. The NGOs used the amount as drug revolving fund or for construction of own accommodation.

Technical assistance and facilitation at thana, union, ward and zonal levels

Some of the NGOs provide technical assistance and facilitate to counterparts with local-level planning related activities at different levels. The technical assistance or facilitation includes assisting in organizing meetings and workshops, developing and reviewing of action plans, reviewing performance and involvement in promotional activities. The following table shows the areas addressed by the organizations:

Areas addressed by different organizations to promote local-level planning

Areas		Organizations with local-level planning interventions										
		TFIPP	FPMD	BRAC	Swanirvar Bangladesh	Pathfinder International	Aga Khan Community Health Program	CARE	CWFP	Chakaria Community Health Project	ORP Rural	ORP Urban
Involvement of community representatives in planning process		✔	✔		✔	✔	✔	✔	✔	✔		✔
Involvement of community representatives in progress review		✔	✔	✔	✔	✔	✔	✔	✔	✔		✔
Joint planning with stake holders	DGHS	✔		✔	✔	✔	✔	✔		✔		✔
	DFP	✔	✔	✔	✔	✔			✔	✔	✔	✔
	DCC						✔		✔			✔
	NGO	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Social Welfare	✔	✔					✔		✔		
Provision of soft fund		✔	✔		✔	✔						
Incentive for good performance (providers)		✔	✔	✔	✔	✔	✔		✔		✔	
Community contribution or local fund generation		✔		✔	✔	✔	✔	✔		✔		
Technical assistance and facilitation at thana and union levels		✔	✔	✔	✔	✔		✔		✔	✔	
Technical assistance and facilitation at ward and zonal levels							✔		✔			✔

Review of International Experiences

Studies conducted in less developed countries on planning and development indicate that the essential task for system planning are determination of goals and policies; identification of problems; development of information; analysis of constraints; design and specification of programs and projects to achieve goals; development of criteria for decision making; implementation; evaluation; review and revision [25].

Study conducted by the Tanzanian and Swiss governments in Dar es Salaam revealed that it is possible to improve service delivery through establishing process oriented approach in health service planning. The study also added that this approach intended to fix targets at operational level which could be easily monitored [26].

In India studies at health centers revealed that different planning strategies appropriate to the particular configuration of factors affecting PHC performance were required. In this context three different foci were indicated: ensuring needed inputs, planning for workers' performance, and activity planning based on clients' needs [27].

An experiment conducted for improving the effectiveness of multi-purpose PHC worker, also in India proved that an activity planning process can help to improve the efficiency and effectiveness of the multi-purpose worker, particularly in the area of family welfare. The most important components of such processes are: planning should be done at the workers' level and a culture has to be created in which data are used at their levels to understand the profile of clients and villages, and to plan appropriate activities on the basis of this analysis [28].

Effective decentralized planning stimulates community participation to determine the needs of the community, inter-sectoral collaboration to confirm congruity between the goals of the Ministry of Health and programme operational levels, and consolidation of services, manpower, equipment, training etc. [29].

The Korean Ministry of Health and Social Affairs mobilized the rural mothers' club to expand family planning programming to the village level and to encourage family planning activities from the people rather than being imposed from the above. Study findings revealed that today a network of 25,000 married women's club with more than 500,000 members functions throughout rural Korea. These clubs meet to discuss family planning among themselves and with programme field workers, recruit new acceptors, counter unfavorable rumors, and distribute supplies. The study has also indicated a higher level of knowledge about contraception among members [30].

Lessons Learned

1. The success of the local-level planning interventions seems to be heavily determined by the commitment and skills of thana managers. Some practical training on planning, systematic performance review and supervision could help to enhance the skills of thana managers.
2. In the government set-up, there are committees at district, thana and below which are supposed to meet every month for planning and reviewing performance. These committees are largely ineffective. NGOs can provide generalized support to GoB to make the committees more effective in urban areas, there is a need for continuation of external facilitation (by some NGOs) to make zonal committees functional.
3. The potential of the zonal committees is hampered by the absence of systematic monitoring at higher levels.
4. Involvement of all of the stakeholders in zonal committee activities is limited. This may be due to the ambiguity over the role of municipal bodies and MOHFW departments in coordinating urban health programme. The limited

participation of MOHFW officials can seriously affect the implementation of some activities of the committees. The involvement of MOHFW officials in the committees, therefore, need to be enhanced through advocacy with the respective departments.

5. Traditionally, Ward Commissioners are engaged on development activities other than health. Therefore, the expectations about involvement of community leaders in the interventions need to be realistic.

6. There is some evidence that the community networking activities using indigenous organizations are feasible and could lead to improvement of health conditions.

7. Lessons learned from supervision and community involvement are not always well documented in NGO settings.

8. In most of the pilot projects in the areas of local-level planning in both GoB and NGO settings, a considerable amount of additional inputs are provided, this inputs may include as consultant staff, provision of transport for field workers and supervisors, fund for clinic repairs, construction of training centers and special funds for activities at union and thana levels.

Needs for the Future

The following issues need to be addressed in designing the intervention to promote local-level planning and coordination for effective delivery of ESP:

- **Emphasize the change from Family Planning and MCH to ESP**
  The introduction of the Essential Services Package (ESP) as part of the Health and Population Sector Strategy poses new challenges. Organising the delivery of ESP calls for a "systems approach" that has been largely absent from previous interventions. In other words, past interventions were limited by systemic factors to selected services such as child immunization or family planning. Therefore, the future interventions need to emphasize the change from family planning and MCH to ESP.

- **Focus on the transition from doorstep to static clinics**
  The traditional emphasis on home visits by health and family planning staff has been replaced with community clinics, as the key service delivery strategy. Planning and coordination activities, information systems, monitoring practices and supervision guidelines need to be adapted to this change. So the interventions should focus on the transition from doorstep to static clinics.

- **Increase the involvement of NGOs in the local-level planning process**
  The MOHFW has plans to review its own internal procedures to determine ways and means to ensure maximum productivity from MOHFW/NGO partnerships, with particular attention to accountability and cost effectiveness. Increase involvement of NGOs in the local-level planning process has to be considered prior to designing an intervention.

- **Ensure involvement of community**
  Increased support from the community will be needed to generate additional programme resources, to increase client motivation, and resolve service delivery problems at local level. So future interventions should ensure involvement of community for sustaining health and family planning programme.

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Persons Contacted

1. Thana Health and Family Planning Officer, Thana Family Planning Officer, Medical Officer-Maternal and Child Health of Abhoynagar, Mirsarai and Patiya Thanas.

2. Two Family Planning Inspectors of Abhoynagar and one Family Planning Inspector of Mirsarai Thana.

3. One Health Inspector and two Assistant Health Inspectors of Abhoynagar Thana.

4. Officials of urban service delivery partners (Concerned Women for Family Planning, Population Services and Training Centre and Progati Samajkallan Prothistan).

5. Officials of rural service delivery partner (BRAC, Pathfinder International and Swanirvar Bangladesh).

6. Officials of Thana Functional Improvement Pilot Project, Comilla, Bagarhet and Dhaka.

7. Officials of Family Planning Management Development.

8. Staff members of Operations Research Project , Abhoynagar, Mirsarai and Patiya field stations.

Annex-1

Questionnaire used for collection of information related to Local-level planning, supervision and monitoring

Date of Collection: _____

Name of the Organization: _____

Name of Union: _____

Name of District: _____

Designation of the respondent: _____

01. Is there any LLP process in your Department/Programme?
Yes ☐ No ☐

02. If yes, what are those, explain (check/collect the related document)?

03. If no, how do you plan, supervise and monitor your programme?

04. Do you think that the existing LLP mechanism fulfill your programme goal?
Partially ☐ Fully ☐

05. If it is partially helpful, which area needs further modification and how?

06. Do you think that planning, supervision and monitoring is needed for your programme?
Yes ☐ No ☐

07. How do you supervise, do you use any tools for supervision?

08. Do you Have any schedule for supervision?
Yes ☐ No ☐

09. How frequently do you supervise your staff?

10. What do you do with the supervision findings?

11. Do you have any suggestion to improve the supervision system?

N.B. Collect all the relevant tools and formats.

Annex-2

মিটিং পর্যবেক্ষণ চেকলিষ্ট

অপারেশন্স রিসার্চ প্রজেক্ট

হেলথ এন্ড পপুলেশন এক্সটেন্শন ডিভিশন (HPED)

আইসিডিডিআর,বি

তারিখঃ /___/___/___/
দিন মাস বছর

মিটিং শুরুর সময়ঃ |__|__|__|__|

মিটিং শেষ করার সময়ঃ |__|__|__|__|

ইউনিয়নঃ |__|

মিটিং এর ধরণঃ

- FWC পাক্ষিক মিটিং |__|

- মিড-লেভেল সুপারভাইজার মিটিং |__|

- বেতন প্রদান দিবস মিটিং |__|

- অন্যান্যঃ _____ |__|
উল্লেখ করুন

.....

মিটিং এ উপস্থিতঃ কোড নম্বর ব্যবহার করুন, যেমন-

৭জন | ০ | ৭ | হলে ১১ জন | ১ | ১ | হলে, অথবা নিম্নের প্রযোজ্যটিতে দাগ দিন।

সরকারী পক্ষ থেকেঃ

TH&FPO|___| FPO|___| MO-EPI|___| MO-MCH|___| MO-FW|___|

ATFPO|___| SFWV|___| FPI|___| MA|___|___| FWV|___|___|

FWA|___|___| AHI|___|___| MA|___|___|

অন্যান্য (পদবী লিখুন) _____

মিটিং কে পরিচালনা করেছেন? _____

	সংগঠন	হ্যাঁ	না	প্রযোজ্য নয়	মন্তব্য
1.1	মিটিং এ কোন লিখিত বা অলিখিত আলোচ্যসূচী অনুসরণ করা হয়েছিল কি?				
1.2	আলোচনা লিপিবদ্ধ করার জন্য কাউকে কি নির্ধারণ করা হয়েছিল? (হ্যাঁ হলে, মন্তব্যের ঘরে পদবী লিখুন)				
1.4	পূর্ববর্তী মাসের মিটিং রেগুলেশন পড়ে শুনানো হয়েছিল কি?				
1.5	সভার আলোচ্য বিষয় সমূহ লিপিবদ্ধ করা হয়েছিল কি?				
2.0	**তথ্য উপস্থাপন**				
2.1	***FWV তথ্য:***				
2.1.1	প্রত্যেক FWA-র CAR (বৃদ্ধি বা কমতি) নিয়ে আলোচনা হয়েছিল কি?				
2.1.2	প্রত্যেক FWA-র কাজের অগ্রগতি নিয়ে আলোচনা করা হয়েছিল কি?				
2.1.3	প্রত্যেক FWA-দের পরিত্যাগকারীর সংখ্যা এবং তার কারণ ব্যাখ্যা করা হয়েছিল কি?				
2.1.4	FWA-দের CAR এর তুলনামূলক আলোচনা হয়েছিল কি?				
2.1.5	কোন FWA-র কাজের প্রসংসা করা হয়েছিল কি?				
কোডঃ হ্যাঁ=১, না=২, বলার পরে করেছেন=৩, প্রযোজ্য নয়=৯ (যেটি সঠিক তাতে গোল দাগ দিন)					
2.2 HA তথ্য:					
2.2.1	কতগুলো ম্যালেরিয়া রুগী চিহ্নিত করা হয়েছে?				
2.2.2	ম্যালেরিয়া চিকিৎসা সংক্রান্ত আলোচনা হয়েছে কিনা?				
2.2.3	কতগুলো রক্ত কাঁচ সংগ্রহ করা হয়েছে?				
2.2.4	নিম্ন লিখিত রোগ সম্পর্কে আলোচনা হয়েছে কিনা? ক) ডায়রিয়া খ) কলেরা গ) টাইফয়েড ঘ) হেপাটাইটিস				
2.2.5	মহামারী আকারে কোন রোগ দেখা দিয়েছে কিনা এবং তা নিয়ে আলোচনা হয়েছে কিনা?				
2.2.6	ইপিআই কার্যক্রমের অগ্রগতি আলোচনা হয়েছে কিনা?				
2.2.7	ভিটামিন-এ বিতরণ/রাত কানা রোগ সম্পর্কে আলোচনা হয়েছে কিনা?				
2.2.8	পরিবার পরিকল্পনা পদ্ধতি বিতরণ ও অনুসরণ নিয়ে আলোচনা হয়েছে কিনা?				

সংগঠন	হ্যাঁ	না	প্রযোজ্য নয়	মন্তব্য
3. তথ্য ব্যবহার				
3.1 FWA/HA-দের রেজিষ্ট্রার পরীক্ষা করা হয়েছে কি? (মন্তব্যের ঘরে FWA/HA-দের নাম লিখুন)				
3.2 ওআরএস (FWA/HA) সম্পর্কে আলোচনা হয়েছিল কি? (মন্তব্যের ঘরে নাম লিখুন)				
3.3 ইপিআই (FWA/HA) সম্পর্কে আলোচনা হয়েছিল কি?				
3.4 স্যাটেলাইট ক্লিনিক/ইপিআই কার্যাবলী সম্পর্কে আলোচনা হয়েছিল কি? (মন্তব্যের ঘরে নাম লিখুন)				
3.5 মা, শিশু-স্বাস্থ্য সেবা সম্পর্কে আলোচিত হয়েছিল কি?				
4. মাঠ পর্যায়ের সমস্যাঃ				
4.1 অসহযোগী ক্লায়েন্ট (স্বাস্থ্য ও পরিবার পরিকল্পনা) সম্পর্কে কোন আলোচনা হয়েছিল কি?				
4.2 সেবা গ্রহণকারীর পার্শ্ব প্রতিক্রিয়া বা জটিলতা সংক্রান্ত কোন আলোচনা হয়েছিল কি?				
4.3 জটিল গর্ভ সংক্রান্ত মায়েদের সম্পর্কে আলোচিত হয়েছিল কি?				
4.4 অন্যান্য কোন সমস্যা কি আলোচিত হয়েছে?				
4.5 সরবরাহ সমস্যা সম্পর্কে কোন আলোচনা হয়েছিল কি?				
5. প্রশাসনিক বিষয় সমূহঃ				
5.1 FWA/FPI/FWV/MA/HA/AHI-দের ছুটি সংক্রান্ত বিষয় আলোচিত হয়েছিল কি?				
5.2 FPI/AHI সাহেব, FWA/HA বা অন্যান্যদের নিকট নতুন কোন নির্দেশনা নিয়ে আলোচনা করেছেন কি? (মন্তব্যের ঘরে লিখুন)				
6. প্রশিক্ষণঃ				
6.1 কোন প্রশিক্ষণের প্রয়োশনীয়তা নিয়ে আলোচনা হয়েছিল কি?				
6.2 কোন প্রশিক্ষণ দেয়া হয়েছিল কি? (মন্তব্যের ঘরে নাম লিখুন)				
6.3 কোন বিষয় সম্পর্কে প্রশিক্ষণ দেয়া হয়েছিল? (মন্তব্যের ঘরে তালিকা বদ্ধ করুন)				

কোডঃ হ্যাঁ=১, না=২, বলার পরে করেছেন=৩, প্রযোজ্য নয়=৯ (যেটি সঠিক তাতে গোল দাগ দিন)

পর্যবেক্ষণের উপর ভিত্তি করে আপনার মন্তব্য লিখুন।

মন্তব্য লিখার সময় যে সমস্ত বিষয় বিশেষ গুরুত্ব দিতে হবে, তা হলোঃ

(১) Supervisor এর ভূমিকা সক্রিয় ছিল কিনা (২) বিলম্বে উপস্থিতির জন্য supervisor কোন মন্তব্য বা কোন ব্যবস্থা গ্রহণ করেছিলেন কিনা (৩) FWA/HA-র ভূমিকা সক্রিয় ছিল কিনা (৪) FWV কতক্ষন সময় মিটিং এ ব্যয় করেছিলেনঃ মিটিং-এ MA সাহেবের কোন ভূমিকা ছিল কিনা, মিটিং এ কোন থানা কর্মকর্তা উপস্থিত ছিল কিনা এবং তার ভূমিকা কি ছিল?

Supervisor দের জন্য প্রযোজ্যঃ

	FPI	AHI
১। কতদিন কর্মীকে পরিদর্শন করেছে	_____	_____
২। কতদিন উপাত্ত যাচাই করেছে	_____	_____
৩। কয়দিন স্যাটেলাইট/ইপিআই কেন্দ্র পরিদর্শন করেছে	_____	_____
৪। কতজন পরিত্যাগকারীকে অনুসরণ করেছে	_____	_____
৫। কতজন পার্শ্ব-প্রতিক্রিয়ার ক্লায়েন্টকে পরিদর্শন করেছে	_____	_____
৬। মাঠের সমস্যা নিয়ে আলোচনা করেছে কিনা	_____	_____
৭। সরবরাহ সংক্রান্ত বিষয় নিয়ে আলোচনা করেছে কিনা	_____	_____

পর্যবেক্ষণের উপর ভিত্তি করে আপনার মন্তব্য রাখুন।

Annex - 3

Existing status of LLP intervention in Abhoynagar and Mirsarai

Components	Current status		Reasons behind the activities going on or not	
	Abhoynagar	Mirsarai	Abhoynagar	Mirsarai
1.Develop micro plan (action plan): - detailed activity planning at the worker's level - identify problems - find solutions at local and higher levels - set targets and time frame - assess supports - assign responsibilities	- Not carrying out	- Developed action plan by FPIs and FWAs for their unions	- There is no clear-cut instruction from district authority to continue the activity - Our project's support to the intervention does not continue after evaluation of the intervention - The supervisors (FPIs) and thana managers are not committed to carrying out the activities	- Thana managers are interested in carrying out the activity
2. Strengthening HFWC and supervisory meetings: - provide problem solving support - motivate staff - negotiate with higher authorities for support	- HFWC meetings are going on, but the meetings are not organized according to the mechanism designed for the intervention i.e.: - no agenda for discussion - no meeting minutes of last meeting and no notes were taken for minutes of current meeting - MCH and health issues were not discussed in the meeting - supervisory findings were not shared in the meeting.	- The component is functioning in supervisory meeting. i.e. : - the meeting held in time - there was written minutes of last meeting and one person was assigned for taking notes - there was agenda for discussion - exclusive performance review was done - some local problems were discussed and solved at the meeting - The component is also going on in HFWC meeting which was informed us by FPI.	- Weak accountability - Lack of intensive support from ICDDR,B - Conflict between health and family planning wings resulted to stop the supervisory meeting.	- Thana managers are interested in carrying out the activity to make the forum useful.

Components	Current status		Reasons behind the activities going on or not	
	Abhoynagar	Mirsarai	Abhoynagar	Mirsarai
3. Introducing follow-up review process in the meetings: - review and monitor performance - revise action plan - reassign tasks/ responsibilities	- Component not in place	- Component is going on well at supervisory meeting. The meeting reviewed the performance of the workers of LLP intervention unions. Moreover, performance of all other interventions is being reviewed using the mechanism developed for the LLP intervention	- Lack of commitment among thana managers . - Conflict between health and family planning wings	- Thana managers as well as supervisors find it as a useful mechanism for improving program performance
4. Introducing monitoring tools for FPIs, AHIs and SFWVs	- Neither FPI nor AHI diaries are used by the supervisors.	- FPI diary is used by the FPIs. THE&FPO is interested to introduce AHI diary in his thana.	- They consider the diary as an extra burden.	- Thana officials feel that these are useful tools for supervision and monitoring

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. In 1982, the MCH-FP Extension Project (Rural) with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, 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 governmental 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, management information systems, and 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.

The Centre and USAID, in consultation with the government through the Project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. In 1994, the Centre began an MCH-FP Extension Project (Urban) 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 in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve t he commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.

The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to program managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid 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 underserved and population-in-need. There are various projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures. These cut across several Divisions and disciplines in the Centre. The Operation Research Project (ORP) is the result of merging the former MCH-FP Extension Project (Rural) and MCH-FP Extension Project (Urban). These projects built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. Together with the Environmental Health and Epidemic Control Programmes, the ORP provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. For one, the public health research activities of these Projects are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, 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 program performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national program at Thana, Ward, District and Zonal levels both in the urban and rural settings.

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