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**Bangladesh's Experiences
with Human Resource
Development Strategies
in Family Planning
Service Delivery:**

**A Critical Look at the Past and
Directions for the Future**

**Syed Shamim Ahsan
Aye Aye Thwin**



**Operations Research Project
Health and Population Extension Division**

1998



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Abstract

As the new millennium draws near, Bangladesh continues to face challenges such as poverty, poor health and population growth. The country has experienced significant decline in fertility and childhood mortality with highly successful family planning and immunization programmes that are acclaimed internationally. As a response to the population crisis problem of the early seventies, the delivery of family planning services was given full attention with strong donor support and political pressure. The ultimate result was the creation of a vertical programme of mammoth proportions that concentrated primarily on increasing contraceptive use and reducing fertility. After two decades of aggressive implementation and a steady progress in demographic indicators, the attention shifts toward developing a viable infrastructure enabled to meet the demands of market forces. A sector-wide strategy was developed to reform and restructure the national health service delivery systems where family planning services providers and managers address a broader context of reproductive health integrated within a package of essential health services. Policy makers now face the daunting challenge of implementing human resource development strategies that prepares personnel to provide these services and address the demands of a consumer population that is increasingly becoming empowered with improved economic and educational opportunities.

Current priorities include enhancing efficiency through decentralised management systems, and creating a service environment that focusses on quality, improving accountability and effective career development mechanisms. Discontentment in the past regarding job security, transfers, posting, career pathways, and encadrement are challenges of the present times. Laws and regulations regarding personnel administration need to be reviewed to ensure their appropriate use in recruitment, termination, severance and the improvement of public accountability. The essential task at hand is to prepare the organisational climate to enable restructuring of service delivery systems and the provision of a wider range of services.

Initiatives to mobilise other resources such as community volunteers, depot holders and local leaders are also being explored. Efforts to enhance the role and capacity of NGOs in health care delivery gain momentum through large scale programmes, such as the USAID-funded National Integrated Population and Health Project (NIPHP) and the Health and Population Sector Programme (HPSP).

Existing human resource development programmes need to be redesigned to enhance clinical and managerial skills, especially to improve the quality of services for clinical contraception, and to address emerging problems of sexually transmitted diseases, reproductive tract infections, HIV/AIDS, etc. One critical task would be to develop programme activities geared towards integrating family planning service delivery within the essential health services package. Overall, there is need to have long-term goals for human resource development, to develop strong trainers and training managers, to institutionalise monitoring systems and databases that augment training programmes, and to explore training opportunities within the private sector. It is also essential to strengthen linkage and coordination between human resource development strategies and the country's overall educational development initiatives.

As the government, with the support of donors and other development partners, explores and embarks on health sector reform, strong leadership and political support are essential to enhance commitment amongst stakeholders in facilitating and participating in the change process.

Introduction

Bangladesh's development agenda place health and population as urgent priorities to be addressed with full political support. The nation's population is currently estimated at 123 million, and is projected to grow to 250 million, to stabilise only after 40-50 years. The socio-economic scenario required to counteract this state, feed and sustain a population of this magnitude is beyond the current capacities of the country. The current level of GNP per capita at US \$240.00 is among the lowest in the world, and poor health indicators pose a major problem. Over 90 percent of children are malnourished, and people remain plagued with poverty-related infectious diseases worsened by the effects of poor nutritional status. Bangladesh is the most densely populated country in the world, and is also undergoing rapid urbanisation with inadequate basic services for its people. In this sense, the need to control population growth is still urgently required, in spite of major advances and achievements made so far.

Even in the midst of such a scenario, the nation is at a positive stage in its history. It seems that the political system is stabilising and social progress is gradually achieved by direct investments in women's education and employment opportunities. Tremendous gains have been made through small scale credit and entrepreneurial activities that empower the poor, stabilise the rural economy and enable fertility decline. The contribution of leading non-governmental organisations (NGOs), such as BRAC and Grameen Bank, in social mobilisation and grass roots development have been internationally acclaimed. The nation's leaders emphasise structural reforms for enhanced accountability and improved services for the people. A consensus has been reached between the Government, the donors and other stakeholders to improve health and reduce population momentum through improvements in both quality and availability of health and family planning services.

Bangladesh's strong population programme has made remarkable progress. It is the only country among the poorest, where sustained fertility reduction has occurred over the last 15 years, despite its slow socio-economic development. Contraceptive use has increased from 3 percent in 1971 to 49.2 percent in 1997, with a dramatic fertility decline from 7 births per woman to 3.3 over the same period (Mitra *et. al.*, 1997). At present, policy makers face the challenge of adapting the programme from one that used to emphasise contraceptive use prevalence, to one that addresses unwanted fertility. It is now

critical to reduce unmet need for family planning services, and sustain demographic transitions achieved so far. Therefore, the fundamental principle of the future population policy of Bangladesh is to understand and respond to the underlying causes of unwanted births and demographic momentum.

In line with the rhetoric of the International Conference on Population and Development (ICPD) held in Cairo in 1994, the population programme needs to move away from target-driven demographic goals towards a holistic approach aimed to serve individual clients' needs, especially that of women's. The emphasis is to empower women to exercise their reproductive rights, make informed choices, and take advantage of an entire range of services that sustain their health, not just control their fertility. Bangladesh is at the crossroads of reform where previously vertical programmes of health and population are now to be merged into a single strategy that offers quality services, has adequate delivery capacity and is financially sustainable. The fundamental principle of the sector strategy is to enable poverty alleviation and gender equity in development benefits, and also to target the underserved population groups.

Such changes in strategic direction require the reengineering of human resource development strategies that enable service providers and programme managers to perform the required responsibilities. ICPD's objectives emphasises "retention, motivation and participation of appropriately trained personnel working within effective institutional arrangements, as well as relevant involvement by the private sector and non-governmental organisations" (ICPD, 1994). It calls for adequate management capability of the personnel, for strategic planning and programme execution. The specific objectives for human resource development in ICPD's Programme of Action indicate the need to improve national capacities, skills and accountability of managers and service providers especially to the most vulnerable groups in society. The present paper reviews the lessons learned to inform what future directions are required to tailor to the changing context of the programme.

History of Population Sector Development

Bangladesh's population movement has undergone several dynamic, evolutionary transformations and continues to make an impact on both societal and programmatic fronts. The country's programme has changed in strategy, structure, content, goals and overall dimension over the last 35 years, and will again be restructured to meet present needs.

The population programme was initiated in the early fifties as a voluntary effort of social and medical workers by a non-governmental organisation (NGO), the Family Planning Association of Bangladesh. By 1960, the underlying issues of impending population growth started to emerge, and a population policy aimed at fertility reduction through a National Family Planning Programme was launched in 1960. This brought the advent of delivering family planning services through government health care facilities.

The next ten years reconfirmed the initial antinatalist policy, and the post-liberation period witnessed large scale field-based government family planning programmes administered by an autonomous board. During the seventies, the programme received unanimous high level political support and a separate organisational structure was created to provide family planning services, in close linkages with the general administration.

After liberation of Bangladesh, there were some attempts to integrate the population programme into health services delivery which were later aborted. The programme remained separate, and was managed by the "Population Control and Family Planning Division" created within the Ministry of Health and Family Planning. The division had the responsibility to formulate policy and establishing demographic goals, development of strategies and programmes and coordination of family planning activities.

The late seventies also introduced an important milestone where maternal and child health (MCH) became a fundamental principle to family planning services delivery through multi-sectoral approaches. The programme was committed to extend coverage and accessibility among women. Thus, doorstep delivery of contraceptive services by female field workers was initiated to address social barriers that limit the mobility of female clients to seek services. The "MCH-based" family planning programme strategy aimed at integrating primary health care, maternal and child health and family planning at the field level. A "cafeteria" approach was applied, to enable choice based on an entire range of family planning methods. Non-governmental organisations (NGOs) contributed considerably towards mobilising community participation and support. Substantial inputs were given to training to strengthen skills in clinical services and communications strategies. Innovative activities, evaluations and operations research were carried out to monitor programme outcomes.

All successive governments that came into power in Bangladesh gave priority to the population programme. In late 1989, a high level, broad-based National Council for Population Control (NCPC) was formed, headed by the

President of the People's Republic of Bangladesh. Senior policy makers, religious leaders, experts and representatives from various development organisations participated in this forum. The public was sensitised at all levels on population issues confronting the nation, and population became a social movement towards achieving national development goals. This council was later renamed, and evolved into the National Population Council headed by the Prime Minister in the early nineties.

The Recent Past: A Situational Analysis

Service delivery infrastructure

The Government of Bangladesh has been the main provider of family planning services with a substantial contribution from the commercial sector and the NGOs. At the central level, the Ministry of Health and Family Welfare (MOHFW) was responsible for macro-level policy and planning, and formulated the National Family Planning Programme and its goals. The Ministry was the highest executing authority with two Directorates, one for health services and the other for family planning programmes. Thus, for two decades, Bangladesh presented a unique picture of bifurcation between health services and family planning programmes, which also connected to a divide between the two sectors of health and population. The Ministry was guided by the National Population Council, which consisted of over 350 persons from different settings, including members of parliament, professional groups, women groups, private sector and NGOs. The council provided policy guidelines and recommended strategies for family planning programme implementation.

Until recently, the priorities of the population policy were to enhance national commitment and create a social movement to promote small family norms. There was concern to focus family planning activities on under-served groups, newly wed couples and low performing geographical areas. There were also attempts to encourage the participation of local, community leaders in the programme, and extend family planning activities through inter-sectoral family welfare programmes through pilot projects. The programme faced challenges to effectively promote quality of care and appropriate method choice, and was rife with numerous organisational conflicts and management problems. Supervision and monitoring were deficient at all levels of service delivery. Considerable attention was given towards enhancing collaboration between government and

NGOs, delineating specific functional areas and targets. However, with heightened emphasis on coverage indicators, NGOs ended up performing a substitutory role to cover programme areas that the government infrastructure was not able to reach. Ultimately, there was duplication of roles which limited the capacity of these private voluntary organisations to be truly innovative and risk-taking in addressing unmet demand, serving the poorest of the poor and developing alternative means for service delivery.

The National Family Planning Programme was implemented through the Directorate of Family Planning headed by a Director General, and supported by Directors of functional units with service delivery structures reaching union (county) level. Three distinct sectors, i.e. the Government, NGOs and the private sector (such as the Social Marketing Company) participated in family planning programme implementation. Within the public sector, family planning service delivery comprised a country-wide organisational set-up to provide quality services through a large cadre of personnel. There were managers at division, district and thana (sub-district) levels. Clinical services were provided by doctors and paramedics. Field workers and their supervisors mainly delivered domiciliary services. The family planning infrastructure at District and Thana levels also included other personnel that performed managerial and supervisory roles, especially for clinical contraception.

In 1997, there were 93 Maternal and Child Welfare Centres (MCWCs), 401 MCH units at the Thana Health Complexes, and 3000 Health and Family Welfare Centres (H&FWCs) at the union level. Outreach facilities included 30,000 satellite clinics scattered throughout the country. The family planning services infrastructure deployed 23,500 field workers at the community level through the public sector, with additional support from 12,000 more from the network of NGOs. A rough total of 35,500 field workers provided contraceptive services at the door-step of consumers. The role of field workers were mainly to provide information, counseling and motivation for method choice, advice for antenatal care, and referral for clinical contraception and other health service needs. Family Planning field workers also assisted in public health initiatives such as with the Expanded Programme of Immunisation (EPI). Paramedics, based at union-level H&FWCs, provided basic curative care, clinical contraception services, antenatal care, safe delivery and preventive health services for children under five years of age.

The government infrastructure had 94 percent of all positions filled. The number of vacancies was highest among doctors, pharmacists and programme

managers or trainers. This limited the potential of the programme to effectively implement clinical contraception programmes, and reduced the capacity for monitoring and supportive supervision. Field workers who distributed pills and condoms through home visits comprised the highest number of filled positions, and henceforth, the programme relied primarily on temporary methods. Service delivery personnel constituted more than 81 percent of total occupied positions which largely reflected the government's role as the main producer of family planning services in the country. Strangely enough, there was very little association between the ratio of population per public sector family planning personnel, and contraceptive use indicators, implying the extent of demand forces in society. Poverty, economic opportunities and socio-cultural factors had also influenced fertility behaviour. Certain geographical areas such as Barisal Division, in the south, exhibited high levels of contraceptive use, even with the worst supply of family planning workforce. In contrast, the opposite occurred in the South-east, in Chittagong Division, where contraceptive use was low in spite of low population/personnel ratios. These issues reflected certain societal dynamics in the market for family planning services, and questioned the role of the government machinery in the population programme.

In the private sector, the contribution of NGOs was substantial. Approximately 1,000 NGO family planning projects were established in the country. Social marketing outlets for oral contraceptives and condoms increased gradually in the commercial sector, to a total of 7,372 stockists and 44,306 retailers; 18 percent of these outlets provided pills, and 65 percent provided condoms.

The analysis of gender distribution in the workforce illuminated certain anomalies. Public sector family planning services have been predominantly managed by men and implemented by women. Certain categories of grassroots field workers and paramedics have been exclusively female. Women represented 69 percent of all available positions, but were seriously under-represented in management and supervision positions. Only 12 percent of trainers and 10 percent of managers were female. The situation needed to be adjusted to enable the forthcoming agenda that place female empowerment, gender equity and women's reproductive health rights as focal issues.

Prevailing problems with human resource development

Most cadres of field personnel were trained by the National Institute of Population Research and Training (NIPORT). The institute has training institutes

for paramedics at the district level, and thana (sub-district) level regional training centres for field workers' skills development. The training infrastructure is spread throughout all regions of the country to enable equal opportunities for human resource development and to facilitate training according to the needs of the local setting. The institute is equipped with its own in-house research unit that conducts operations research on training and generates evaluative information on the quality and management of training programmes. Although NIPORT has been the main hub of training for the national maternal and child health and family planning programme, there were still a lot of other agencies and organisations both within the public and NGO sector that have training resources. In spite of various attempts to develop systematic plans for training, urgent demands to fulfill targets in service coverage often resulted in ad-hoc responses to implement training programmes (Khuda *et. al.*, 1994). This created a strain on training resources, and invariably affected the quality of training in adverse ways. Inadequate skill-mix of trainers, their insufficient understanding of, and/or experience with, field conditions all added to sub-optimisation of training programmes. As training institutions were mainly funded through external assistance, the lack of job security for trainers create a high degree of anxiety with adverse effects on organisational climate. However, the growing emphasis on sustainability created the move to develop a strategy and long-term plans for human resource development for the population sector. In early 1998, the MOHFW formulated a Master Plan for Human Resource Development for both health and family planning service delivery systems.

Although the population sector had ample opportunity to employ professionals from various disciplines, the career pathways of personnel have been quite limited, both at central and field levels. Management and supervisory systems were fairly weak, and personnel were often overburdened with managerial tasks that they are often untrained for. Unrealistic and demographically driven targets, combined with low government salaries and limited prospects for career development reduced job satisfaction and commitment towards providing services and/or managing programmes (Haider, 1996; Begum, 1996). Personnel trained in specialised areas were often misplaced in settings with little opportunity to utilise their skills in an optimal manner which led to brain-drain of trained professionals. As a consequence, the quality of service delivery according to standard guidelines reduced considerably. Planners are now faced with formidable challenges to address quality improvement as an integral component to effectiveness and sustainability in the forthcoming phases of the programme.

Bangladesh's population issues had taken on the mantle of being a social movement, and as the programme matured, there were many novel approaches towards resource mobilisation geared towards increasing access and ensuring programme sustainability. Promotion of fertility control and family planning through voluntarism, which first initiated the programme, continued either as social experiments and/or community-based interventions. There was considerable attention towards enhancing community participation, involvement of local leaders and identifying informal outlets for contraceptive distribution such as with depot holders, and traditional birth attendants. Temporary contraceptive methods were also distributed by local shops, drug stores and pharmacies, and sometimes, the counselor is the sales person. The gamut of human resources that participated in providing access to, and promoting family planning became quite diverse, through planned and unplanned market-driven channels. Not all resources and outlets were linked with formal skill-based training programmes, let alone be appraised and regulated for quality control. With increasing emphasis on clinical contraception, certain experiments to explore ways to enable private for-profit providers to provide injectable hormonal contraceptives (DMPA) and intrauterine devices (IUDs) were planned.

This led to an emerging debate over the future role of the government, from being the main producer of services to that of establishing standards, supervising and regulating service provision from private non-profit organisations and the commercial sector. The programme needed to be planned according to market forces, and the government's responsibility was to provide safety nets for market failures, such as the poorest of the poor and the marginalised population. It was essential for human resource development planning to weave in strategies to enhance capabilities and critical thinking for leadership and advocacy.

The Government's education policy aims at poverty alleviation and improving the productive capacity of the workforce. The main groups who have the least access to educational opportunities were the rural landless, the urban poor and women. Limited access and low quality educational services have consistently been constraints towards female participation in all subsectors of education, including vocational training. Special attention was given towards improved opportunities for women through scholarship programmes and food for education initiatives (Jones, 1992). The latter enabled girls to study at primary schools for incentives of food for the family, and is primarily directed at rural areas. Such initiatives facilitated considerable progress in improving women's

opportunities. Although overall gender inequalities still remain, girls' enrollment at primary school levels, based on total enrollments rose from 38 percent in 1977 to 47 percent in 1993. The gender gap in enrollment (100 - the ratio of females to males) in primary school also reduced from 61% to 14% between 1960 and 1990 (Human Development Report, 1994). The percentage of female teachers, however, remains low in all subsectors, especially in technical and vocational training. This was a deterrent towards motivating girls to remain in school, which in turn, minimized the pool of educated women who could be recruited as service providers and programme managers.

Lessons Learned from Past Strategies and Directions for the Future

The population programme in the past was implemented aggressively to fulfill demographic targets, and was highly successful in this regard. Relatively less attention was given towards developing a stable infrastructure that would sustain itself as a viable management system over the years. The investments towards retaining field personnel through local/national funding sources was rarely explored, and with reducing donor funds, the job security of the peripheral workforce is now at risk. This created a high degree of anxiety among field personnel, with adverse effects on organisational climate and also performance. Structural reform measures would have to consider how to safeguard job security and establish a practical system of performance appraisal to achieve optimal productivity.

The strategy of using field workers for door-to-door service delivery was essential in the beginning of the programme as the priority was to increase awareness about the need for family planning. With heightened emphasis on a holistic approach towards women's reproductive health through an essential service package, the role of field workers needed to be redefined. Providing a range of services to address clients' needs and enhance programme sustainability also calls for service delivery through clinics and static centres. In this context, conventional door-step delivery, once viewed as radical, is no longer practical for future programme needs: Thus, human resource development activities should adapt to changes in strategic vision and the demands of a consumer population that is increasingly becoming empowered with improved economic and educational opportunities.

As the earlier phase of the programme emphasized coverage through field workers, the range of family planning service was limited to temporary methods such as pills and condoms. Current priorities now stress the need to enhance the delivery, quality and use of longer term, clinical contraception. Improving the capabilities of service providers and programme managers to effectively deliver a clinical contraception programme together with a range of other reproductive health and child survival activities definitely call for major investments in reorientation and retraining. At present, the personnel are quite unprepared to tackle other recent priorities interwoven with family planning, such as the problems of sexually transmitted infections, reproductive tract infections and the critical issue of HIV/AIDS. The Government and its development partners are committed to launch full-scale programmes on research, training and service delivery to address these problems.

In earlier days, the programme was built and implemented on the basis of demographically driven targets, and providers and managers became conditioned to concentrate on achievements by geographic areas and cross-sectional rates and ratios. The new approach towards client-centredness necessitates the assessment of needs, and reproductive history of individual consumers and a perspective towards health improvement rather than just promoting service use. It requires a change of *ethos* through sensitivity training and reorientation of priorities.

Although the family planning programme had employed a huge workforce of women at field level, there is a dire need for more women programme managers and policy makers, especially if women's reproductive health rights are to be at the forefront. The programme, earlier on, emphasised coverage and accessibility to family planning services among married women of reproductive age. Although female clients - as a captive audience - were targeted with major success, the programme was deficient in addressing the needs and responsibility of men in reproductive health decisions. At present, even though men generally approve of family planning, actual contraceptive use is still considered a "female burden". The large army of male personnel in family planning programme have been deployed either as programme managers or supervisors, and very few have been given the mandate of serving men. Currently, the system has few service providers that can motivate, or mobilise men towards family planning services, and much less for a broader spectrum of reproductive health decisions.

At present, as programme costs escalate from increasing demand for services and reducing efficiency, it is inevitable that structural reforms be

explored to further improve programme outcomes. One major organisational effort has been to review the feasibility of integrating health and family planning programmes to provide an essential package of basic services. The main elements of the services package consist of reproductive health care, child survival services, communicable disease control, limited curative care and behaviour change communication. Subsequently, the process of reorganising the administrative structures and streamlining support systems becomes a monumental and controversial task. It requires managing change to maintain job satisfaction and commitment of personnel. The role of local government, in connection with more effective implementation, is also being explored, and has raised considerable debate. Enhancing clinical and managerial skills of personnel is a major hurdle in reorganisation and requires a great deal of advance planning. Sattar (1982, 1984) reports that population programmes grew so rapidly in the past that there was very little time for proper organisation and integration of personnel, which in turn, caused a variety of human dynamics problems. Such lessons highlight the need to have a sound and logical change process that ensures transitions with minimal disruption.

Future Priorities of Human Resource Development in the Population Sector

The increasing cost of health care delivery had induced the government to focus on providing an optimal mix of services that would improve efficiency and maximise benefits. Interventions that are public-goods in nature, with important externalities, and those that address the health of mothers and children were prioritised, reflecting the message of the 1993 World Development Report (World Bank, 1993). The priorities of health care delivery for the nineties and beyond highlight an essential services package that aims to improve the health needs of the entire family. The service package is geared towards maximising health benefits relative to per capita expenditure, meet felt needs of the clients, strengthen service delivery and improve system management (MOHFW, 1998).

The basic elements of the essential services package fall into the following areas:

(i) Reproductive Health Care

- including safe motherhood services, i.e. antenatal care, safe delivery and obstetric first aid and referral services, postnatal care;
- family planning services to increase distribution of pills and condoms, emphasise clinical contraception with particular attention to low-performing areas and under-served groups;
- prevention and control of RTI/STD/AIDS, especially in behavioural change communication and condom promotion;
- maternal nutrition;
- adolescent care, emphasising behavioural change messages on proper nutrition and hygienic practices, information regarding puberty, safer sexual behaviour, and avoidance of health risks including STD/HIV/AIDS;
- services that address problems of infertility, particularly if caused by RTIs and STDs such as sexually transmitted chlamydia infection.

(ii) Child Health Care

- includes the provision of basic preventive and curative care for infants and of school children children for ARI, CDD, vaccine-preventable diseases and vitamin A;
- Integrated Management of Childhood Illness (IMCI) as a child survival strategy directed at improved prevention and case management of measles, malaria, malnutrition, diarrhoea and bacterial pneumonia;
- services to address malnutrition especially chronic energy deficiency, protein energy malnutrition, low birth weight and micronutrient deficiency;
- school health services such as first aid care, and periodic health check-ups.

(iii) Communicable Disease Control

- includes services that prevent and manage infectious diseases that have severe health impact (TB, leprosy, malaria, *kala-zar*, and other emerging and re-emerging diseases).

(iv) Limited Curative Care

- refers to the care of common illnesses and injuries (basic first aid, treatment of medical emergencies, pain relief and advice, especially for those in poverty).

(v) Behaviour Change Communication (BCC)

- concerns the provision of information, education and communication (IEC) services to support access to and utilisation of the ESP and to promote healthy behaviour change.

The elements of essential services packages (ESP), are originally taken from the World Development Report (WDR) 1993 and therefore, mostly similar except in grouping the interventions under different headings and in prioritizing the interventions to implement. Under the Health and Population Sector Programme of the GoB, the elements of the ESP are summarized under four main headings as it is in WDR.

A "sector-wide approach" to health service delivery was adopted and the Health and Population Sector Strategy (HPSS) and the subsequent Sector Programme chronicle several major reforms. These documents echo the intentions of ICPD and represent the Government's response to the changing health care market. Thus, the original theme of health care for women and children was expanded to encompass men's health, men's access to services, and enhancing male involvement and responsibility in reproductive and child health decisions. The new programme reaches beyond the provision of health care to ensuring and safeguarding family welfare.

The present approach is programme oriented, and its success is contingent on availability of good managers. The crux of the matter concerns the current state of human resources, and whether there is adequate clinical and managerial skills to deliver the essential services package throughout the country. Decision makers are now confronted with the indomitable task of developing programmes to equip service providers and managers with the appropriate skills, and establish the necessary trappings of career development pathways, personnel planning and management systems. Certain issues are unavoidable, such as whether more family planning paramedics need to be trained, whether it is justified to have more female doctors, what should be the fate of specialised auxiliary workers such as the Family Welfare Assistant (FWA) and the Health Assistant (HA). The

USAID-funded national initiatives (NIPHP) and its predecessor, the Family Planning and Health Services Project (FPHSP) represent reform measures where NGOs are the main vehicles in delivering health services. These programmes herald the need to equip NGO personnel with the proper clinical skills and managerial capacity, together with parallel efforts to create systems that enable government to regulate, supervise and maintain standards.

The broader range of reproductive health and child survival services require a substantial degree of counselling services to promote service use and ensure behavioural change. In such situations, one needs to decide and plan how such skills can be transferred in a rapid and effective manner. Training resources and expertise are scarce in the public sector to address recent priorities such as HIV/AIDS and other reproductive tract and sexually transmitted infections. With uncertainties of how these problems may be addressed, the role of the public sector health care providers and stances on policy are yet to be formulated. At present, macro-level programmes to address these problems are still in infancy and human resource development strategies are only at the exploratory stage.

The present situation of workforce in the population sector indicate that 91 percent of the available 53,000 positions are occupied. The highest number of vacancies are among pharmacists and doctors. The salaries of 87 percent of personnel, particularly paramedics and field workers, are paid from the development budget, i.e. funds from loans, grants from donor agencies, which raises serious issues concerning their sustainability. There is widespread discontentment among government employees especially in the lower ranks, as being hired through external funds, limits their entitlement to encadrement and promotion within the sector, retirement benefits, and job security. At the threshold of planning for reform and restructuring the service delivery system to fit a broader context of reproductive health service delivery, decision makers confront these issues and work out their solutions. Davis (1972) discussed that the fear of change amidst deeply rooted social systems can be as disruptive as change itself. Inadvertently, the desire for new experience and the rewards that come with change are often the factors that offset people's tendency to resist change.

Nonetheless, special attention should be given towards addressing certain areas of concern in the sector's human resource development strategies at the systemic level. It is imperative to develop a human resource development policy with long-term perspectives that considers changing programme context and

forthcoming reform measures. Bangladesh's Government is in the midst of developing a macro-level health policy and it is essential that human resource development would be guided by, and should contribute to the overall national health and population policy. Planners now advocate that there should be more coherent linkage and coordination with the country's overall educational development initiatives (Shahid, 1996).

Discussions among stakeholders have deeply delved into the merits and demerits of a rapid change over to deliver the entire essential services package through a restructured health service delivery system in all 467 sub-districts of the country versus a pilot phase implementation with a few, i.e. 50 sub-districts. Later events have led more towards the former option, requiring full-scale review and preparation of the organisational environment to ensure the viability of the system. Actions to mobilise human resources available in the community such as volunteers, local leaders, depot holders, etc., to enhance awareness and participation in health care initiatives are being initiated. The role of local government in health care delivery is another area where considerable experience from pilot demonstration projects can be further applied into mainstream programme planning.

At the implementation level, concerted efforts to develop decentralised management systems that lead to better efficiency are required. It would not be enough to provide managers with the tools for good management, but they would also need to develop the culture of management for ensuring quality. There has been considerable degree of deterioration of public accountability. Supervisory systems need to be strengthened to enhance the level of accountability of managers and service delivery personnel. It is necessary to develop alternative supervisory mechanisms that emphasise regular and supportive participation of supervisors in monitoring field-level progress through operations research. Rao (1989) discussed the importance of performance-based career planning, training and development, stating that employees are happier and more motivated when their basic needs are addressed through welfare measures, and when their capabilities are used to the fullest extent. Because of this, personnel management systems should institutionalise fair, transparent and equitable posting/transfer and career development systems. Special attention is indeed required to ensure optimal skill-mix and use of trained personnel at service delivery sites. In conjunction, there is a critical need to improve working conditions and attitudinal barriers towards women in the sector workforce, and to reduce exploitation, especially for those who work in the rural areas.

Human resource systems for planning, production and management are often required to undergo fairly complex changes in order to integrate information and research into decision-making (WHO, 1990). The current training programmes need to be improved to enhance both clinical and managerial skills that reinforce critical thinking, encourage problem solving, and the desire to improve one's skills. It is essential to select trainees and personnel based on appropriate aptitudes, and to fill vacant positions based on service priorities, and not out of convenience to managers and personnel. Effective implementation of these measures requires the development of a central data base on personnel information system that enables the Ministry of Health and Family Welfare to plan human resource development strategies based on accurate data. Databases are also necessary to keep track of training indicators, and to facilitate regular and efficient refresher's training to maintain standards in performance. However, many organisational changes are required to support the development and effective use of information systems.

Another essential task is to review existing laws and regulations for personnel deployed by population sector organisations. In the past, disciplinary or penal action has been quite infrequent in public sector infrastructure by any professional organisation. Complaints against violation of ethical issues, duties and responsibilities, have been uncommon especially with inadequate staff to monitor adherence to ethics and regulations (MOHFW/WHO, 1996). Administrative reforms require revision and/or creating legislation that institutionalise recruitment, termination, compensation and severance. Policy makers also need to review rules and regulations relevant to postings, transfers, training and promotion opportunities. The relevance of legal procedures for personnel management and development is a critical factor in ensuring the quality of human resource development strategies.

In December 1996, a National Plan of Action for Population and Development was endorsed, in harmony with ICPD's priorities. The strategic directions emphasized formulating a role for the Government to supervise and regulate service delivery rather than to centrally manage and produce services. Planners are now recommending increased use of private sector and NGO facilities for reproductive health care services. These strategies call for reengineering human resource development strategies that improves the managerial capacity of the Government to establish and ensure maintenance of standards of quality and productivity. Further measures are necessary to enhance service quality especially in providing information, and improving interpersonal communication and counselling skills by service providers.

Alternative training strategies are required to improve the skills of providers in the commercial sector. The critical task at present is to upgrade training programmes further to specifically improve the quality of clinical contraception services and to have sufficient skills among service providers to provide an essential reproductive health care package at all levels, i.e. community, union, thana and district.

As the nation proceeds to formulate policies and plans for the population sector, certain issues shall have to be addressed as soon as possible. It would be important to ensure the sustainability of human resource development efforts, which require the following strategies:

- a. develop long-term plans and goals for human resource development, with sustainability planning built into the programme that forecasts future requirements based on future role of the public sector in the population programme;
- b. develop the leadership and managerial capacity of the Government to regulate and supervise, rather than to produce services;
- c. strengthen the training of trainers emphasizing training quality;
- d. develop strong training managers that have field experiences, training expertise and management skills;
- e. institutionalise monitoring systems for human resource development that facilitate policy makers and programme managers to plan optimally;
- f. ensure coverage and quality of training programmes, and ensure regular and effective refresher training through innovative channels such as distance learning;
- g. explore private sector training opportunities, and develop regulatory systems to ensure the quality of standards and skills.

Even with all efforts geared towards reducing population momentum and improving health status, Bangladesh's population still continues to grow although at much slower rate. There will be twice the number of Bangladeshis in twenty years time, and the nation's leaders need to focus significantly on human resource development efforts that enable systems to adequately address basic human needs. At present, it is still unclear how education, housing, health services, food and agricultural production, etc., can be planned on a long-term basis to counteract the burden of human suffering under those circumstances in the future. The Bangladesh Constitution categorically indicates that such

commodities be provided as basic human rights for each and every member of the nation's population:

"The right to the provision of the basic necessities including food, clothing, shelter, education and medical care;

The right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work;

The right to reasonable rest, recreation and leisure;

The right to social security, that is to say public assistance in cases of undeserved wants arising from unemployment, illness, or disablement, or suffered by widows and orphans, or in old age, or in other such cases.

Article 15, The Constitution of the People's Republic of Bangladesh.

Strong political support and leadership are necessary to strengthen a sense of commitment and accountability of population programme personnel, especially in times when the government is exploring channels of reform. The task at hand is to inspire service providers and programme managers to participate in the movement to ensure equity, poverty alleviation, and a sense of pride in producing services quality.

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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 the 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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