

Working Paper No. 145

# Performance Planning and Monitoring at the Local Level

Yousuf Hasan  
Barkat-e-Khuda  
Ali Ashraf

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

1998



**CENTRE**  
FOR HEALTH AND  
POPULATION RESEARCH



## The Centre

The Centre is a unique global resource dedicated to the highest attainable level of scientific research concerning the problems of health, population and development from a multidisciplinary perspective. The Centre is in an exceptional position to conduct research within the socio-geographical environment of Bangladesh, where the problems of poverty, mortality from readily preventable or treatable causes, and rapid population growth are well-documented and similar to those in many other developing countries of the world. The Centre currently has over 200 researchers and medical staff from 10 countries participating in research activities. The Centre's staff also provide care at its hospital facilities in Dhaka and Matlab to more than 100,000 patients a year and community-based maternal/child health and family planning services for a population of 100,000 in the rural Matlab area of Bangladesh. In addition, the Centre works closely with the Government of Bangladesh in both urban and rural extension projects, which aim at improving the planning and implementation of reproductive and child health services.

The Centre is an independent, non-profit international organization, funded by donor governments, multilateral organizations and international private agencies, all of which share a concern for the health problems of developing countries. The Centre has a rich tradition of research on topics relating to diarrhoea, nutrition, maternal and child health, family planning and population problems. Recently, the Centre has become involved in the broader social, economic and environmental dimensions of health and development, particularly with respect to women's reproductive health, sexually transmitted diseases, and community involvement in rural and urban health care.

The Centre is governed by a distinguished multinational Board of Trustees. The research activities of the Centre are undertaken by four scientific divisions: Clinical Sciences Division, Community Health Division, Laboratory Science Division, and Health and Population Extension Division. Administrative functions are undertaken by two divisions, namely Finance and Administration and Personnel.

B

# Performance Planning and Monitoring at the Local Level

Yousuf Hasan  
Barkat-e-Khuda  
Ali Ashraf



CENTRE  
FOR HEALTH AND  
POPULATION RESEARCH

International Centre for Diarrhoeal Disease Research, Bangladesh  
Mohakhali, Dhaka 1212, Bangladesh

1998

ICDDR,B Working Paper No. 107

C

**Editing:** M. Shamsul Islam Khan

**Layout Design and Desktop Publishing:** Jatindra Nath Sarker  
Subash Chandra Saha

*ISBN: 984-551-144-9*

**Operations Research Project Working Paper No. 145**  
**ICDDR,B Working Paper No. 107**

© 1998. International Centre for Diarrhoeal Disease Research, Bangladesh

**Published by:**  
**International Centre for Diarrhoeal Disease Research, Bangladesh**  
GPO Box 128, Dhaka 1000, Bangladesh  
Telephone: 880-2-871751 (10 lines); Cable: CHOLERA, Dhaka; Telex: 675612 ICDD BJ  
Fax: 880-2-871568, 880-2-883116 and 880-2-886050

---

**Printed by: Bangladesh Progressive Enterprise Press Ltd., Dhaka**

*d*

## Acknowledgments

The Operations Research Project (ORP) is a collaborative effort of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the Ministry of Health and Family Welfare (MOHFW) of the Government of the People's Republic of Bangladesh. The Project is supported by the United States Agency for International Development (USAID) under the Cooperative Agreement No. 388-A-00-97-00032-00 with the ICDDR,B. The purpose of ORP is to improve the service delivery system at operational level in the national health and population programme through operations research and technical assistance.

ICDDR,B is supported by the aid agencies of the governments of Australia, Bangladesh, Belgium, Canada, Japan, the Netherlands, Norway, Saudi Arabia, Sri Lanka, Sweden, Switzerland, the United Kingdom, and the United States; international organizations, including Arab Gulf Fund, European Union, United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), and the World Health Organization (WHO); private foundations, including Aga Khan Foundation, Child Health Foundation (CHF), Ford Foundation, Population Council, Rockefeller Foundation, Thrasher Research Foundation, and the George Mason Foundation; and private organizations, including East-West Center, Helen Keller International, International Atomic Energy Agency, International Centre for Research on Women, International Development Research Centre, International Life Sciences Institute, Karolinska Institute, London School of Hygiene & Tropical Medicine, Lederle Praxis, National Institutes of Health (NIH), New England Medical Center, Procter & Gamble, RAND Corporation, Social Development Center of Philippines, Swiss Red Cross, the Johns Hopkins University, the University of Alabama at Birmingham, the University of Iowa, University of Goteborg, UCB Osmotics Ltd., Wander A.G., and others.

The authors are grateful to M/s. Akhteruzzaman and Sohrab Ali of Management Information System (MIS) Unit of the Directorate of Family Planning and Dr. Bruce Caldwell for reviewing this paper and for making valuable comments on an earlier draft of the paper. In addition, Ms. Toni Rahman is acknowledged for her editing assistance.

# Contents

	Page
<b>Executive Summary</b> .....	iv
<b>Introduction</b> .....	1
<b>Objectives</b> .....	2
<b>Intervention</b> .....	2
Strengthening of H&FWC and supervisory meetings involved two specific activities .....	4
Micro-level planning workshop at the union level .....	5
Monitoring tools for first-level supervisors .....	6
<b>Methodology</b> .....	6
Field visit .....	7
Supervision .....	7
Meetings .....	7
<b>Findings</b> .....	7
Field visit .....	7
Supervision .....	9
Meetings .....	11
<b>Discussions, Conclusions, and Policy Implications</b> .....	15
<b>References</b> .....	17

## Tables

	Page
<b>Table 1:</b> The number of visits made by the front-line supervisors .....	8
<b>Table 2:</b> Percentage of attendance of FWV and FWA and the number of side-effect management cases referred to and treated at SC .....	9
<b>Table 3:</b> Observation of field activities .....	10
<b>Table 4:</b> Observation of meetings at Mirsarai .....	11
<b>Table 5:</b> Observation of meetings at Abhoynagar .....	12
<b>Table 6:</b> Number of micro-plans, identification of problems and development of solutions during January 1995 - December 1996 .....	12
<b>Table 7:</b> Major problems identified by FWA .....	13

## Figures

<b>Figure 1:</b> Contact rate by FWA at Mirsarai .....	13
<b>Figure 2:</b> Contact rate by FWA in the intervention area .....	14
<b>Figure 3:</b> Contact rate by FWA in the comparison area .....	14
<b>Figure 4:</b> Gaps between service and survey statistics in treatment and comparison area, Mirsarai .....	15
<b>Figure 5:</b> Gaps between service and survey statistics in treatment and comparison area, Abhoynagar .....	15

## Executive Summary

Local-level planning is a process that enables a supervisor to standardize supervisory visits potentially improving fieldworker-client contact and strengthening the link between a fieldworker and a supervisor, thereby increasing productivity. By institutionalizing a systematic learning process of reviewing data collected by the fieldworkers, and interpreting data by linking it with performance, the supervisor can largely contribute to improved performance, as well as the quality of data. Continuing education on performance indicators, planning and monitoring at the implementation level is likely to enhance greater understanding of the planning and management capability of a primary supervisor and an immediate supervisor.

The intervention was implemented during January 1995 - June 1996 in four unions of both Abhoynagar and Mirsarai thanas. The comparison unions were selected from both within and outside the intervention thanas. The methodology followed a process design, aiming at improving the planning capability of the supervisors and managers at the operational level. The observation checklists, longitudinal surveys, and service statistics were collected at a regular interval.

The frequency of field visits by the fieldworkers showed a consistent increase since June 1995 in the intervention unions of Mirsarai thana compared to the non-intervention unions. In the intervention unions, supervisory visits of the primary supervisor to the field increased from two to 11 in Mirsarai and from four to 14 days per month in Abhoynagar. The attendance of Family Welfare Visitor (FWV) and Family Welfare Assistant (FWA) at the Satellite Clinic (SC) also increased. An increase in referral and management of side-effect cases has similarly been observed. The presence of Family Planning Inspectors (FPIs) in the field had also increased. They were found to talk to couples and check the FWA Register in the field. The meetings have been systematized to include a review of the performance of the fieldworkers, discussion of problems, and possible solutions. The gaps between survey and service statistics was reduced quite significantly at both the intervention sites.

The results of the study point out that institutionalization of various steps, such as planning, review of information and monitoring mechanism in local-level planning, is essential for effective management, and in the process, most critical responsibilities, however, lie on the shoulders of the thana managers. The experiment warrants continuous higher-level support and modification of the existing district level meeting process to effectively address the problems identified at thana requiring solutions from higher authority.

## Introduction

The family planning programme in Bangladesh has achieved a noteworthy success over the past decade. The national contraceptive prevalence rate (CPR) has increased from 18.6 percent in 1981 [1] to 49.2 percent in 1996-1997 [2]. Achievement of this success has been possible through the establishment of a wide health-care network, including the government agencies and non-government organizations (NGOs).

Despite an overall increase in coverage, there are significant variations in the extent of coverage and quantity of services [3-4], due mainly to variations in local client environment, physical environment, and management support [5]. Even within a thana, family planning performance varies from union to union. Thus, there is a need to develop planning mechanism at the district, thana and union levels to identify problems, find solutions, and mobilize resources in the low-performing areas. Programme failures in most developing countries can be attributed to a top-down planning process, which leaves very little discretion in the hands of lower-level officials [6]. Except in areas with experimental or pilot projects, such local-level planning is rarely undertaken because of organizational weaknesses in the public system planning process.

In Bangladesh, within the government family planning programme, planning is carried out at three levels. Top management usually formulates policies and strategies, plans for human resources development, sets national and regional targets for CPR, and allocates resources. The mid-level, Deputy Director - Family Planning (DD-FP), and operational-level managers, Thana Family Planning Officer (TFPO), within the prescription formulated by the top-level management, focus their planning on activities, such as scheduling home visits by workers, monitoring field activities through supervision and maintenance of record keeping, managing logistics, and carrying out personnel functions, such as salary disbursement, transfers, leave, and provision of travel and daily allowances. This system renders planning at the local level identical for the entire country, even when clear variations in input and environment exist. The programme, thus, fails to achieve the desired results, when local situations demand locally-adjusted planning.

The relevant questions that arise are: whether under these circumstances, is it feasible to introduce local-level planning within a public system that has not undergone any organizational change; and whether such local-level planning would induce any change toward better strategy, thereby increasing the performance of the low-performing areas. Since changes in strategy is a function of supervisory and managerial capabilities, performance improvement will also require strengthening the management capabilities of operational-level managers and supervisors [7].

## **Objectives**

The main objective of this study was to examine whether local-level planning in the family planning programme contributed to an overall improvement in performance. The specific objectives were to examine whether the introduction of:

- planning mechanism at the union level regularized the frequency of FWA field visits and FWA contact with a primary supervisor;
- use of the FPI diary improved the systematic verification of couples' reproductive and contraceptive status and the quality of data; and
- systematic review process helped identify the problems and generate solutions.

It can be hypothesized that if all the objectives are fulfilled, there is likely to be an improvement in the programme output.

## **Intervention**

Despite the recent accomplishments of the national family planning programme, there are large variation in performance from area to area. The 1996-97 Demographic and Health Surveys [2] reported a low fieldworker contact rate, and low CPR in Chittagong division.

The MCH-FP Extension Project (Rural) has been providing technical assistance to the Ministry of Health and Family Welfare (MOHFW) to improve the national family planning programme since the early 1980s. In 1994, the Project was requested to direct its efforts to the low-performing areas. Mirsarai thana of Chittagong district was selected as the site to field-test various strategies to improve MCH-FP performance. The Project began its operation in Mirsarai thana with a needs assessment survey conducted in early 1994, to assess health and family planning needs. Subsequently, various interventions designed by the MCH-FP Extension Project (Rural), and were field-tested in one or more unions of Mirsarai thana.

The rationale for undertaking this intervention is based on the assumption that further improvements in programme performance planning and management capabilities are likely to occur if the thana managers are capable of (i) using available data to identify units/unions having poor/high performance; (ii) brain-storming with their workers to identify factors that hinder performance or facilitate better performance; (iii) developing alternative solution(s) within the existing resources; (iv) helping workers/supervisors develop work plans; (v) reviewing performance, using appropriate indicators; (vi) helping supervisors in their use of monitoring tools; (vii) enhancing the quality of data; and (viii) increasing motivation among the workers and supervisors.

The intervention, "Performance planning and monitoring at the local level", is aimed at enhancing the skills of thana-level managers, union supervisors, and Family Planning Inspectors (FPIs). The thana managers and the FPIs were trained on how to use data to identify poor performance-related problems, seek solutions to the problems identified, and help the workers set goals for better performance in future.

In July 1991, the intervention was introduced at the two unions of Abhoynagar thana. Evaluation in 1992 indicated a success; the thana managers were found to the review of performance not only to Contraceptive Acceptance Rate (CAR)-based targets, but also on the method-specific targets [7]. The intervention was subsequently extended to two additional unions of the thana in October 1994 at the request of thana and district managers and continued till December 1996. The intervention was introduced at four unions of Mirsarai thana in November 1994 and continued for two years.

The methodology followed a process design, aimed at improving the planning capability of the supervisors and the managers at the operational level. Four distinct components of this process are: (i) use of meetings to include a follow-up and review process; (ii) development of micro-plans at the union level; and (iii) introduction of a monitoring tool for the front-line supervisors, called the Family Planning Inspector (FPI) Diary and (iv) the use of Senior Family Welfare Visitors (SFWVs) checklist.

### **Strengthening of H&FWC and supervisory meetings involved two specific activities**

**Workshops for thana and district officials:** The workshops were intended to orient the thana and district officials to function as a team with the objective of enhancing performance assessment skills, planning for performance improvement, and supervision and monitoring. A manual on "*Performance planning and monitoring at the local level*" was used at the workshops. The workshops were attended by DD-FP, Assistant Director, Clinical Contraception (AD-CC), Medical Officer, Maternal and Child Health (MO-MCH), TFPO, Assistant TFPO, and Senior FWV.

**Training Workshop at the union level:** The FPIs of the intervention unions were given two days training on: (i) how to conduct H&FWC meetings; (ii) how to identify problems and seek solutions, set goals with the workers, and make plans to reach the goals; (iii) how to review performance; and (iv) how to review indicators from the FPI Diary. The workshop was also attended by the FWVs and Medical Assistants (MAs) of the intervention unions. The Assistant TFPO and Senior FWV were also included in the process as trainee. The TFPO and the MO-MCH acted as the facilitators in the workshop.

A monthly performance review system was initiated at both the union and thana levels. At the thana level, the district officials participated in the bi-monthly meetings, and as such, they were readily available to provide solutions that required their inputs. In this way, the districts were able to be part of the processes. Some key indicators, already developed by the Extension Project, were used for review the performance, based on which plans of action were revised and assignments readjusted. Indicators, such as

CPR, trends in the proportion of temporary method users, the number of supervisory visits, and the results of verification of the eligible couples' reproductive and contraceptive status by supervisors, the number of Satellite Clinics (SCs) performed and pregnant women attended, were reviewed each month. Some indicators were reviewed biannually, i.e. parity-wise user status (to prioritize the target groups), method-mix (to identify client segments for special efforts by the field workers), follow-up on non-users intending to use family planning methods, and the method-specific drop-out rate (to ascertain the quality of services).

### **Micro-level planning workshop at the union level**

The thana officials visited each of the unions, and held a one-day workshop with the union supervisors and fieldworkers at the H&FWC. At the workshop, each worker's performance of the past year was reviewed. The FWA was asked to identify any problems she faced in her work area – both programmatic and non-programmatic. The workers were given a simple framework for performance diagnosis, which included inputs, support activities, their own skills and knowledge, and the client environment. This helped the workers identify the issues to be addressed.

A biannual micro-level plan was organized in each intervention union. In such a plan, the fieldworkers, along with union, thana and/or district-level supervisors, jointly sought solutions to the problems identified and prepared action plans. For each solution, a plan of action was prepared and required support was identified. The responsibilities were distributed among the fieldworkers, union-level supervisors and support staff, and thana and district officials, depending on the type of solution(s) and action plan(s) prescribed. The H&FWC meetings were systematized accordingly. The FPIs were trained to carry out meetings in a systematic manner, which included the preparation of the meeting agenda, review of performance by each fieldworker and minutes taking (minutes were sent to the TFPO after each meeting). The H&FWC meeting, thus, provided an opportunity for continuing education of the fieldworkers with the aims of reducing drop-outs for the quality of services and better linkages with the FWV. An activity planning format was also introduced to facilitate the process.

## **Monitoring tools for first-level supervisors**

Supervisory monitoring tools already developed for the FPIs were introduced. These tools helped the supervisors identify the key problems of the workers, identify areas where they should extend more support, and review the contributing factors in their own programme area. Key indicators, based on these monitoring tools, were built into the follow-up review process.

## **Methodology**

The methodology used indepth interviews to the providers, observation of FPIs and FWAs, observation of meetings and the review process. Survey and service statistics from both experimental and comparison areas were analyzed to see changes in performance. A longitudinal surveillance system (SRS) organized by the ORP was used to receive the contact rate and Contraceptive Prevalence Rate (CPR) from the community.

For the purpose of the evaluation, during January-February 1997, a self-administered questionnaire was completed out by all FPIs. The FWAs of the intervention unions were asked to complete a different questionnaire. Unscheduled observation of all FPIs and selected FWAs was also made, using the appropriate observation checklists by the experienced ICDDR,B staff. Thus, it was possible to have detailed information on such indicators as field visit patterns, supervision, and meetings to assess improvement made as a result of the intervention. The FPI Diary was as well reviewed and used for comparing claimed and observed performance. Observation data from 16 Satellite Clinics (SC) in four intervention unions, and 24 SCs in the non-intervention unions, along with data from the Projects' Sample Registration System (SRS), have also been used when appropriate.

Three broad categories have been used for comparing the results between the intervention and non-intervention unions. The categories are:

## **Field visit**

Regularity of the FWAs doorstep visitation, i.e., contact rate, FWA's attendance at the SC, referral to the static clinics, acceptance of clinical methods, and drop-outs have been analyzed as activity outcome variables.

## **Supervision**

Supervision has been measured in terms of the number of days the FPI visited the field, the number of times the FPI visited the FWAs in the field and at the SC, the number of couple's reproductive and contraceptive status verified, inconsistencies detected and corrected.

## **Meetings**

To systematize the meetings at the H&FWC and at the thana level, the Project concentrated on whether meetings were regularly held; someone chaired the meeting; an agenda was used; review of progress reported by the FWAs was made; verification of reported data was made; problems were identified; provision for solutions was made; recommendations or remedial actions were followed up and supervisory support was provided by the thana managers; and the minutes were recorded.

## **Findings**

### **Field visit**

Interaction with eligible women is likely to improve if the FWA completes her routine visit. This requires the FWA's primary supervisor to make uniform supervisory visits, and verify the data collected by the FWAs. During a locally-organized training session held prior to the launching of this intervention, the FPIs were asked to report the number of visits they made to each FWA and to the SC during the previous month. Similar questions were repeated in December 1996. The FWAs were also asked to report the number of times they were visited by the supervisor at the field and SC. A large gap between the claimed and reported visits was observed (Table 1).

**Table 1.** The number of visits made by the front-line supervisors

No. of days visited	Mirsarai				Abhoynagar			
	1994		1995-1996		1993		1995-1996	
	LLP	NLPP	LLP	NLPP	LLP	NLPP	LLP	NLPP
<b>Claimed by FPI</b>								
Visited by FWA	5	6	10	9	7	2	10	9
Visited SC	5	6	7	6	2	2	8	6
<b>Total</b>	<b>10</b>	<b>12</b>	<b>17</b>	<b>15</b>	<b>9</b>	<b>4</b>	<b>18</b>	<b>15</b>
<b>Reported by FWA</b>								
Visited by FPI	1	2	6	1	2	2	8	4
Visited to SC/EPI	1	1	5	3	2	3	6	5
<b>Total</b>	<b>2</b>	<b>3</b>	<b>11</b>	<b>4</b>	<b>4</b>	<b>5</b>	<b>14</b>	<b>9</b>

**LLP** = Local level planning area, **NLPP** = Non Local level planning area

Source: Need assessments survey 1994; Final survey, 1996.

The table 1 shows that in LLP unions the number of FPIs' visit to the FWA and SC/EPI spot has improved during 1995-1996 as reported by the FWA. But an average of two visits to the FWA's area may not be sufficient to provide quality support. According to current job description (1991), the FPI is not required to make field visits for any specific number of days.

Regular attendance of the FWAs at the SC can contribute to the improved management of contraceptive side-effect cases, thereby reducing the drop-out rate. The SCs have been routinely observed by the female ICDDR,B field staff. Observational data of 16 SCs from four LLP unions and 24 SCs from the non-LLP unions were used for comparing the fieldworker's attendance at the SC in the management of contraceptive side-effects (Table 2).

**Table 2.** Percentage of attendance of FWV and FWA and the number of side-effect management cases referred to and treated at SC

Items monitored	Mirsarai				Abhoynagar			
	LLP (n=4)		Non-LLP (n=4)		LLP (n=4)		Non-LLP (n=4)	
	Dec 1994	Apr 1996	Dec 1994	Apr 1996	Dec 1994	Apr 1996	Dec 1994	Apr 1996
Attendance of FWV	35	85	30	40	70	90	70	70
FWA	50	100	40	70	90	100	85	80
<b>Total side-effect cases</b>								
Referred	5	18	5	10	18	24	15	16
Treated	1	18	2	5	16	24	12	10

**Note:** 10 SCs were observed in the LLP unions and the non-LLP unions from each of Mirsarai and Abhoynagar thanas

The data have been extracted from the SC checklist, since no baseline data were available.

### Supervision

Studies on the FPIs highlighted the inadequacy of field visits, but there was no explicit discussion on the content of FPIs visit to the FWAs. Ashraf *et al.*, 1996 [8] identified the importance of adequate field visitation, but noted that the FPIs lacked the tools they needed to do their jobs, i.e., they were not sure about what needed to be accomplished when they go to the field; they were also not sure about the type of assistance to be provided to the FWAs; and what the FWAs were required to do when they are not performing their responsibilities in the field. Training on supportive supervision can remedy this. Thus, the Extension Project organized training on supervision for all

FPIs to address the above issues. Unscheduled observation of all FPIs showed that the presence of the FPI and FWA in the field had increased, FPIs were talking with the couples, the FWA register was being checked, and attempts were being made to look for the FWAs elsewhere in cases where the FWA was absent in the field. There have been some improvements at both the LLP and non-LLP unions (Table 3).

**Table 3.** Observation of field activities

Field activities	Mirsarai				Abhoynagar			
	1994		1995-1996		1993		1995-1996	
	LLP	NLLP	LLP	NLLP	LLP	NLLP	LLP	NLLP
FPI present in field	40	35	80	60	63	40	70	51
Diary carried in field	NA	NA	10	80	70	40	90	65
FWA present in field	25	30	0	40	70	60	87	70
Talked to couple	14	10	65	22	70	70	80	70
Looked for FWA elsewhere	12	15	40	32	63	63	88	75
Checked FWA Register	32	8	60	40	63	55	80	55

NA= *Not available*

These data should be interpreted carefully, since some biases may have been introduced due to the presence of an ICDDR,B observer. While there appears to have been improvement, practice has been initiated though not institutionalized. Supervisory visits by the thana officials have improved performance in this regard.

## Meetings

One of the main components of performance planning was to make sure that the mandated meetings were held both at the H&FWC and thana level.

Systematic holding of meetings at the H&FWC level can ensure the monitoring of data. A distinct improvement was visible at Mirsarai in terms of topics covered at the meeting and the average duration of each meeting (Table 4).

**Table 4.** Observation of meetings at Mirsarai

Activities	LLP (n = 26)	Non-LLP (n = 20)
Agenda prepared	100	30
Minutes read	100	20
Field problems discussed	64	40
Field problems resolved	64	35
Performance reviewed	74	30
FWA Register checked	82	60
FWA questioned	58	20
FWA appreciated	58	30
SC issue discussed	62	30
Supply issue discussed	34	0
Attendance of thana officials	25	10
Average duration	153 minutes	106 minutes

There are major differences between the LLP and Non-LLP unions. The Project's experience demonstrates that improvements can be made gradually with little inputs from an external agency.

The situation in Abhoynagar is much better than Mirsarai because of its long involvement in the process of local-level planning as can be seen in Table 5.

**Table 5.** Observation of meetings at Abhoynagar

Activities	LLP (n = 25)	Non-LLP (n = 16)
Agenda prepared	100	65
Minutes read	100	60
Field problems discussed	90	50
Field problems resolved	52	36
Performance reviewed	64	14
FWA Register checked	52	36
FWA questioned	40	29
FWA appreciated	52	29
SC issue discussed	52	36
Supply issue discussed	33	11
Attendance of thana officials	16	14
Average duration	210 minutes	170 minutes

Because of the extended presence of the Extension Project at Abhoynagar, the meetings in the LLP and non-LLP unions were routinely held. Problems were discussed and the possible solutions were recommended. The number of six-month micro plans developed in the meeting, problems identified and solutions developed are shown in Table 6. Table 7 shows the category of problems identified by the FWAs in Mirsarai. Identification of less problems by the FWAs indicate improvements in resolving some of the problems.

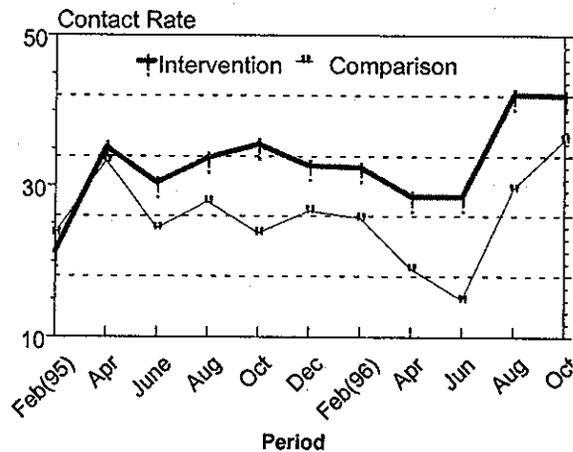
**Table 6.** Number of micro-plans, identification of problems and development of solutions during January 1995 - December 1996

	Mirsarai	Abhoynagar
Number of micro-plans developed	8	8
Number of problems identified	33	28
Number of problems resolved	24	21
Number of problems continued	9	7

**Table 7. Major problems identified by FWA**

Field workers in Mirsarai intervention area	No. of FWAs identified as problems	
	Jan 1995	Dec 1995
Field workers are irregular	11	5
Poor side-effect management by FWV	11	6
Poor supervision	8	1
Objection by husband/in-laws in accepting contraceptive methods	8	2
Fear about CuT and sterilization	8	1
Irregularity in holding H&FWC and Satellite Clinics	5	2
Lack of knowledge in the community about family planning methods	5	3
Poor motivation skills of workers	3	1
Number of satellite clinics is not enough	3	1
Poor communication between hostile husbands and FPI	1	-
Worker is afraid to visit hill areas	1	1
HA takes money for TT	1	1
FWA spends money to bring sterilization clients	1	1

The contact rate was frequently used as an indicator of the extent of FWA visit. The bi-monthly contact rate as followed in the intervention unions of Mirsarai increased from 14 percent in February 1995 to 40 percent in August 1996, while the rate in the comparison unions rose from 24 percent in February 1995 to 30 percent in October 1996, (Fig.1).



**Fig.1.** Contact rate by FWA at Mirsarai

Source: SRS-MIS (Form 2)

The contact rate shown in Fig. 2 in the intervention unions of Abhoynagar fell sharply over the period for reasons beyond the control of the Project. Long leave, taken by the TFPO and Senior FWV for medical reasons, and severe conflict between the technical and non-technical personnel, along with a "go slow" programme aggravated the field situation and may be assumed to have influenced the contact rate. The Senior FWV of both the field sites often did not visit the field due to their "chronic sickness" as reported by them. Therefore, Senior FWV checklist was not always reviewed in the thana-level meeting. Steps could not be taken to improve the situation by the thana Managers. Political unrest throughout the country also caused a wide variation in the contact rate in both the areas. The contact rate is shown in Fig. 3. The comparison areas also fell in December 1996.

A major focus of the intervention was to ensure that the FPI make a sample check of data reported at the end of the year. The quality of data reported by the service providers has improved in the LLP unions. This improvement was due to the reduction of gap between service and survey statistics in the LLP and non-LLP unions. The CPR gap between survey and service statistics in 1994 was 20 percentage points, while this figure was reduced by about one half in 1996 (Fig. 4). In the Mirsarai comparison area, the CPR gap was 26 percentage points in 1994,

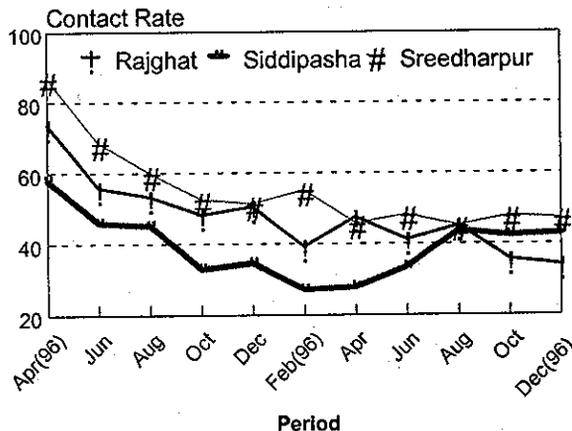


Fig.2. Contact rate by FWA in the intervention area  
Source: SRS-MIS (Form 2)

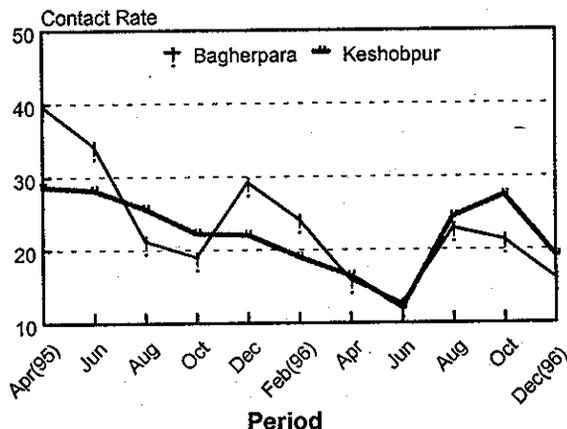


Fig. 3. Contact rate by FWA in the comparison area  
Source: SRS-MIS (Form 2)

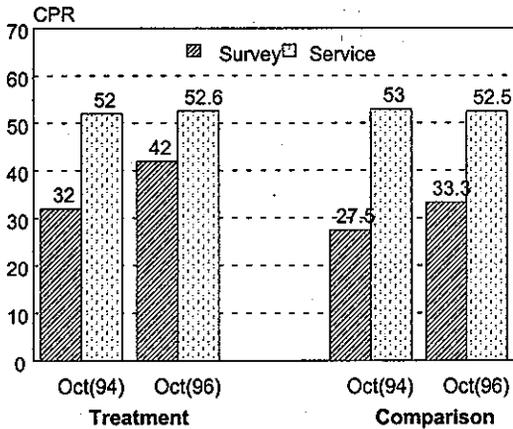


Fig.4. Gaps between service and survey statistics in treatment and comparison area, Mirsarai

Source: SRS-MIS (Form 2)

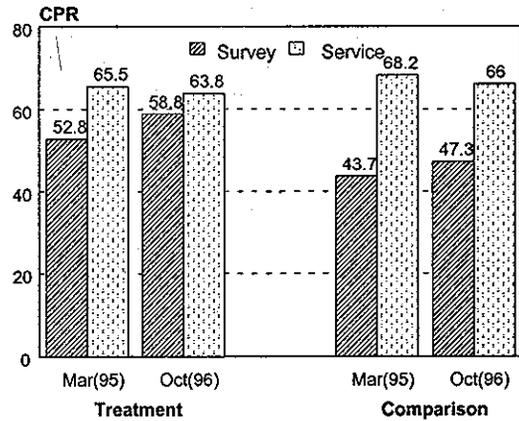


Fig 5. Gaps between service and survey statistics in treatment and comparison area, Abhoynagar

Source: SRS-MIS (Form 2)

while it was about 19 points in 1996. In Abhoynagar, the CPR gap was about 13 percentage points in 1995, but only seven percentage points in 1996, (Fig. 5). In the comparison area, the gaps were 25 percentage points and 19 percentage points for the years 1995 and 1996 respectively. This clearly shows an improvement in the quality of data recording and reporting in the LLP areas.

## Discussion, Conclusions, and Policy Implications

Despite wide advocacy for local-level planning in the national family planning programme, the institutionalization of the process has not been adequately enforced. The process involves a clear understanding of the various steps necessary for effective management, including adequate supervisory skills and ability to understand and interpret data in the form of indicators.

The performance data reported by the fieldworkers to be examined should not be limited to CAR, but should also include method-specific CAR, and the overall fieldworker performance weighted against the individual fieldworker's performance. Moreover, meetings can be used for soliciting more information from the fieldworkers regarding barriers to optimal performance, and methods that could be used for overcoming these barriers successfully. This setting could also be used for the supervisors and managers to volunteer their knowledge and assistance.

During the intervention, it became clear that the union-level supervisors and thana managers had the capacity to understand the indicators and use them in their

own organizational environment. The FPIs are the key persons to ensure routine implementation. Thus, with some training on the practical aspects of supervision, a significant improvement could be made in the contact rate and quality of data. The FPI Diary has demonstrated potential in guiding the FPIs in the field. A planning activity format, which can be completed by the workers together with their supervisors, must be pursued and the current reporting format (MIS-2) should be modified, so that it is more relevant and is easy to understand. A manual, showing how to develop plans, and how to complete the activity formats with appropriate indicators, is a useful instrument for the managers and the supervisors. Systematically organized regular meetings at the union and thana levels help identify the problems and develop solutions. The supervisors and the paramedics can also use HFWC meetings as a forum for continued training for improving the quality of services and develop a closer link with them. Systematic training of the FPIs on the use of data improves the use of services of workers and facilities as well as the quality of information.

The most critical responsibilities, however, lie on the shoulders of the thana managers. The experiment warrants a continuous higher-level support and modification of the existing district-level meeting process to address the problems effectively which were identified at the thana and which require higher level solutions.

## References

1. Ministry of Health and Population Control (MHPC). Bangladesh Contraceptive Prevalence Survey, 1981. Dhaka: MHPC, 1983.
2. Mitra and Associates. Bangladesh demographic and health Survey 1996-1997 (preliminary report), 1997. Dhaka: National Institute of Population Research and Training (NIPORT) and Macro International .Inc. Calverton, Maryland, USA.
3. Barkat-e-Khuda, Barkat A, Hilali J, Miller P, Haaga J. Population policy in Bangladesh: a review of ten priority areas. Dhaka: University Research Corporation, Bangladesh, 1993.
4. Barkat-e-Khuda, Barkat A. The Bangladesh family planning programme: key programmatic challenges and priority action areas. Prepared for the International Conference on Population and Development Cairo. Dhaka: University Research Corporation, Bangladesh, 1994.
5. Tunon C, Maru RM, Haaga JG. Management issues and family planning performance in Chittagong division. Dhaka: MCH-FP Extension Project, International Centre for Diarrhoeal Disease Research, Bangladesh, 1992. (Working paper, 79).
7. Hasan Y, Maru RM. Performance improvement through local planning: findings from an action research project in Bangladesh, Dhaka: MCH-FP Extension Project, International Centre for Diarrhoeal Disease Research, Bangladesh, 1993. (Working paper, 89).
8. Ashraf A, Dunston AG, Hasan Y, Khuda B, Maru R. Strengthening front-line supervision to improve performance of family planning fieldworkers in Bangladesh. Dhaka: MCH-FP Extension Project, International Centre for Diarrhoeal Disease Research, Bangladesh, April 1996. (Working paper, 110).

## MCH-FP Extension Work at the Centre

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

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of 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, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

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 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 Operations 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.

---



**CENTRE**  
FOR HEALTH AND  
POPULATION RESEARCH

**Operations Research Project (ORP)**

**Health and Population Extension Division (HPED)**

International Centre for Diarrhoeal Disease Research, Bangladesh

GPO Box 128, Dhaka 1000, Bangladesh

Telephone: 871751-871760 (10 lines)

Fax: 880-2-871568 and 880-2-883116