

# STRATEGIES FOR IMPLEMENTING CHANGE IN A RURAL HEALTH AND FAMILY PLANNING PROGRAM IN BANGLADESH

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## Introduction:

The MCH-FP Extension Project is an organization development effort designed to improve the implementation capability of the public sector family planning program of Bangladesh. The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is collaborating with health and family planning officials in two of the 465 upazilas in an attempt to apply the experience of running a successful experimental project to the government program. The project has both a research and an intervention component. In this paper, we review the intervention strategies designed to overcome existing barriers to program implementation. We also highlight accomplishments as well as upazila-level constraints in the use of an "organization development" approach to improving program services. Organization development, as will be seen, is not only an attempt to apply the theory and findings of behavioral science research to organization renewal efforts, it is also, and perhaps above all, a learning experience.

The central question of the Extension Project is to what extent can public sector programs be improved through outside intervention without change in the basic parameters of existing program strategy, organization and bureaucratic procedures. The project is concerned with improved management; that is, with affecting organization process, not structure. It seeks to improve the competence, skill and motivation of human resources to assure more effective and efficient program functioning. The project is explicitly constrained not to go beyond policies and regulations of the government in its attempt to transfer lessons from Matlab to the public sector. The purpose of the project is not, as it was in Matlab, to take charge of implementation, but rather to improve the managerial process in the public sector. This is by definition a lengthier, more laborious and involved process than establishing one's own, small-scale, autonomous operation.

The collaboration between the Ministry of Health and Population Control and the ICDDR,B has been organized in the following manner: Joint action teams have been constituted at local and national levels. The Project Implementation Committee in each of the experimental upazilas consisted of key upazila health and family planning officials, ICDDR,B senior field staff, and district health and family planning officials as ex-officio members. The National Coordinating Committee consists of senior officials of the Ministry, relevant research organization, and senior ICDDR,B staff. Project Implementation Committees and sub-committees meet formally and informally. They are responsible for setting objectives, formulating plans and supervising implementation. They report problems and progress to the National Coordinating Committee which can then address major operational barriers and integrate, where appropriate, changes into policy-making at the national level.

The following discussion deals with our experience of organizing interventions in two experimental areas. These interventions are anchored in a system's view of organization and management. We argue that a focus on any one component alone will not work; interventions must address the management system as an interrelated whole and barriers to effective program implementation are indeed interrelated. One may, in examining problem areas, focus on a specific element, for example, on the

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quality of field work. But since the determinants of quality are embedded in a complex managerial system, interventions must address not just the specific components but their interrelationships as well.

## Training

One of the major intervention activities of the Extension Project has been launching a training program for all field staff and their immediate supervisors. The training program is well under way and will be completed by September, 1984. We discuss key features of the training program and lessons learned in the course of its implementation.

### Training Partnership with Upazila Officials

Training was jointly organized and conducted by ICDDR,B staff and upazila officials. Only on exceptional occasions are upazila officials given the responsibility to conduct training courses for field staff. The decision to engage in a collaborative training program with government officials at the upazila level had several distinct advantages. First and above all, it provides upazila officials with the necessary motivation to participate in the training program. The quality of the lectures and training sessions for which upazila staff assumed responsibility varied. The technical quality of the training program might have been slightly superior if only ICDDR,B trainers who relied heavily upon the experience and participation of Matlab personnel, had been in charge. However, this would have been at the expense of what became an intense involvement and interest of upazila officials in this training program and thereby indirectly in the overall project. Thus the decision to organize a training partnership with government officials was one of the most productive decisions that has been made.

Each session was jointly conducted by an ICDDR,B trainer and upazila staff. As a consequence, upazila officials were exposed to their field staff for a longer period of time than they ever had to deal with them. Moreover, since ICDDR,B trainers set the tone and insisted upon group discussion, upazila officials were obliged to work with trainees in a guiding, directing role and not in the disciplinary mode which they normally adopt. Indirectly then, the training program contributed toward improving the supervisory skills and field orientation of upazila officials. This, we believe, is the major reason for organizing a joint training program.

### Location of Training

Training took place at the upazila using the physical facilities of the health complex. With the exception of special programs, training is normally the responsibility of officials at the district, the next higher level in the administrative hierarchy.

The original intention of the project staff was to organize the training program at the union, not the upazila level. Upazila officials were taken to Matlab to familiarize them with decentralized training at the Health and Family Welfare Center (H&FWC). However, we were not successful in persuading upazila officials to adopt this approach because of their concern that decentralized training would be informal and would not justify a training honorarium. They may also have been apprehensive about the travel time involved and the inconvenience of leaving the health complex — thereby losing the advantages of proximity to their normal duties and their residence.

### Participants

Classes brought together all health and family planning workers in order to support the then in-place government policy of establishing integrated teams. Joint training of workers from one union, it was hoped, would encourage teamwork in addition to developing the necessary competencies in both health and family planning. Since initiation of the training, the government has changed its policy of integration, abandoning the team concept and insisting only upon "functional integration", that is, each worker is expected to perform both health and family planning activities. Thus, implementation of one particular aspect of government policy was marred by a rapid change in the government's directions.

From the very inception of the project, the ICDDR,B felt committed to train all workers in the upazila, not only those in the treatment unions. Upazila officials concurred with this notion readily and would have in all likelihood insisted upon it if ICDDR,B had wanted to limit itself to a narrower training effort. The implications of this decision for the overall scope of the training tasks were not initially appreciated by

senior staff of the Project. Training the total field staff and field supervisory staff of all unions in the two upazilas meant organizing a total of nine training sessions, each lasting one month, to cover all the 18 unions involved. The first training course was started in August, 1983, the last will be completed by September, 1984. Thus, more than a full year of continuing, intensive organizational endeavor has been required to honor this commitment. Training is essential, but a somewhat reduced training program would have made it possible to focus more heavily on field implementation.

Health and family planning field workers as well as their immediate field supervisors were trained together, however, the content of the course was designed around the needs of field workers. While the technical and motivational skills imparted were certainly of value for field supervisors, there was nothing in this training that addressed their role and function as supervisor. Supervisors were treated more as field workers than as supervisors. A major lesson has been that training courses must develop the managerial skills of this cadre of frontline supervisors if they are to play a stronger role in the field. This was not done because upazila officials downgrade the role and authority of field supervisors. The training strategy reflected the images portrayed by upazila officials and government generally, for it is also the pattern in other government training programs to train field supervisors jointly with field workers. A major emphasis of future activities will be to develop the roles of these field supervisors through counterpart support from Matlab supervisors and assistance with performance oriented meetings at the FWC.

#### Nature of Training

The training program was focused on developing skills in those areas which are in fact relevant for the scope of work conducted by the field staff: all family planning methods, diarrhoeal disease management and EPI, specifically tetanus toxoid immunization. Upazila trainers were eager to add lectures on a range of subjects, for example, leprosy, which are in no sense part of the responsibilities of the field staff. This might have been due to the fact that government had a mandate to do such training. Eventually, it was possible to persuade them, however, to keep the course focused on relatively few topics, with emphasis on those with relevance for implementation.

Besides focusing on the three major areas --- family planning, oral rehydration and tetanus immunization --- the course included training on a simple recordkeeping system from Matlab, on the preparation of work schedules and development of team work. Training on recordkeeping is important, since workers are generally unaware of its usefulness in managing their everyday activities. Training workers on the Matlab system was more difficult than anticipated and required extensive follow-up in the field. Also, the Matlab system was in part a duplication of existing recordkeeping efforts. More detailed, prior knowledge of these existing systems which workers felt had to be maintained even if they believed in the value of the Matlab system, would have been helpful.

Although the place of training was the upazila health complex, there was a strong attempt on the part of ICDDR,B staff to organize a field-oriented training program. Field trips were in fact undertaken at the end of each major topic covered in the course. However, these trips were relatively short and not carefully structured. There is a strong momentum in the government bureaucracy that keeps all training in the classroom. To break out of this mode takes considerable effort. Given the limited size of the ICDDR,B training team, the ideal of field-oriented training could not be fully realized. We plan to compensate for this deficiency in the future through continuous training at the FWC with emphasis on close field supervision.

The Matlab training program is based on continuous training. After no more than one week of formal training at the very beginning of the program in 1976, CHWs have received extensive training, but this has always been organized in the context of the biweekly meetings at the H&FWC. When major new interventions have been added in Matlab, a special one-week training is set up and its implementation monitored over at least a six-month period prior to any further additions. In developing a training curriculum jointly with the government officials, the ICDDR,B team moved away from the Matlab pattern in favor of a four-week comprehensive training course. The very size of the task involved and the organizational culture of the bureaucracy which makes continuous training not an easily managed task, explain the decision of the ICDDR,B team. We had to learn that as change agents, we are not only exerting influence over others but are subject to change and influence ourselves. In the next months of

One of the first lessons learned in implementing the counterpart support scheme was that it is indeed possible to use community health workers from Matlab for work in another district and upazila. Most of the CHWs had never left Matlab upazila and for all of them, it was a major step seven years ago when they began to make rounds in their own villages in Matlab upazila. Most women in Bangladesh, especially in rural areas, continue to lead traditional lives, even if they are educated. All of the CHWs have families, some with still young children. Thus, there was some uncertainty, even among senior ICDDR,B project staff whether the transfer of the CHWs to upazilas of the Extension area was practicable. That CHWs responded well to this challenge is testimony to their faith and that of their families in the leadership of the Matlab program and in the self-confidence CHWs have acquired during the past seven years. They have come to symbolize the notion of transferability.

In a public sector program where there is essentially no field supervision, the counterpart support worker assumed — quite unintentionally, functions normally performed by supervisors. By keeping regular working hours, CHWs influence FWAs to keep regular hours as well, especially since it is known that CHWs report to senior project staff about working patterns in the field. Reactions of FWAs to this control function ranged from hostility to grudging acceptance.

The difference in the response to the CHWs may be related to variations in the physical environment and differences in program organization in the two project upazilas. The upazila where CHWs encountered the most hostility is regularly affected by shifts in the river bed of the Jamuna, consequently changing unions and ward size and making migration a necessity. As a result, several female workers do not reside in the ward where they work. This has had a negative influence on the quantity of their work and the regularity with which they go to the field. It is thus not surprising that the CHWs' presence and the demand for regular work hours produced resentment. While the presence of CHWs led to an increase in the quantity of the work effort, this impact was uneven. CHWs assumed more than a control function. In those cases where working relationships were good, CHWs provided an inspiration to the FWA, providing the kind of support and guidance which is not forthcoming through the supervisory system.

The overall conclusion reached so far about the counterpart support system is that it is a positive influence on the quality and quantity of the overall field work performed by government field workers. It provides a type of ongoing peer training which is valuable in a context of a pervasive supervisory vacuum. However, there remain several questions and concerns which we are unable to answer at this point.

Using counterpart support staff to bolster the field capability of a program constitutes a new endeavor for the ICDDR,B. It is a logical extension of the attempt to transfer learning from Matlab to other areas, and is singularly appropriate in a project whose purpose is to assist in the development of a cadre of field workers already in place. The major concerns we have are as follows: How does one assure that CHWs are in fact focused on developing the skills of FWAs rather than on simply substituting for her during the time they work together? What is the appropriate training or preparation for CHWs who are to function as counterpart support? So far, preparation has consisted of a session in Matlab with project leaders in which the purposes of the Extension Project and the need for counterpart support were explained as well as ongoing discussions with CHWs in the field. Do they need more formal training in order to be fully effective? How does one assure that their positive impact is sustained even after they withdraw?

Matlab CHWs on assignment in Extension areas receive a salary adjustment to compensate for their absence from their home village. This, as well as recent upgrading of all ICDDR,B staff, results in a salary discrepancy with government workers. Female workers in the government have resented this discrepancy and requested compensation to make up for the extra effort they put forth because of project activities. While this reaction on the part of the government worker is understandable, it pinpoints a fundamental problem. The purpose of the Extension Project is to strengthen an ongoing programmatic effort. If field staff and higher level officials as well perceive project activities as requiring an effort above and beyond what they consider their normal duty, the chances of a lasting impact on the quantity of work performed is slim.

The question of lasting impact can also be raised with regard to the quality of work, but here one can make a more persuasive argument that the impact is likely to continue. As long as improved quality of work does not entail greater effort, there is no reason to assume that FWAs would not continue the approaches they have learned under the guidance of the CHW.

## Upazila Management Capabilities

Three officials at the upazila health complex are the administrators of the government's outreach health and family planning program: A physician-administrator with overall authority; a physician responsible for medical back-up in MCH/family planning; and a family planning administrator. These officials interpret and implement regulations passed to them from the Ministry, and respond to other requests made from central government. There are, however, major barriers to an effective outreach program. It is also apparent that these barriers are not being dealt with at the upazila level, although change with regard to some of them is within their discretion. Officials are rarely seen in the field, although their job description requires such. Their actual contact with village-based activities is therefore minimal. To effect any improvement in the program, therefore, meant first working with upazila officials to get their active cooperation.

The selection of the upazilas in which we were to work was made at ministerial level. A formal letter sent by government instructed upazila officials to collaborate with us on the project. ICDDR,B staff determined that the way to begin was to set up routine monthly meetings of project staff with both district and upazila health and family planning officials. This met with initial resistance until lunches and teas were added (Simmons, et.al., 1984). Staff meetings aimed at diagnosing and solving problems are not a part of the traditional bureaucratic procedures in Bangladesh. During the first meetings of the Project Implementation Committee, officials adopted a largely passive stance: "Whatever you want to do, we will support you." It became obvious after a number of meetings that our discussion of research and survey results were not of interest to the officials and could not be expected to move them into an active collaborative mode. Programmatic action was required.

The breakthrough came in one of the experimental upazilas when an experienced ICDDR,B organizer demonstrated that few resources were required to develop a much-needed Family Welfare Centre at the union level -- only good managerial and organizing skills. This alerted officials to the fact that change could occur within the constraints of their program and that they could effect it. A second initiative was needed, however, before they became active collaborators. The development of the training course for health and family planning field workers and their participation as trainers provided that spark. Although their activity in the training was probably triggered by the honoraria paid per lecture, the result has been sustained active participation in the Project Implementation Committee meetings and other interventions at the Upazila Health Complex. It has not resulted in a major change in priorities, however, and field orientation, including field visits, by the officials still requires considerable effort on the part of the ICDDR,B staff.

Incentives are an obvious means to capture an official's attention if not his activity, and as we represent large resources in the eyes of these officials, the pressure is always upon us to provide them. We have availed ourselves of these means, but attempted to remain within reasonable limits. Honoraria for training lectures are provided at a rate slightly higher than government offers for similar training. Teas are a common feature of any meeting in Bangladesh, although a lunch is quite special. Other incentives provided are goal-oriented and aimed at satisfying other factors that may motivate the officials: a trip to Matlab to observe activities was of considerable interest to officials who requested a second trip; training at ICDDR,B in Dhaka proved beneficial during an ensuing epidemic. Such exposure is important not only for its content but because of the contacts formed during these visits, the exposure to other programs, and the prestige they bring. One of the officials has used these trips to acquaint himself with training methodologies in which he has sincere interest.

Another form of incentive has occurred: Outside officials have begun to visit one of the upazilas to examine progress. The Secretary and Additional Secretary of the Ministry of Health and Population Control have visited, as well as the Director General of Implementation. International visitors are also becoming common. Upazila officials explain the Project in terms of ownership and proudly guide the visitors on "tours".

There is no prescribed formula for energizing upazila officials, however, and the sequence of steps described above have not proved as successful in the other experimental upazila. That upazila is the center of a large administrative unit and, as such, its health and family planning officials have administrative responsibilities over several upazilas. No officials exist specifically for this upazila,

although these posts have recently been created. As such, the supervisory problems of the government's field MCH-FP program are an order of magnitude greater than in the first upazila described. This second site has also been the recipient of several extra inputs — our project being only one — and hence the passivity of the officials is very pronounced. Thirdly, the terrain is far more difficult; a river splits the unions of this upazila and populations on one side of the river migrate during the monsoon. Shifts in government personnel have recently brought in a district-level official whose interest in a higher level of contraceptive performance in the area coincides with project goals. Because of this one person's input, active collaboration has begun.

### **ICDDR,B as a Change Agent**

In this project, the ICDDR,B has been hired as the consultant to effect change in the public sector health and family planning outreach program toward attaining its goal of higher contraceptive prevalence. To do this, ICDDR,B staff work with government officials at the managerial level of the program — the upazila — and report findings to the ministerial officials at the National Coordinating Committee. We do not perform the services for the government in these upazila, but attempt to influence their provision of the services. By this means, we identify barriers to effective implementation of services and experiment with strategies to overcome them. However, the public sector health and family planning outreach program is a massive machinery with traditions of functioning that have remained impervious to even government-directed policy changes. In light of this organizational momentum, the scope of the task at hand is very large and no quick solutions can be given. We are partners with the government in this project and, as such, we must compromise and they must compromise in order to reach collaboration. The collaboratively-developed training curriculum is a good example of these compromises. The is a curriculum with components similar to those in Matlab's training, but the presentation more closely resembles government training courses. We, the change agents, are also changed by the host organization. The greater the host organization's traditional momentum, the larger the task is to effect change and the more likely it is for the compromises to be weighted in favor of the organization, at least in the initial stages.

This was to have been a paper about the intervention of the ICDDR,B team designed to energize the functioning of the government program. While we have in some areas been able to do this, the paper can also be read as a continuation of Dr. Koblinsky's paper on barriers to implementation. This just goes to reinforce the message we would like to convey in conclusion. While it is indeed possible and absolutely important to engage in partnership with government on the improvement of the programs in the public sector, this task is in fact immense and one should not have illusions about how easily or quickly improvements can be attained.

Well-managed programs succeed. An important benefit of the Extension Project lies in the learning that occurs about mechanisms to improve the implementation process. At the moment the Project is still focused on managerial renewal with the assistance of an outside change agent team. We are also concerned about the question of how such renewal can be sustained without outside assistance or extended to other areas. But these questions can only be answered once we are assured that organization development, as conceptualized here, has in fact occurred.

# PROJECT IMPLEMENTATION

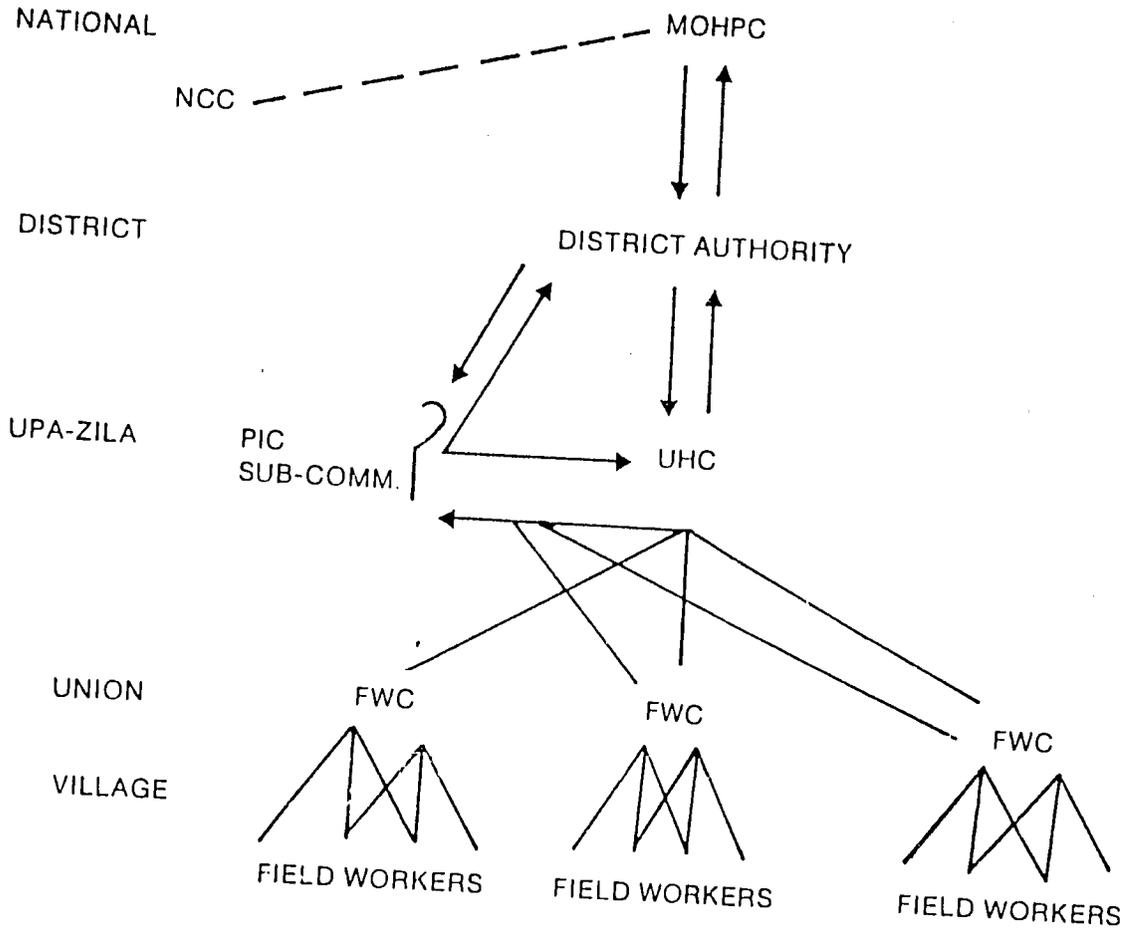


FIGURE 1

- NCC = NATIONAL COORDINATION COMMITTEE
- PIC = PROJECT IMPLEMENTATION COMMITTEE
- PWC = FAMILY WELFARE CENTRE
- UHC = UPA-ZILA HEALTH COMPLEX

# INTERVENTION STRATEGY

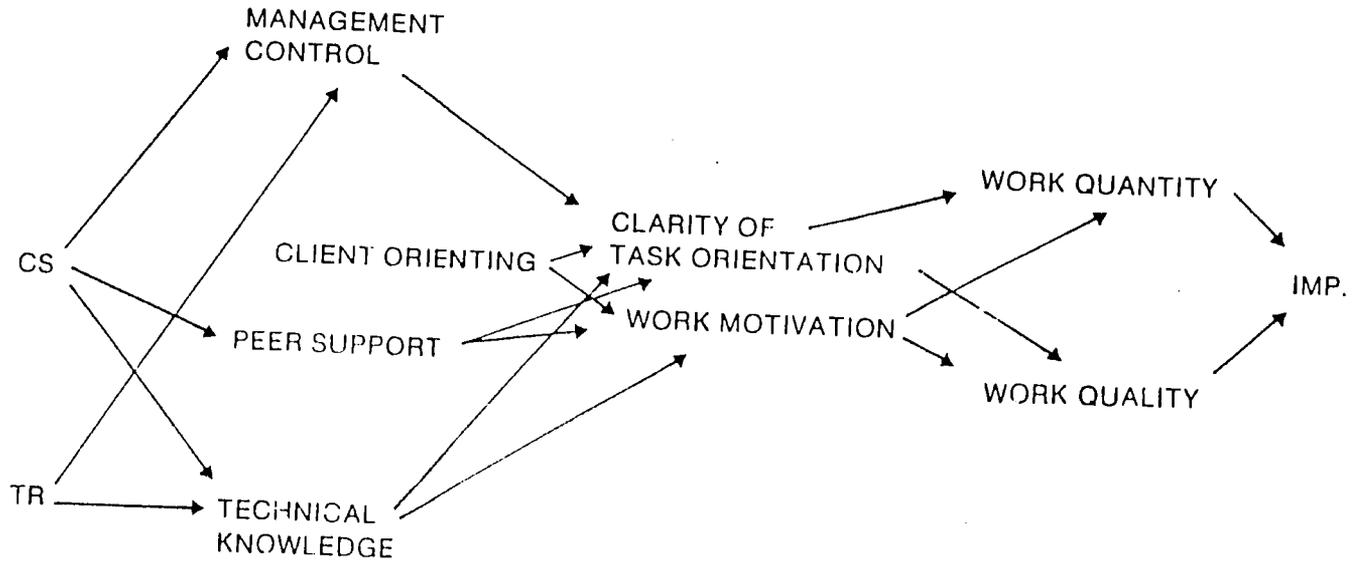


FIGURE 2

CS = COUNTERPART SUPPORT  
TR = TRAINING